Quality Payment
PROGRAM

Merit-based Incentive Payment System (MIPS)

2026 MIPS Value Pathways (MVPs) Implementation Guide

Table of Contents

Purpose:

This resource focuses on reporting Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs), providing practical information about MVP participation, reporting, scoring and preliminary registration information for the 2026 performance year.

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

What is the Quality Payment Program?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have resulted in a significant cut to Medicare payment rates for clinicians. MACRA advances a forward-looking, coordinated framework for clinicians to successfully participate in the QPP, which rewards value in 1 of 2 ways:

If you're a MIPS eligible clinician, you will be subject to a performance-based payment adjustment through MIPS.

If you participate in an Advanced APM and achieve QP status, you will be excluded from MIPS.

The Merit-based Incentive Payment System

If you're eligible for MIPS:

- You 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 for each performance year will be available in the Traditional MIPS Scoring Guide, APM Performance Pathway (APP) Scoring Guide, and MIPS Value Pathways Implementation Guide. These resources are updated annually and 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 you meet case minimum for any cost measures.

What Is The Merit-based Incentive Payment System? (Continued)

If you're eligible for MIPS (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 MIPS final score will determine whether you receive a negative, neutral, or positive MIPS payment adjustment.
  - **Positive payment adjustment** for clinicians with a final score **above** the performance threshold (**75 points** in 2026 – 2028 performance years).
  - **Neutral payment adjustment** for clinicians with a final score **equal to** the performance threshold (**75 points** in 2026 – 2028 performance years).
  - **Negative payment adjustment** for clinicians with a final score **below** the performance threshold (**75 points** in 2026 – 2028 performance years).

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

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.

Introduction

What's New with MVPs in 2026?

1

We finalized 6 new MVPs to be available for reporting in the CY 2026 performance period:

- Diagnostic Radiology
- Interventional Radiology
- Neuropsychology
- Pathology
- Podiatry
- Vascular Surgery

We also finalized modifications to the 21 previously finalized MVPs.

2

To register for MVP reporting as a group, a practice will need to attest to their specialty composition (whether you're a single specialty* group or multispecialty small practice** during the MVP registration process.

- We won't make this determination for you.
- Multispecialty groups with 16 of more clinicians won't be able to report an MVP as a group.

*Single specialty group – a single Taxpayer Identification Number (TIN) with one specialty or single focus of care regardless of practice size.

**Multispecialty small practice – a single TIN with two or more specialties or multiple foci of care and 15 or fewer clinicians.

Overview

MVPs are one reporting option that can be used to meet MIPS reporting requirements.

MVPs include a subset of measures and activities that are related to a given specialty or medical condition, allowing MVP participants to report on a smaller, more cohesive subset of measures and activities (within the measures and activities available for traditional MIPS).

MVPs also have enhanced performance feedback for participants, providing feedback for like clinicians reporting within the same MVP.

Each MVP candidate includes what is referred to as the foundational layer, which includes the Promoting Interoperability performance category measures and two population health measures. The foundational layer is the same for every MVP.

There are 27 MVPs currently finalized for the 2026 performance year.

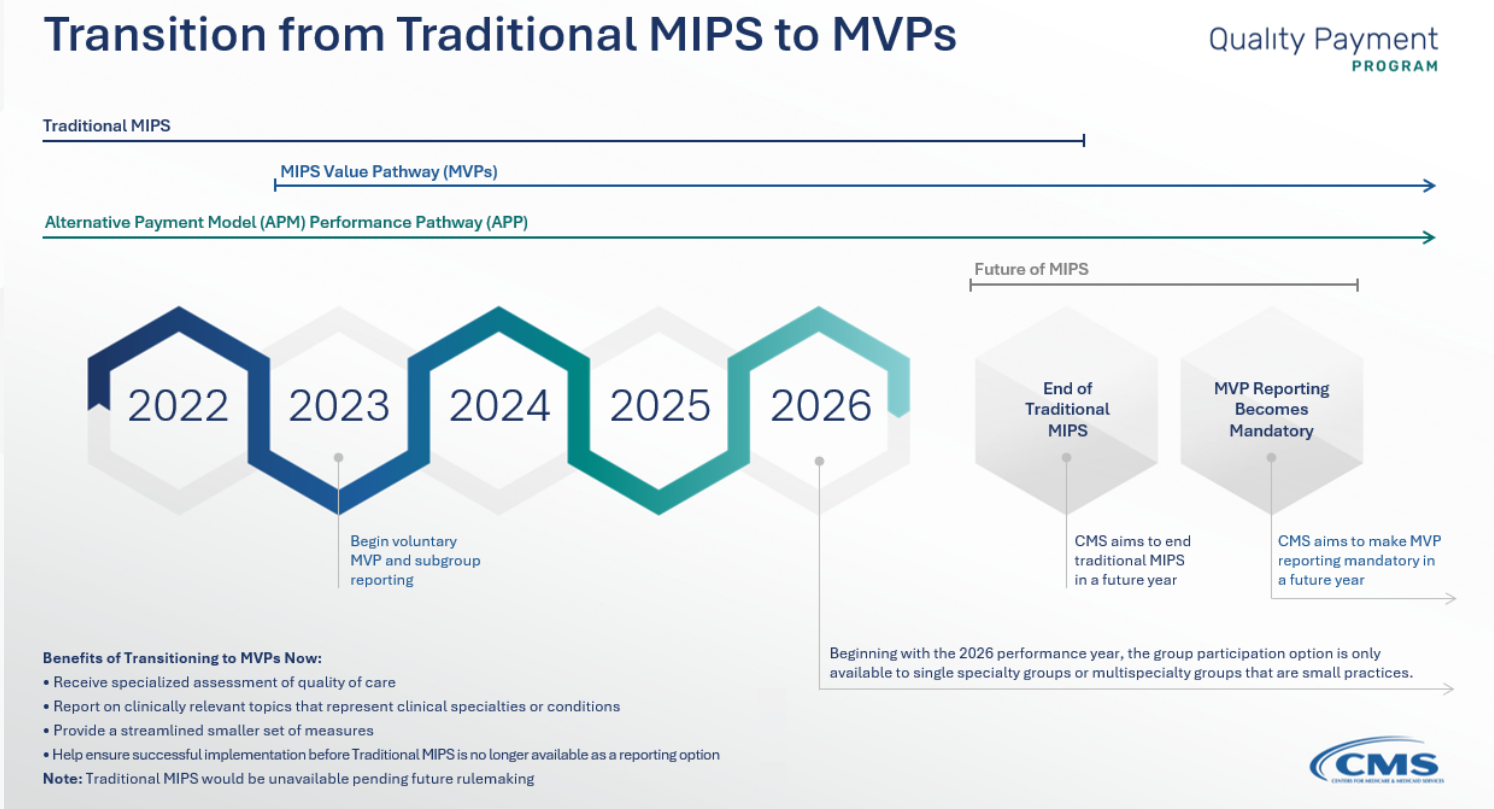
Visit Explore MVPs to find more information on the MVPs finalized for the 2026 performance year.

Don't see a relevant MVP for your scope of practice?

CMS will continue to expand MVPs to include more specialties and subspecialties that participate in MIPS through future rulemaking.

Clinicians also continue to have the option to report traditional MIPS or report the APM Performance Pathway (APP).

Overview (Continued)



The timeline for sunsetting traditional MIPS hasn't been finalized, but MVP reporting will become mandatory at some point in the future. Now is a good time to get started reporting MVPs to familiarize yourself with the requirements while participation is voluntary.

Participation

How to Decide if You Should Report an MVP?

Start by reviewing the MVPs finalized for the 2026 performance year.

- Review Explore MVPs (on the QPP website) for details about the quality measures, improvement activities, and cost measures available in each MVP.
  - MVPs include select measures and improvement activities available within the MIPS inventory that best align with a given specialty or medical condition.
  - The same Promoting Interoperability measures and population health measures are included in every MVP.
  - Each MVP also aligns with clinicians who practice as part of an identified specialty that may want to report that MVP. There are currently MVPs most applicable – but not limited – to the following specialties:

- Anesthesiology
- Behavioral Health
- Cardiology
- Cardiothoracic Surgery
- Certified Registered Nurse Anesthetists
- Chiropractic Medicine
- Dermatology
- Emergency Medicine
- Family Medicine
- Gastroenterology
- Geriatrics

- General Surgery
- General Urologists
- Gynecology
- Hematology
- Infectious Disease
- Internal Medicine
- Mental Health
- Midwife
- Nephrology
- Neurology
- Neurosurgery
- Nurse Practitioners

- Nonphysician Practitioners
- Obstetrics
- Occupational Therapy
- Oncology
- Ophthalmology
- Optometry
- Orthopedic Surgery
- Otolaryngology
- Physician Assistants
- Physical Therapy
- Physiatry

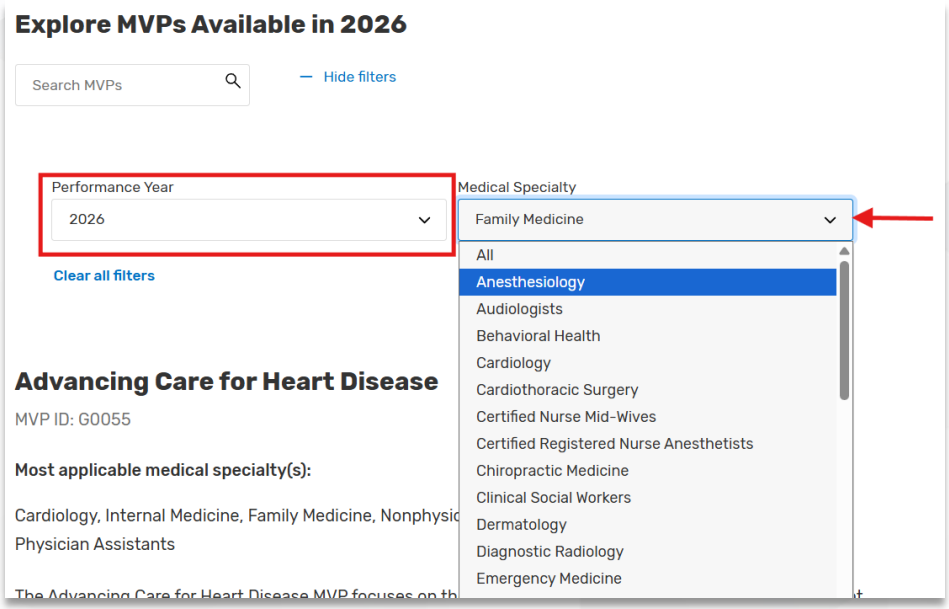
- Pulmonology
- Preventive Medicine
- Psychiatry
- Rheumatology
- Sleep Medicine
- Thoracic Surgery
- Urogynecology
- Urology
- Urology Oncologists
- Vascular Surgery

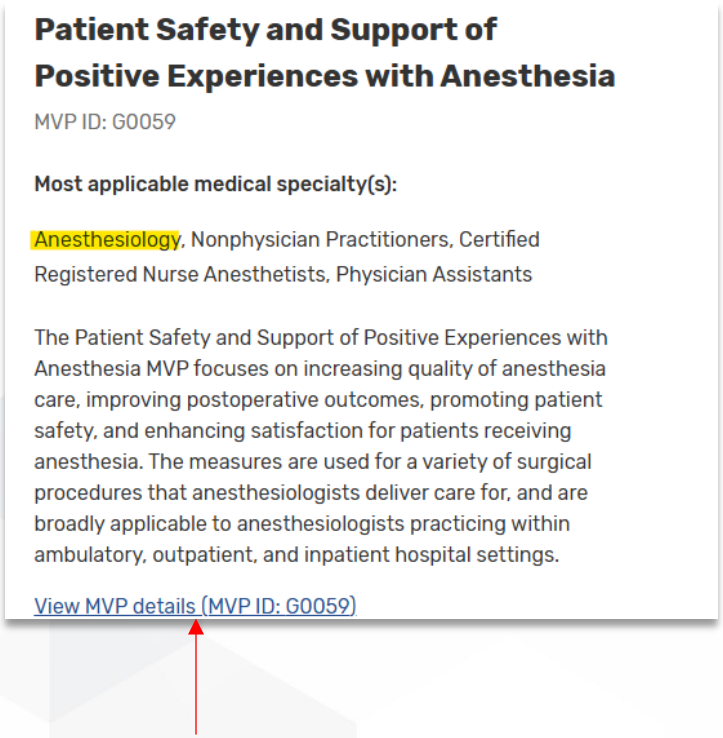
Find an MVP for Your Specialty

Each MVP aligns with clinicians who practice as part of an identified specialty that may want to report that MVP.

To find which MVPs may apply to your specialty, use Explore MVPs:
1) Select 2026 from the "Performance Year" drop down.
2) Select your specialty from the "Medical Specialty" drop down.

A list of MVPs that best align with the specialty will populate.





Click "View MVP details" to review the measures and activities included in each MVP.

If a clinically relevant MVP isn't available, you can still report traditional MIPS. Clinicians in a MIPS APM can also report the APM Performance Pathway (APP).

Participation Options for MVP Reporting for 2026

Individual Eligible Clinician

A single individual MIPS eligible clinician identified by their individual National Provider Identifier (NPI)'s association with a single TIN.

Group

A single TIN with the small practice special status (15 or fewer clinicians); or, a practice that consists of clinicians in one specialty type or clinicians involved in a single focus of care.

The group participation option is only available for small practices and single specialty groups.

Subgroup

A subset of a group (identified by a single TIN) which contains at least one MIPS eligible clinician. Each subgroup is assigned a subgroup identifier following registration, which is used to identify the subgroup's submission.

APM Entity

An entity that participates in an APM or other payer arrangement through a direct agreement with CMS or other payer or through Federal or State law or regulation.

Clinicians who are individually opt-in eligible or aren't eligible for MIPS, can't report an MVP as individuals. However, they can report an MVP as part of an eligible group or subgroup.

Virtual groups can't report an MVP for the 2026 performance year.

Learn more about MIPS participation options on the QPP website.

TIP: An MVP participant (defined as an individual clinician, single specialty group, multispecialty group that is also a small practice, subgroup, or APM Entity) can only select and report one MVP. However, an individual clinician can participate in multiple ways to report multiple MVPs. For example, an individual clinician may report an MVP as part of a group and report a different MVP as part of a subgroup. You're able to report MVPs **in addition** to traditional MIPS or the APP.

What Is a Subgroup?

A subgroup is a subset of clinicians from the same group (identified by Taxpayer Identification Number, or TIN).

A subgroup must include:	A subgroup may NOT include:	A subgroup may include:
✓ At least 2 clinicians. ✓ At least 1 individually eligible MIPS eligible clinician (based on initial – not final – MIPS eligibility results).	× A clinician from a different TIN. × A clinician participating in a different subgroup under the same TIN. • You may only report in one subgroup per TIN/NPI (National Provider Identifier) combination.	✓ Clinicians who are opt-in eligible at the individual level ✓ Clinicians who are MIPS eligible at the group level (these clinicians may be exempt from MIPs as individuals but eligible at the group level)

Additional Requirements:

- The affiliated **group (TIN) must exceed the low-volume threshold** at the group level.
  - Clinicians in an opt-in eligible group may not form a subgroup

Subgroups **won't** be evaluated for the low-volume threshold or special statuses at the subgroup level. They inherit eligibility and special statuses from their affiliated group.

Learn more:

For more information about participation and eligibility and the low-volume threshold and special statuses, refer to:

- MIPS Eligibility and Participation User Guide (once available)
- MIPS Eligibility Determination and Low-Volume Threshold Information
- Special Status Information

Did You Know?

An individual clinician affiliated with multiple practices (TINs) can participate in one subgroup per TIN/NPI combination.

How Do Subgroups Collect and Report Data?

Data is collected at **both** the subgroup and group level for subgroup participation:

Subgroup level

- ✓ **Quality measures** must be collected and reported at the subgroup level, which means the subgroup must be able to submit aggregated measure data limited to the clinicians in the subgroup.
  - **Exception:** Any measure calculated through administrative claims (including population health measures) are calculated at the affiliated group level.
- ✓ **Improvement activities** must be performed by at least 50% of the clinicians in the subgroup.

Affiliated group level

- ✓ Subgroups will submit the aggregated **Promoting Interoperability** data of their affiliated group.
  - This data must be submitted separately from any Promoting Interoperability data submitted for the group (i.e., if the group is reporting traditional MIPS or a different MVP).
- ✓ **Cost measures** (and population health quality measures) don't require data submission as these measures are calculated from administrative claims; subgroups will be evaluated at the affiliate group level.
  - If the affiliated group can't be scored on any cost measures, we'll reweight the cost performance category for the subgroup.

Why Participate as a Subgroup?

Subgroup reporting can offer more meaningful data collection and feedback, particularly for clinicians in a large or multispecialty group. A large practice can form multiple subgroups and therefore report to more than one MVP based on clinical relevance.

Beginning in 2026, multispecialty groups (except multispecialty groups that meet the definition of a small practice) reporting MVPs won't be able to report an MVP as a group; instead, they'll be required to report as subgroups or individual MIPS eligible clinicians.

Examples of potential subgroups include:

1) A practice's cardiovascular service line, which includes cardiologists, cardiothoracic surgeons, and other associated professionals.
2) The west side practice, which uses one electronic health record (EHR) platform and collaborates on patient care across orthopedic surgeons, physical therapists, NPs, and other associated clinicians.

Learn more:

For more information about participation and eligibility and the low-volume threshold and special statuses, refer to:

- MIPS Eligibility and Participation User Guide (once available)
- MIPS Eligibility Determination Period
- Low-Volume Threshold Information
- Special Status Information

Third Party Intermediary Requirements

New for 2026: QCDRs and Qualified Registries must fully support a newly finalized MVP, if applicable to their clinicians, no later than one year after the MVP is finalized.

Third party intermediaries* (i.e., Qualified Clinical Data Registries (QCDRs) and Qualified Registries) that support MVPs:

- Must identify and support MVPs that are relevant to the clinicians and groups they support. (They don't need to support all MVPs.)
- Must support the measures and activities within a relevant MVP that are applicable to the clinicians they support but aren't required to support all collection types for a given measure.
  - If an MVP includes several specialties, then the QCDR or Qualified Registry is only expected to support the measures that are pertinent to the specialty of their clinicians.
  - **Note:** Only QCDRs that have been given permission to borrow a QCDR measure can support the QCDR measures within an MVP.
  - Cost and population health measures are collected through administrative claims data and don't require external data submission support.
- Must support subgroup reporting.
  - This requirement also applies to CMS-approved Consumer Assessment of Healthcare Providers & Systems (CAHPS) for MIPS Survey vendors who must support subgroups administering the CAHPS for MIPS Survey measure as part of their MVP reporting.

* Please note that we've eliminated the health information technology (IT) vendor category of third party intermediaries beginning with the 2025 performance year.

Registration

How to Register to Report an MVP

To report an MVP for the 2026 performance year, you must register between April 1 and November 30, 2026. If you're administering the CAHPS for MIPS Survey measure associated with an MVP, you must complete your MVP and a separate CAHPS for MIPS registration by June 30, 2026.

- You'll register on the QPP website.
- You must have the QPP Security Official Role to complete an MVP registration.
- More information about the MVP registration process is available in the 2026 MVP Registration Guide.
- You can learn more about CAHPS for MIPS Survey registration on the QPP website.

You can make changes to your MVP registration throughout the registration window, until it closes on November 30, 2026, but can't change your CAHPS for MIPS Survey registration after June 30, 2026.

- You can't make changes to the MVP selection or subgroup registration after the registration window has closed.
- You can still report through traditional MIPS or the APP even if you have registered for an MVP.
- You can't report an MVP that you didn't register for during the MVP registration period.

If you complete an MVP registration but don't ultimately report the MVP, you'll receive the highest final score that can be attributed to you from any reporting option and participation option, with the exception of virtual groups.

How to Register to Report an MVP (Continued)

At the time of registration, all MVP participants (individuals, groups, subgroups, and APM Entities) will select:

One MVP to report **AND** Any outcomes-based administrative claims measure (if applicable) that you'd like to report as 1 of your 4 required measures for the quality performance category.

Groups. Beginning with the 2026 performance year, the MVP group participation option is only available to single specialty groups or multispecialty groups that are also small practices. In addition to the information above, you must also attest to your group's specialty composition.

Attest to being a single specialty group means a group that consists of clinicians in one specialty type or a single focus of care regardless of practice size. **OR** Attest to being a multispecialty small practice (two or more specialties or multiple foci of care and 15 or fewer clinicians).

Subgroups. In addition to the information above, you must also provide the following information to register to report an MVP as a subgroup:

A list of clinicians (NPIs) to be included in the subgroup (at least 2 clinicians, with at least one individually eligible MIPS eligible clinician) **AND** Plain language name for the subgroup for public reporting on Care Compare **AND** Description of the composition of the subgroup.

Upon successful subgroup registration, we'll assign a unique subgroup identifier. This will be separate from the individual NPI identifier, the group TIN identifier, and the MVP identifier.

Performance Year 2026 MVP Registration Timeline

April 1, 2026

MVP registration opens
April 1, 2026

June 30, 2026

MVP and CAHPS registration deadline for those reporting the CAHPS for MIPS Survey

- To report the CAHPS for MIPS Survey as part of an MVP, you must complete your MVP. registration by 8 p.m. on June 30, 2026, to align with the CAHPS for MIPS registration deadline.
- You must separately register to participate in the CAHPS for MIPS Survey.

November 30, 2026

MVP registration deadline for those not reporting the CAHPS for MIPS Survey

- Registration closes at 8 p.m. ET, November 30, 2026.

Can we register and then become ineligible for reporting the MVP we registered for?

Yes, if you register to report an MVP as an individual or group*. You can't voluntarily report or opt-in to MVP reporting; you must be MIPS eligible to report an MVP.

Eligibility timeline:

- Initial 2026 MIPS eligibility was available in December 2025, before the 2026 MVP registration period.
- Final 2026 eligibility will be available by early December 2026.

Just as with traditional MIPS, individuals and groups that register for an MVP must confirm their final eligibility for the 2026 performance year when it's published on the QPP Participation Status tool.

An individual (identified by TIN/NPI combination) or group (identified by TIN) that becomes ineligible or opt-in eligible when final eligibility is released can't report the MVP they registered for.

Instead, they can:

1. Voluntarily report traditional MIPS.
2. Opt-in to traditional MIPS reporting (if applicable).
3. Do nothing/don't report. (Ineligible and opt-in eligible clinicians and groups aren't required to report.)

***Please note that this doesn't apply to subgroups.** We only use initial eligibility results to determine a subgroup's eligibility to register for and report an MVP (83 FR 70043). If the subgroup's affiliated group becomes ineligible, or opt-in eligible, when final eligibility is released, the subgroup can still report the MVP for which they registered. If the subgroup reports, the MIPS eligible clinicians in the subgroup will receive the associated payment adjustment.

Where can I learn more about eligibility?

You can learn more about eligibility and how it can change by reviewing the QPP website and the 2026 MIPS Eligibility and Participation User Guide.

Reporting Requirements

Overview

MVPs have reduced reporting requirements in comparison to traditional MIPS and include quality and cost measures and improvement activities that are specific to a given specialty or medical condition.

Each MVP also includes the foundational layer, comprised of Promoting Interoperability measures and population health measures.

Refer to Explore MVPs to see the list of measures and activities available for reporting within each MVP for the 2026 performance year.

Review your patient population to ensure you'll be able to meet the case minimum on the quality measures you choose to report within the MVP.

Quality Performance Category

Select and report **4 quality measures** from your chosen MVP, including 1 outcome measure*.

- If no outcome measure is available or applicable, or you're unable to meet the case minimum requirements for any of the outcome measures available in the MVP, you may report a high priority measure.
- The 4 required quality measures don't include the required population health measures evaluated as part of the foundational layer.

*If available in an MVP, you may choose to include an outcome measure calculated by CMS through administrative claims.

Example: You can select Measure 480: Risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) for MIPS measure as 1 of your 4 required measures for the Improving Care for Lower Extremity Joint Repair MVP.

TIPS

- Before selecting an outcomes-based administrative claims measure as 1 of your 4 required measures, make sure your patient population will allow you to meet the case minimum; if not, you will receive 0 achievement points for the measure.
  - **Exception for small practices** who will continue to earn 3 points for these measures.
- Similar to traditional MIPS, if you report more than the required quality measures, we'll select the highest scoring measures (starting with the highest scoring outcome measure) to fulfill your reporting requirements.
- Similar to traditional MIPS, you can report your quality measures through multiple submission formats (e.g., JSON and QRDA III files).

You can review the measures (and their detailed measure specifications) included in each MVP on the Explore MVPs page of the QPP website.

Quality Performance Category (Continued)

Measure Collection Types:

Electronic Clinical Quality Measures (eCQMs)

- Requires 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.
  - A CEHRT ID is now required when submitting eCQM data for the quality performance category.

MIPS Clinical Quality Measures (MIPS CQMs)

- Often collected by third party intermediaries and submitted on behalf of MIPS eligible clinicians.
- Can be submitted directly by clinicians.

QCDR Measures

- Specialized measures developed by QCDRs.
- Can only be reported by QCDRs licensed to report the measure.

Medicare Part B Claims Measures

- Only available to small practices with 15 or fewer clinicians.

CAHPS for MIPS Survey Measure

- Only available to groups, subgroups, and APM Entities that register by June 30, 2026.

Administrative Claims Measures

- Calculated automatically by CMS from Medicare claims.

Collection Type refers to the way you collect data for a MIPS quality measure.

While an individual MIPS quality measure may be collected in multiple ways, each collection type has its own specification (instructions) for reporting that measure.

You'll follow the measure specifications that correspond with how you choose to collect your quality data.

Learn more about collection types by reviewing the Quality Performance Category: Learning about Collection types fact sheet (PDF, 493KB).

Small Practices Reporting Quality Measures through Medicare Part B Claims: if your selected MVP has fewer than 4 Medicare Part B claims measures available in the MVP, you don't need to report additional measures to meet quality reporting requirements.

Quality Performance Category (Continued)

Population Health Measures

- We'll calculate both population health measures (if you meet the case minimum) and assign the higher of these measures to your quality score. (You won't be scored on both measures, even if you meet case minimum for both.)
- The population health measure doesn't count as 1 of the required 4 quality measures but will be included in your score for the quality performance category.
- We calculate the population health measures for you using administrative claims data; no data submission is required.

Measure 479: Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System (MIPS) Groups

OR

Measure 484: Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions

If neither of the population health measures can be calculated, we'll exclude them from scoring.

Improvement Activities Performance Category

To meet MVP reporting requirements, all MVP participants, including small practices, must attest to 1 improvement activity from those available within the selected MVP.

- Attestation to IA_PCMH: Electronic submission of Patient Centered Medical Home or Comparable Specialty accreditation results in an improvement activity score of 100 percent.

While you don't have to submit any supporting documentation when you attest to completing an improvement activity, you must keep documentation of the efforts you undertook to meet the improvement activity for 6 years following data attestation.

Documentation guidance for each improvement activity can be found in the 2026 Improvement Activities Inventory (ZIP, 464KB).

Cost Performance Category

You don't have to submit any data for this performance category, just as in traditional MIPS.

- We use Medicare claims data to calculate your cost measure performance.
- Each MVP includes cost measures that are relevant and applicable to the MVP clinical specialty or medical condition.
- We'll calculate performance exclusively on the cost measures that are included in the selected MVP using administrative claims data, even if additional cost measures (outside your selected MVP) are available for scoring.
  - If you don't meet the case minimum for any of the cost measures in your selected MVP, we'll reweight the cost performance category to 0%.

Promoting Interoperability Performance Category

Promoting Interoperability Performance Category

You must use electronic health record (EHR) technology certified to the Office of the National Coordinator for Health Information Technology (ONC) Certification Criteria for Health Information Technology (at 45 CFR 170.315). The same Promoting Interoperability measures and attestations are required for traditional MIPS, MVPs, and the APP.

- The list of Promoting Interoperability measures, and their specifications, are available on Explore MVPs.

You must collect data for the required measures in your certified electronic health record technology (CEHRT) for a minimum of 180 continuous days during the calendar year.

Subgroup Reporting (Promoting Interoperability)

If you're reporting an MVP as a subgroup, you'll submit your affiliated group's data for the Promoting Interoperability performance category. This submission is separate from any Promoting Interoperability data reported by the group.

APM Entity Reporting (Promoting Interoperability)

If you're reporting an MVP as an APM Entity, you can choose to report Promoting Interoperability data at the individual, group, virtual group, or APM Entity level.

- When reporting at the individual and/or group level by the MIPS eligible clinicians in the APM Entity, the APM Entity will receive a score based on the weighted average of the data submitted, just as in traditional MIPS.

Promoting Interoperability Performance Category (Continued)

Promoting Interoperability Reweighting

Just as in traditional MIPS, you qualify for reweighting of the Promoting Interoperability performance category if you:

Have a **certain special status** (automatic reweighting)

OR

Have an **approved** MIPS Promoting Interoperability Performance Category **Hardship Exception**

Special Status:

- Small Practice
- Ambulatory Surgical Center (ASC)-based
- Hospital-based
- Non-patient Facing

Small Practices:

- We will automatically reweight the Promoting Interoperability performance category to 0% for small practices. You aren't required to report Promoting Interoperability data or submit a Promoting Interoperability Hardship Exception application.
- When Promoting Interoperability is reweighted, there's a different redistribution policy specifically for small practices: quality performance category 40%, cost performance category 30%, improvement activities performance category 30%, Promoting Interoperability performance category 0%.

Subgroups:

- You'll inherit reweighting from your affiliated group. For example, if your affiliated group has the non-patient facing special status, your subgroup also qualifies for automatic reweighting of Promoting Interoperability.

Groups qualify for automatic reweighting when the group has one of the special statuses above or when 100% of the MIPS eligible clinicians in the group qualify for reweighting as individuals for any combination of reasons.

A submission meeting the minimum criteria for a qualifying data submission (performance data and applicable exclusions for required measures, required attestations, CEHRT ID, and performance period dates) will override reweighting and you'll receive a Promoting Interoperability score. A partial submission that doesn't meet the minimum criteria for a qualifying data submission won't be scored and won't override previously approved reweighting.

Promoting Interoperability Performance Category (Continued)

Promoting Interoperability Hardship Exception Application

When reporting an MVP, you may submit a MIPS Promoting Interoperability Performance Category Hardship Exception application if any of the following reasons apply to you during the performance year:

- You're using EHR technology decertified under the ONC Health IT Certification Program.
- You have insufficient internet connectivity.
- You experienced an extreme and uncontrollable circumstance.
- You lack control over the availability of CEHRT.

APM Entities who choose to report an MVP **can't** submit a Promoting Interoperability Hardship Exception at the APM Entity level.

Subgroups can't submit a Promoting Interoperability Hardship Exception at the subgroup level but will inherit any reweighting approved for their affiliated group.

If your Promoting Interoperability Performance Category Hardship Exception request is approved, the Promoting Interoperability performance category will have a weight of 0% when calculating your MIPS final score. The category weight will be reallocated to another performance category or categories.

A submission meeting the minimum criteria for a qualifying data submission (performance data and applicable exclusions for required measures, required attestations, CEHRT ID, and performance period dates) will override reweighting and you'll receive a Promoting Interoperability score. A partial submission that doesn't meet the minimum criteria for a qualifying data submission won't be scored and won't override previously approved reweighting.

Data Submission

MVP Identifiers (IDs)

Each MVP submission must include the related MVP ID, signaling your intent to report the measure and activity data for your selected MVP.

Any data submitted without the necessary MVP ID will be attributed to traditional MIPS instead of the MVP.

Subgroup submissions must include their subgroup ID in addition to the MVP ID.

Small practices reporting Medicare Part B claims measures for an MVP:

- You must append the appropriate MVP ID to *at least one* Medicare Part B claim that includes an applicable quality data code (QDC) for one of the quality measures in your selected MVP.
- The MVP ID only needs to be reported once during the performance period to attribute your quality measures to the MVP.
    - If you don't append the MVP ID to at least one claim, your Medicare Part B claims measures will be attributed to a quality score in traditional MIPS (and not the MVP).
- Review the 2026 Part B Claims Quality Measure Reporting Quick Start Guide (PDF, 2MB) for more information.

MVP participants manually attesting to improvement activities and/or Promoting Interoperability data: ~~during the submission period:~~

- You'll indicate your MVP reporting option when you sign in to manually report your data during the submission period.
- More information will be available in data submission resources available in late December 2026.

MVP Identifiers (IDs) (Continued)

Each MVP submission must include the related MVP ID, signaling your intent to report the measure and activity data for your selected MVP.

Any data submitted without the necessary MVP ID will be attributed to traditional MIPS instead of the MVP.

Subgroup submissions must include their subgroup ID in addition to the MVP ID.

MVP participants (individuals, groups, subgroups and APM Entities) and third party intermediaries uploading files.

- You must include the appropriate MVP ID in every file you upload that includes MVP measure and/or activity data during the submission period.
  - If you upload a file without the MVP ID, that data will be attributed to and scored in traditional MIPS (not the MVP).
  - Review the 2026 QRDA III Implementation Guide for Eligible Clinicians on the Electronic Clinical Quality Improvement (eCQI) Resource Center for more information about including an MVP ID in your QRDA III file submission.
  - Review the QPP JSON Developer documentation for more information about including an MVP ID in your QPP JavaScript Object Notation (JSON) file submission.

Third party intermediaries submitting data via the QPP Application Programming Interface (API):

You must include the appropriate MVP ID in every submission that includes MVP measure and/or activity data.

- If you submit data without the MVP ID, that data will be attributed to and scored in traditional MIPS (not the MVP).
- Review the QPP JSON Developer documentation for more information about including an MVP ID in your QPP JSON file submission.

MVP Identifiers (IDs) (Continued)

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
G0059	Patient Safety and Support of Positive Experiences with Anesthesia
M0004	Quality Care for Patients with Neurological Conditions
M0005	Value in Primary Care

MVP Identifiers (IDs) (Continued)

MVP ID	MVP Title
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
M1420	Complete Ophthalmologic Care
M1421	Dermatological Care
M1422	Gastroenterology Care
M1423	Optimal Care for Patients with Urologic Conditions
M1424	Pulmonology Care
M1425	Surgical Care

MVP Identifiers (IDs) (Continued)

MVP ID	MVP Title
M1498	Diagnostic Radiology
M1499	Interventional Radiology
M1500	Neuropsychology
M1501	Pathology
M1502	Podiatry
M1503	Vascular Surgery

Scoring

Quality Performance Category Scoring

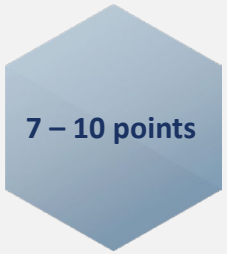
These policies apply to both MVP and traditional MIPS reporting unless otherwise noted:

Measure Achievement Points for the 2026 Performance Period

Measures that can be reliably scored against a benchmark

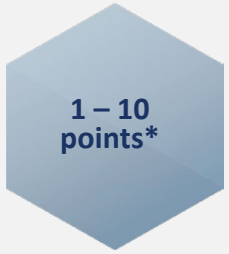
Measure achievement points are based on your performance for a measure in comparison to a benchmark. A measure can be reliably scored against a benchmark when:

- A benchmark (historical or performance period) is available.
- Data completeness and case minimum criteria are met.



You'll earn 7 – 10 points for new measures in their **first year** of the program that can be reliably scored against a benchmark.

You'll earn 5 – 10 points for new measures in their **second year** of the program that can be reliably scored against a benchmark.



You'll earn 1 – 10 points for measures in their **third year** (or later) of the program that can be reliably scored against a benchmark.

Did you know?
These measure scoring policies **do** apply to QCDR measures, but **don't** apply to administrative claims measures.

***Exception:** There are specified, topped out measures that are capped at 7 points. (These measures are identified in Column V of the 2026 Quality Benchmarks file.)

Quality Performance Category Scoring (Continued)

DID YOU KNOW?

There's a **single benchmark for scoring each quality measure** (specific to collection type), whether it's being reported for an MVP, traditional MIPS, or the APM Performance Pathway.

Let's look at an example.

Measure 236 (Controlling High Blood Pressure) can be reported as part of:

- Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes MVP
- Optimal Care for Kidney Health MVP
- Value in Primary Care MVP
- Traditional MIPS
- APM Performance Pathway (APP) and APP Plus

Everyone reporting this measure – whether for any of these 3 MVPs, traditional MIPS, or the APP – will be scored against the same benchmark identified in the 2026 Quality Benchmarks file (or calculated based on performance period data) for their selected collection type.

- Clinicians reporting an MVP **will receive comparative feedback**, comparing their performance in each performance category to other clinicians reporting the same MVP.
- Clinicians reporting an MVP **won't be scored solely in comparison** to the other clinicians reporting that MVP.

Quality Performance Category Scoring (Continued)

These policies apply to both MVP and traditional MIPS reporting unless otherwise noted:

Measure Achievement Points for the 2026 Performance Period

Measures that can't be reliably scored

When a measure meets data completeness criteria but can't be reliably scored, it means either a benchmark (historical or performance period) is unavailable OR the measure didn't meet case minimum criteria.

7 points

You'll earn 7 points for new measures in their **first year** of the program that can't be reliably scored against a benchmark

5 points

You'll earn 5 points for new measures in their **second year** of the program that can't be reliably scored against a benchmark.

0 points

You'll earn 0 points for measures in their **third year** (or later) of the program that can't be reliably scored against a benchmark.

- This includes outcome-based administrative claims measures if available in the MVP and selected by the MVP participant unless they submit a different outcome measure.*

Small practices will continue to earn **3 points.**

Did you know?
These measure scoring policies **do** apply to QCDR measures, but **don't** apply to administrative claims measures.

***For subgroups:** If a subgroup selects an outcomes-based administrative claims measure as 1 of their 4 required measures, we'll evaluate them on it at the affiliated group level. If the affiliated group doesn't meet case minimum, the subgroup will receive 0 out of 10 points for the required outcome measure unless they report a different outcome measure, just like any other MVP participant.

Quality Performance Category Scoring (Continued)

These policies apply to both MVP and traditional MIPS reporting unless otherwise noted:

Measure Achievement Points for the 2026 Performance Period

Required but unreported measures

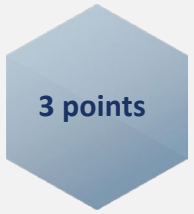
You'll continue to receive 0 points for measures that are required, but unreported. (You must report performance data for the measure to be considered reported.)

MVP-Specific Exception: Small practices reporting an MVP with fewer than 4 Medicare Part B claims measures are only required to report the available Medicare Part B claims measures in the MVP.

Measures that don't meet data completeness criteria

If you aren't in a small practice (small practices have 15 or fewer clinicians), you'll continue to receive 0 points for measures that don't meet data completeness requirements.

Note: This scoring policy also applies to measures in their first and second year of the program.



Small practices will continue to receive 3 points for measures that don't meet data completeness requirements.

Note: This scoring policy also applies to measures in their first and second year of the program.

Quality Performance Category Scoring (Continued)

Population Health Measure

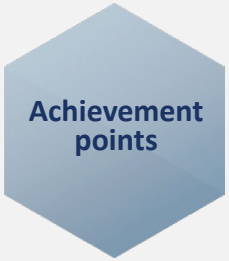
We'll evaluate you on both population health measures but will only assign the higher of these measures to your quality score.

- Population health measures (calculated automatically via administrative claims) can earn between 1 and 10 points based on comparison to a performance period benchmark.
- If you don't meet the case minimum or measure requirements for either population health measure, we'll exclude them from scoring.

Subgroups will be evaluated on the population health measures at the affiliated group level. If the affiliated group doesn't meet case minimum for the subgroup's population health measures, the measures will be excluded from the subgroup's quality performance category score.

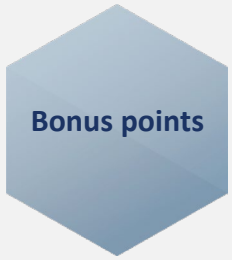
Quality Performance Category Scoring (Continued)

Just as in traditional MIPS, an MVP participant's quality performance category score may include:



Up to 10 achievement points for each quality measure, including the population health measure.

Note: The population health measure won't be scored if the MVP participant doesn't meet case minimum or if the measure doesn't have a benchmark.



6 bonus points for small practices.

1 point for each eCQM that meets data completeness and case minimum requirements submitted by an APM Entity (capped at 5 points for MVP reporting in 2026).

Up to 10 percentage points from quality improvement scoring.

If an MVP participant reports more than the required number of quality measures, we'll use the 4 measures with the highest measure achievement points, including an outcome measure or high priority measure if an outcome measure isn't available.

Quality Improvement Scoring

How is improvement scoring calculated?

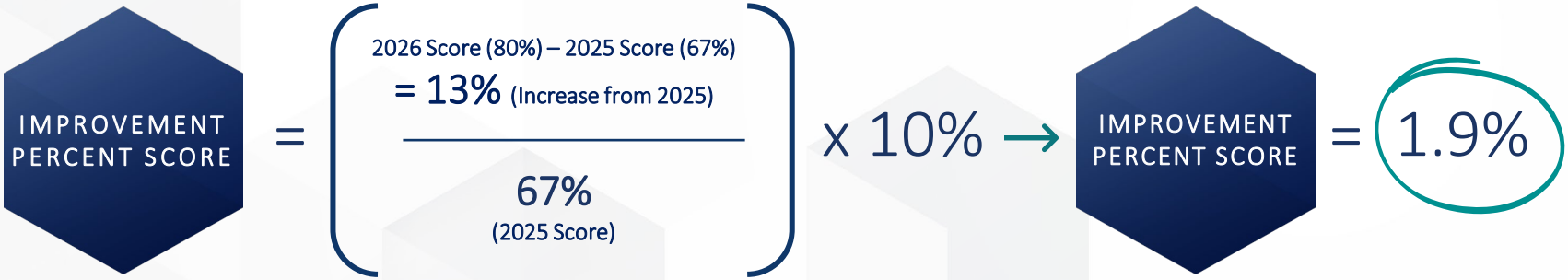
Improvement scoring is calculated by comparing the quality achievement percentage score from the previous (2025) performance period to the quality performance category achievement percentage score for the current (2026) performance period.

Quality Improvement Scoring Example

The following provides an example of how to calculate the improvement percent score.

For the **2025 performance period**, Dr. Johnson earned a quality performance category score of 67% (40 out of 60 measure achievement points*) in traditional MIPS.

For the **2026 performance period,** Dr. Johnson earned a quality performance category score of 80% (32 out of 40 measure achievement points*) reporting an MVP.



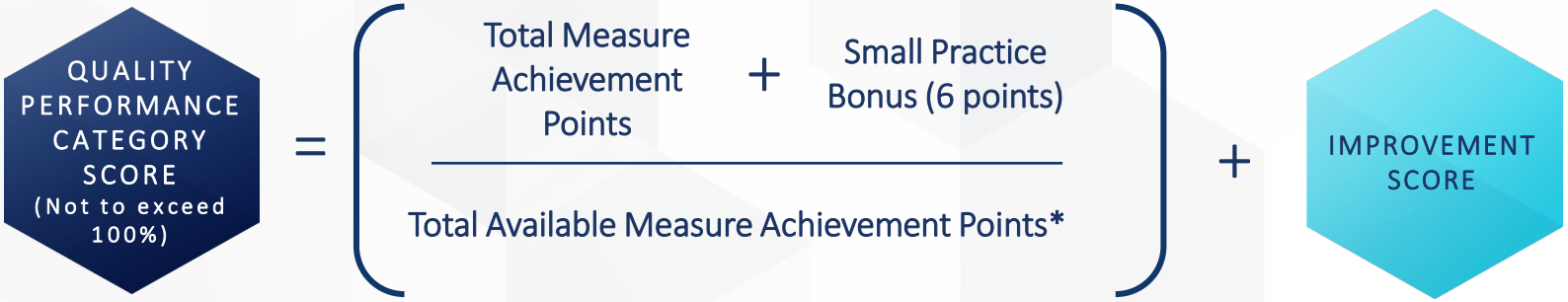
Note: The improvement percent score can't be negative and is capped at 10%.

*Total available measure achievement points = # of required measures x 10

Calculating the Quality Performance Category Score

For individuals, groups, subgroups, and APM entities that aren't a small practice, the quality performance category score is calculated as:

For individuals, groups, subgroups, and APM Entities that are part of **a small practice**, the quality performance category score is calculated as:

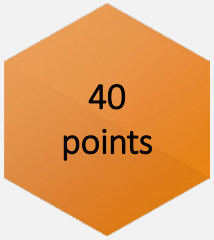


*Total Available Measure Achievement Points = the number of required measures x 10

Improvement Activities Performance Category Scoring

Unlike traditional MIPS, all MVP participants receive full credit (40 out of 40 points) in this performance category for attesting to one improvement activity included in the MVP.

There are no reduced reporting requirements for special status designations when reporting an MVP.



Each activity receives 40 points.
If you're a participant in a recognized or certified patient-centered medical home or comparable specialty practice, you'll earn the maximum improvement activity performance category score by attesting to IA_PCMH during the submission period.

Improvement Activities Performance Category Scoring

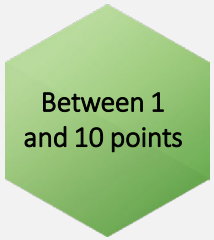
Clinicians, groups, subgroups, and APM Entities can earn a maximum of 40 points in the improvement activities performance category, though the number of points it contributes to your MIPS final score varies according to the performance category's weight.

The improvement activities score, like all performance categories, is capped at 100%.

How is My Improvement Activities Performance Category Score Calculated?

Cost Performance Category Scoring

This performance category will be scored in accordance with the policies established for traditional MIPS, though we'll only evaluate you on the cost measures included in your selected MVP.



You'll receive between 1 and 10 achievement points for each cost measure in the MVP that can be scored.

The number of points you earn is determined by comparing your performance to the measure's benchmark.

If you can't be scored on any cost measures in your selected MVP, this performance category will be reweighted to 0% and its weight redistributed in according with the policies established for traditional MIPS.

Subgroups will be evaluated on cost measures at the affiliated group level. If the affiliated group can't be scored on any of the cost measures, the subgroup's cost performance category will be reweighted to 0% and its weight will be redistributed to other performance categories, just like any other MVP participant.

Cost Performance Category Scoring (Continued)

DID YOU KNOW?

There's a ***single benchmark for scoring each cost measure***, whether it's being scored as part of an MVP or traditional MIPS scoring.

Let's look at an example.

The Heart Failure cost measure can be scored as part of:

- Advancing Care for Heart Disease MVP
- Value in Primary Care MVP
- Traditional MIPS

Everyone scored on this measure – whether for either of these 2 MVPs or traditional MIPS – will be scored against the same performance period benchmark.

- Clinicians reporting an MVP **will receive comparative feedback**, comparing their performance in each performance category to other clinicians reporting the same MVP.
- Clinicians reporting an MVP **won't be scored solely in comparison** to the other clinicians reporting that MVP.

How are MIPS Cost Measures Scored?

We finalized a change to our cost scoring methodology in the CY 2025 Medicare Physician Fee Schedule Final Rule. This change became effective beginning with the 2024 performance period, for cost scores provided in performance feedback in the summer of 2025.

The finalized cost scoring methodology is based on standard deviation, median, and an achievement point value that is derived from the performance threshold. Specifically, under this new scoring methodology clinicians whose average cost equals the median cost for a measure will receive a score equal to 10 percent of the performance threshold established for that MIPS payment year.

- For example, for the 2026 performance period, **a clinician with costs equal to the median cost for a measure will receive 7.5 achievement points for that cost measure**, the performance threshold equivalent.
- The cut-offs for benchmark point ranges will be calculated based on standard deviations from the median cost.

This updated cost scoring methodology will more appropriately incentivize or penalize clinicians with below or above national average spending.

Learn more about the revised cost scoring methodology by reviewing the 2025 QPP Policies Final Rule Fact sheet (PDF, 798KB) and the 2025 Traditional MIPS Scoring Guide (PDF, 3,159KB).

Beginning with the 2026 performance period, there will be a 2-year informational-only feedback period for new cost measures, where clinicians will receive feedback on their measure performance, but the measures won't count towards their cost category score or MIPS final scores.

We note that there are no new cost measures available in the 2026 performance period

Cost Improvement Scoring

How is improvement scoring calculated?

Cost improvement scoring is calculated by comparing the cost performance category score from the previous (2025) performance period to the cost performance category score for the current (2026) performance period.

Cost Improvement Scoring Example

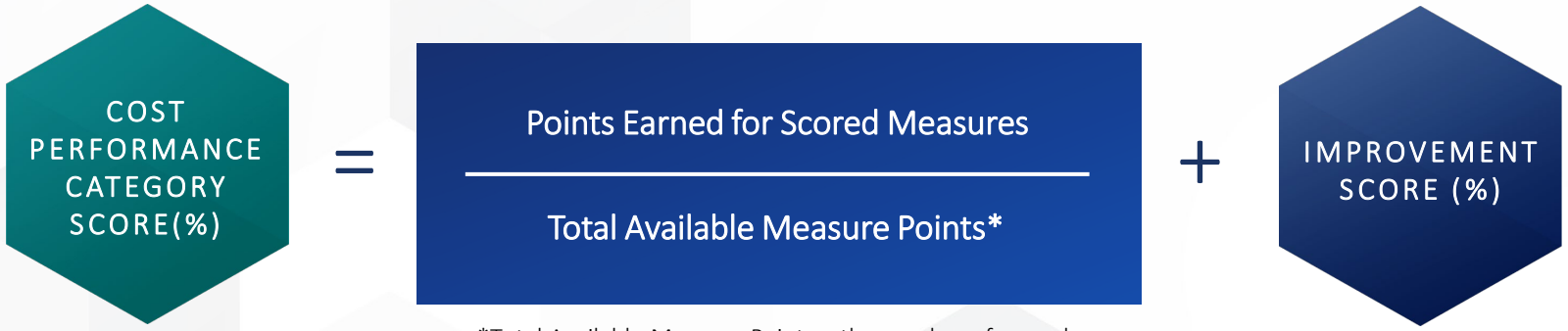
The following provides an example of how to calculate the improvement percent score.

- For the **2025 performance period**, Dr. Johnson earned a cost performance category score of 60% (12 out 20 points) in traditional MIPS.
- For the **2026 performance period,** Dr. Johnson earned a cost performance category score of 70% (14 out 20 points) reporting an MVP.

- Your cost improvement score can't be negative – if your cost performance decreases, your improvement score will be 0%.
- The cost improvement score is capped at 1%.

Cost Performance Category Scoring

The cost performance category score is the equally weighted average of all scored measures plus the cost improvement score, not to exceed 1 percentage point. The cost performance category score is then multiplied by the category weight to determine the number of points the category contributes to the final score.



*Total Available Measure Points + the number of scored cost measures in the MVP x 10

Let's continue the example from the previous slide to calculate Dr. Johnson's 2026 cost performance category score.

MVP Foundational Layer: Promoting Interoperability

Though reported as part of the foundational layer of MVPs, this performance category will be scored in accordance with the policies established for traditional MIPS.

Subgroups submit the aggregated data of their affiliated group.

Subgroups will receive a score of zero in this performance category if they don't submit their affiliated group's Promoting Interoperability data.

Each required measure will be scored based on the performance data you report.

- For measures with a numerator and denominator, we calculate the performance rate based on the complete count of numerators and denominators you submit.
    - A numerator or denominator of zero for any measure will result in a score of zero for the entire Promoting Interoperability performance category.
- For measures that require a "yes" or "no" submission such as the Query of **Prescription Drug Monitoring Program** (PDMP) measure, we assign either full points or zero points.
- As a reminder, if you earn zero points for any required measure or objective, you'll receive a score of zero for the entire performance category.

Each measure will contribute to your total Promoting Interoperability performance category score.

Each required measure (or objective, in the case of the Public Health and Clinical Data Exchange) has a maximum number of points that can be earned based on performance.

- If exclusions are claimed, the points for excluded measures will be reallocated to other measures.

MVP Foundational Layer: Promoting Interoperability

Objectives	Measures		Required	Available Points	Reporting Requirements
e- Electronic Prescribing	e-Prescribing		Required	1 – 10 points	Numerator/ Denominator
	Query of Prescription Drug Monitoring Program (PDMP)		Required	10 points	YES
Health Information Exchange	Option 1	Support Electronic Referral Loops by Sending Health Information	Required* (unless option 2 or option 3 is reported)	1 – 15 points	Numerator/ Denominator
		Support Electronic Referral Loops by Receiving and Reconciling Health Information		1 – 15 points	Numerator/ Denominator
	Option 2	HIE Bi-Directional Exchange	Required* (unless option 1 or option 3 is reported)	30 points	YES
	Option 3	Enabling Exchange under the Trusted Exchange Framework and Common Agreement™ (TEFCA™)	Required* (unless option 1 or option 2 is reported)	30 points	YES

*For the HIE objective, you have the option to report data for the 2 supporting electronic referral loops measures and associated exclusions OR the HIE Bi-Directional Exchange measure OR the Enabling Exchange under TEFCA measure. You need to choose and report 1 of these 3 options.

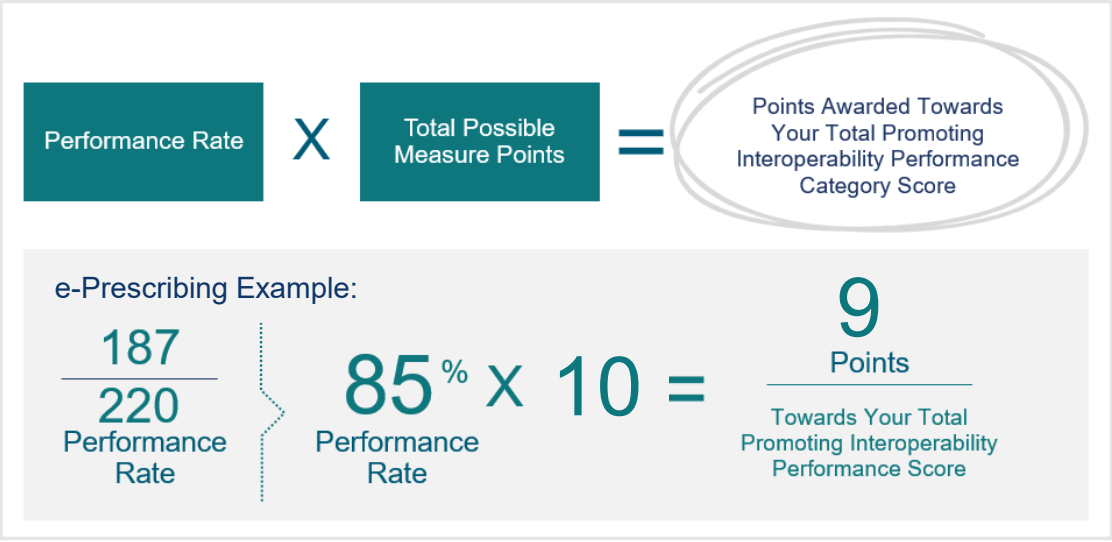
MVP Foundational Layer: Promoting Interoperability

Objectives	Measures	Required	Available Points	Reporting Requirements
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	Required	1 – 25 points	Numerator/ Denominator
Public Health and Clinical Data Exchange	Report the 2 required measures: • Immunization Registry Reporting • Electronic Case Reporting	Required	25 points for the entire objective	Immunization Registry Reporting: YES (you also must submit your level of active engagement) Electronic Case Reporting: YES (you also must submit your level of active engagement)
	Bonus (Optional): • Clinical Data Registry Reporting • Public Health Registry Reporting • Syndromic Surveillance Reporting • Public Health Reporting Using TEFCA	Optional	5 bonus points (whether reporting 1, 2, 3 or all 4 optional measures)	YES (you also must submit your level of active engagement)

MVP Foundational Layer: Promoting Interoperability Measures Submitted with a Numerator/Denominator

For measures submitted with a numerator and denominator, we calculate a score for each measure by dividing the numerator by the denominator you submitted for the measure and then multiplying that performance rate by the maximum points available for the measure.

The example below features the e-Prescribing measure, which is worth up to 10 points.



Important to Note:

- You can earn a maximum of 5 bonus points for submitting 1 (or more) of the optional measures in the Public Health and Clinical Data Exchange objective.
- You'll earn 5 bonus points whether you submit 1, 2, 3 or 4 optional measures.

When we calculate the performance rates, measure and objective scores, and the Promoting Interoperability performance category score, **we generally round to the nearest whole number**.

- When a clinician earns a measure score of less than 0.5, the score is rounded up to 1 as long as the numerator includes at least 1 patient. (A numerator of 0 for any measure will result in a score of zero for the entire Promoting Interoperability performance category.)

MVP Foundational Layer: Promoting Interoperability Measures Submitted with a Yes/No

For the Query of PDMP measure, you'll receive 10 points for this measure when:

You submit a "yes" for the required measure.

If you submit an exclusion, the points will be redistributed to another measure or objective.

For the Public Health and Clinical Data Exchange objective, you'll receive 25 points for this objective when:

You submit a "yes" for the Immunization Registry Reporting measure.* + You submit a "yes" for the Electronic Case Reporting measure.*

OR

You submit a "yes" for one required measure. + You submit an exclusion for the other required measure.

* If you submit an exclusion for both required measures, the 25 points will be redistributed to the Provide Patients Electronic Access to Their Health Information measure.

For Option 2 or 3 in the HIE objective, you'll receive 30 points when:

You submit a "yes" to participating in bi-directional exchange. OR You submit a "yes" to enabling exchange under TEFCA

MVP Foundational Layer: Promoting Interoperability Performance Category Scoring

While there are 105 total points available, individuals, groups, subgroups and APM Entities can't earn more than 100 points in the Promoting Interoperability performance category. The Promoting Interoperability score, like all performance categories, is capped at 100%.

Can the Denominator (Maximum Number of Points) Be Lower Than 100?

No; you'll always be scored out of 100 points in the Promoting Interoperability performance category. If you qualify for and claim an exclusion(s), those points will be reallocated to another measure or objective instead of being removed from the denominator.

Please see Appendix A for detailed information about how points are reallocated when an exclusion(s) is claimed.

How Is the Promoting Interoperability Performance Category Scored?

Individual and Group Participation

We'll add the scores for each of the individual measures (or objectives) and then divide the sum by the total possible achievement points (100 points) to calculate the Promoting Interoperability performance category score.

REMINDER: You'll receive 0 points in the Promoting Interoperability performance category if you fail to: submit a required attestation, report (submit at least 1 in the numerator) on a required measure or claim an exclusion for a required measure (where applicable). Only a submission that meets the minimum qualifying criteria (all required data, measures, and attestations) will be scored.

$$\text{Promoting Interoperability Performance Category Score} = \left(\frac{\text{Total Points Earned for Completed Measures}}{\text{100 Points (Maximum Measure Points Available)}} \right)$$

Final Score

An MVP participant will receive a final score based on the same performance category weights used in traditional MIPS, and the same performance category weight redistribution policies apply.

Subgroups

- Any reweighting applied to the MVP participant's affiliated group will be applied to the subgroup. Subgroups can't request reweighting independent of their affiliated group.
- We won't assign a final score to a subgroup that registers for an MVP but doesn't submit any data as a subgroup.

2026 Performance Category Weights: Individual, Group, and Subgroup Participation

Quality	Cost	Improvement Activities	Promoting Interoperability
30% of MIPS Score	30% of MIPS Score	15% of MIPS Score	25% of MIPS Score

2026 Performance Category Weights: APM Entity Participation

Quality	Cost	Improvement Activities	Promoting Interoperability
55% of MIPS Score	0% of MIPS Score	15% of MIPS Score	30% of MIPS Score

For MVPs, the quality performance category won't be reweighted if CMS can't calculate a score for the MIPS eligible clinician because there isn't at least 1 quality measure applicable and available to the clinician.

Final Score (Continued)

2026 Standard Performance Category Weights for Small Practices (Promoting Interoperability Automatically Reweighted):

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

2026 Performance Category Weights: APM Entities with Small Practice Status

Quality	Cost	Improvement Activities	Promoting Interoperability
50%	0%	50%	0%

For MVPs, the quality performance category won't be reweighted if CMS can't calculate a score for the MIPS eligible clinician because there isn't at least 1 quality measure applicable and available to the clinician.

Final Score Calculation Examples

Example 1 (Group)

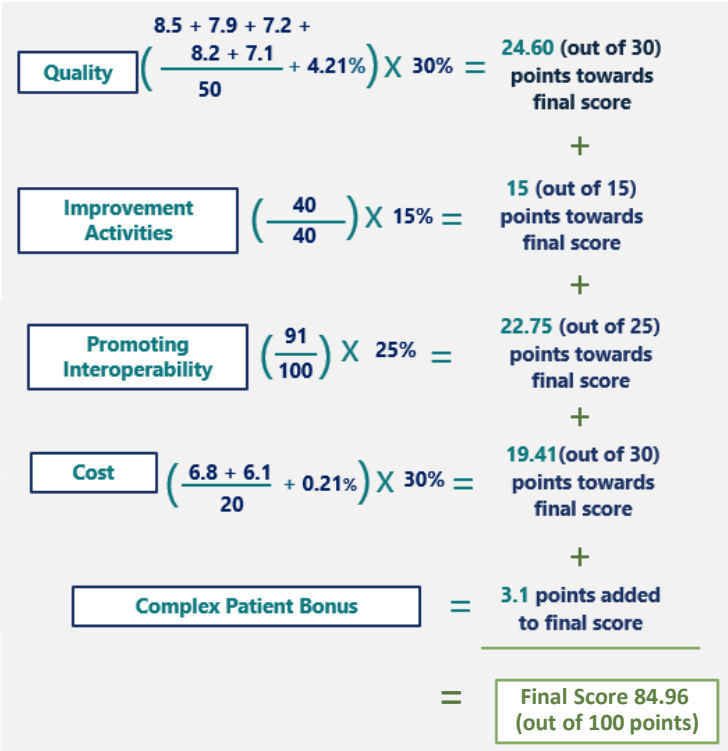
A group of cardiologists registered to report the Advancing Care for Heart Disease MVP as a group; they reported 4 MIPS CQMs and the Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (MCC) was their highest scoring population health measure.

Performance Category	Calculation

Quality	• They report 4 measures available in the MVP, including the outcome measure.
	  ○ They receive 8.5 achievement points for Quality ID 005.
	  ○ They receive 7.9 achievement points for Quality ID 007.
	  ○ They receive 7.2 points for Quality ID 008.
	  ○ They receive 8.2 points for Quality ID 392*.
	• They receive 7.1 points on the MCC population health measure from the foundational layer.
	• They receive 4.21% for quality improvement scoring.

Improvement Activities	• They attested to performing 1 improvement activity in the MVP. ○ They receive 40 points for Use of QCDR data for ongoing practice assessment and improvements.
Promoting Interoperability	• They received 91 out of 100 points for the performance category.

Cost	• They meet the case minimum for 2 measures in the MVP and received 12.9 out of 20 points (64.5%) for the following measures:
	  ○ They receive 6.8 achievement points on the Elective Outpatient Percutaneous Coronary Intervention (PCI) measure.
	  ○ They receive 6.1 achievement points on the Total Per Capita Cost measure.
	• They receive 0.21% for cost improvement scoring.
	  ○ The cost performance category score is the equally weighted average of all scored measures plus the cost improvement score (64.5% + 0.21% = 64.71% in this example).



*Refer to slide 65 for more details.

Did You Know?

Measures without a benchmark receive 0 points.

The MIPS CQM collection type for Quality ID 392 (referenced in the preceding scoring example) doesn't have a 2026 historical benchmark due to an insufficient volume of data submitted in the 2024 performance year.

- Quality 392 had an insufficient volume of data submitted in the 2024 performance year.
- Refer to Column W of the **2026 Quality Benchmarks** (accessible through the Benchmarks page of the QPP website) for more information about the reasons why a measure/collection type doesn't have a historical benchmark.

During the submission period:

Measures without a historical benchmark will show 0 points (3 points for a small practice).

Following the submission period:

We'll evaluate the data submitted for measures without a historical benchmark to determine if we can calculate a *performance period benchmark*.

The scoring in this examples assumes we calculated a performance period benchmarks for Quality ID 392.

If we can't calculate a performance period benchmark for these measures, they would receive 0 points (3 points for small practices).

Final Score Calculation Examples (Continued)

Example 2 (Small Practice)

A small practice registered to report the Advancing Rheumatology Patient Care MVP as a group and didn't meet the case minimum for either population health measure.

Performance Category	Calculation

Quality	• They reported the 2 **Medicare Part B claims** measures available in the MVP.
	  ○ They receive 6.3 achievement points for Quality ID 039.
	  ○ They receive 2.1 achievement points for Quality ID 134.
	• They didn't meet the case minimum for either population health measure.
	  ○ This measure will be excluded from scoring.
	• They receive the small practice bonus (6 bonus points) but **no** quality improvement score.

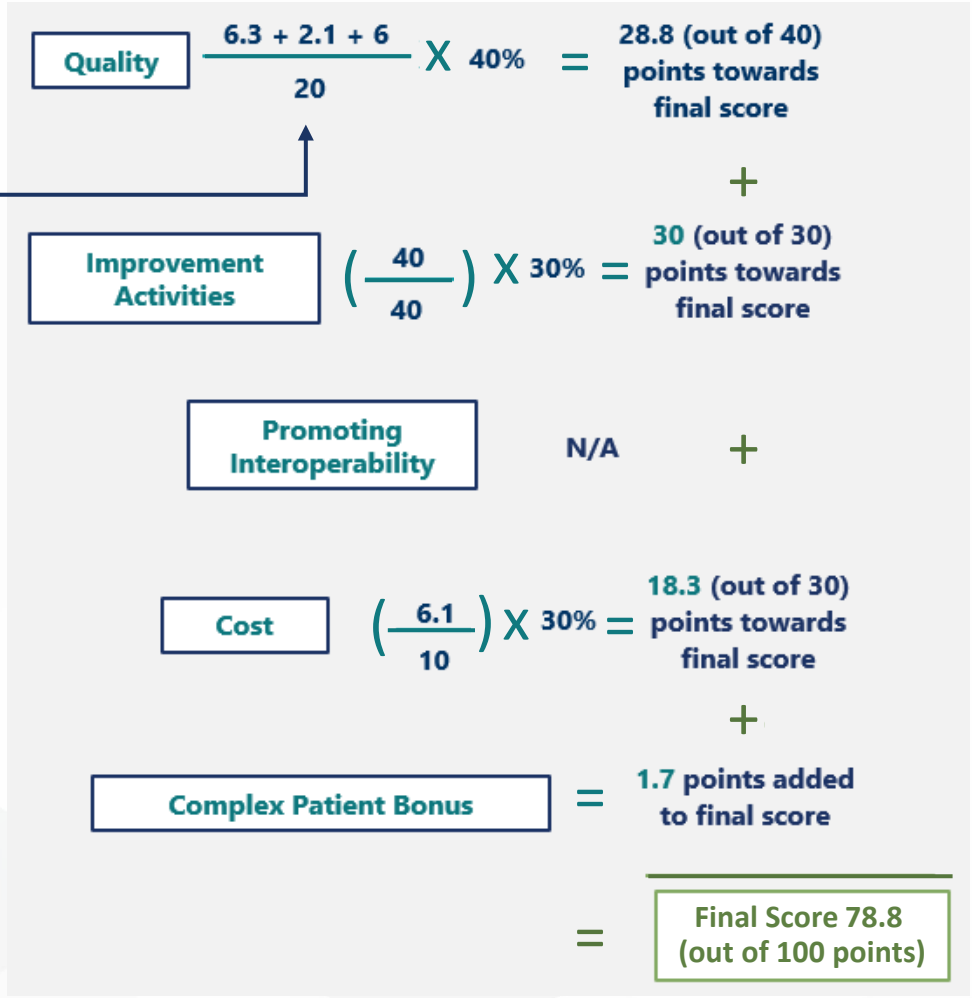
Improvement Activities	• They attested to performing 1 improvement activity in the MVP. ○ They receive 40 points for "use of telehealth services to expand practice access."
Promoting Interoperability	• No data submitted ○ Small practices qualify for automatic reweighting in this category unless data is submitted.
Cost	• They meet the case minimum for the Total Per Capita Cost measure. ○ They receive 6.1 achievement points on the measure. • They **don't** qualify for a cost improvement score.

Final Score Calculation Examples (Continued)

Example 2 (Small Practice) (Continued)

Small practices reporting quality measures through Medicare Part B claims aren't required to report measures from other collection types but do need to report all Medicare Part B claims measures in the MVP to qualify for a denominator reduction.

Small practices receive a different redistribution of performance category weights when Promoting Interoperability is reweighted.



Final Score Calculation

Final Score Hierarchy for MVPs

A MIPS eligible clinician (defined by a unique TIN/NPI combination) will receive the highest final score that can be attributed to that TIN/NPI combination from any reporting option (traditional MIPS, APP, or MVPs) and participation option (as an individual, group, subgroup, or APM Entity) with the exception of virtual groups. Clinicians that participate as a virtual group will always receive the virtual group's final score. Refer to the Scoring section for more details.

An example of the final score hierarchy is provided below:

Participation Type	Reporting Option	Final Score
Group (ABCD)	MVP (Optimizing Chronic Disease Management)	90
Subgroup #1 (AB)	MVP (Coordinating Care to Promote Prevention and Cultivate Positive Outcomes)	80
Subgroup #2 (CD)	MVP (Advancing Care for Heart Disease)	97
Individual Reporter (A)	Traditional MIPS	98
Individual Reporter (C)	Traditional MIPS	60

TIN/NPI	Group Final Score	Subgroup Final Score	Individual Final Score	Final Score Attributed to TIN/NPI	Reason for Final Score Attributed to TIN/NPI
A	90	80	98	98	Individual score is higher than both group and subgroup scores
B	90	80	N/A	90	Group score is higher than subgroup score
C	90	97	60	97	Subgroup score is higher than both group and individual scores
D	90	97	N/A	97	Subgroup score is higher than group score

Performance Feedback and Public Reporting

Performance Feedback

If you report an MVP, we'll provide comparative performance feedback to show you the performance of like clinicians who reported the same MVP. If you report an MVP for the 2026 performance year, comparative feedback will be available as part of your final performance feedback in summer 2026.

This comparative feedback is only available to those who report MVPs and will be provided as part of the annual performance feedback.

Public Reporting of Performance on MVPs

We delayed public reporting of all subgroup-level performance information until the 2025 performance year. Subgroup data reported for the 2025 performance year will be available for public reporting on the compare tool on Medicare.gov in calendar year 2027.

We'll create a separate subgroup workflow that'll allow subgroup performance information to be publicly reported in an online location that can be navigated to from the current individual clinician or group profile pages. We'll indicate from an individual clinician's profile page that he/she participates in reporting as part of a subgroup or group page and link to the corresponding information.

Under existing policy:

- We won't publicly report any new measures for the first 2 years they are used in the quality and cost performance categories, whether reported for an MVP or traditional MIPS.
- We won't publicly report any **new** improvement activities and Promoting Interoperability measures and attestations for the first year they can be reported in an MVP.
  - This means that **new** improvement activities and Promoting Interoperability measures may be available for public reporting under traditional MIPS but will have a one-year delay in reporting in an MVP.

MIPS performance category and final scores for MIPS eligible clinicians participating in MVPs will continue to be publicly reported on the compare tool on Medicare.gov.

Improvement activities and Promoting Interoperability measures and attestations that have already been in MIPS for more than one year and are newly available as part of an MVP would be available for public reporting in their first year included in the MVP.

Help and Version History

Where Can You Go for Help?

Contact the QPP Service Center by emailing us at QPP@cms.hhs.gov, by submitting a QPP Service Center ticket, or calling 1-866-288-8292 (Monday - Friday, 8 a.m. - 8 p.m. ET). 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.

Version History

Version History

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

DATE	DESCRIPTION
03/17/2026	Original version.

Appendix

Reallocation of Points for Promoting Interoperability Measure(s)

When an Exclusion is Claimed

The table below outlines where points are redistributed when an exclusion is claimed.

Objectives	Measures		Exclusion Available	When the Exclusion is Claimed…
~~e~~-Electronic Prescribing	e-Prescribing		Yes	…the 10 points are redistributed equally among the measures associated with the Health Information Exchange objective: • 5 points to the Support Electronic Referral Loops by Sending Health Information measure • 5 points to the Support Electronic Referral Loops by Receiving and Incorporating Health Information measure OR … the 10 points are redistributed to the HIE Bi-Directional Exchange measure OR …the 10 points are redistributed to the Enabling Exchange under the Trusted Exchange Framework and Common Agreement (TEFCA) measure
	Query of PDMP		Yes	…the 10 points are redistributed to the e-Prescribing measure
Health Information Exchange	Option 1	Support Electronic Referral Loops by Sending Health Information	Yes	…the 15 points are redistributed to the Provide Patients Electronic Access to their Health Information measure
		Support Electronic Referral Loops by Receiving and Reconciling Health Information	Yes	…the 15 points are redistributed to the Support Electronic Referral Loops by Sending Health Information measure
	Option 2	HIE Bi-Directional Exchange	No	N/A
	Option 3	Enabling Exchange under TEFCA	No	N/A

Did You Know? If you claim an exclusion for the e-Prescribing measure, you will need to claim one of the Query of PDMP exclusions that is most applicable to you.

Reallocation of Points for Promoting Interoperability Measure(s) (Continued)

Objectives	Measures	Exclusion Available	When the Exclusion is Claimed…
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	No	N/A
Public Health and Clinical Data Exchange	Report the 2 required measures: • Immunization Registry Reporting • Electronic Case Reporting	Yes	… …the 25 points are still available in this objective if you claim an exclusion for one of the required measures and submit a 'yes' attestation for the other required measure in the objective. …the 25 points are redistributed to the Provide Patients Electronic Access to Their Health Information measure if you claim 2 exclusions.
	Bonus (optional): • Public Health Registry Reporting • Clinical Data Registry Reporting • Syndromic Surveillance Reporting • Public Health Reporting Using TEFCA	N/A	N/A

Note: Even if you claim 1 or 2 exclusions for the Immunization Registry Reporting and Electronic Case Reporting measures, you can still earn a total of 5 bonus points by reporting 1, 2, 3 or 4 of the optional Public Health and Clinical Data Exchange measures (Public Health Registry Reporting, Clinical Data Registry Reporting, Syndromic Surveillance Reporting, or **Public Health Reporting Using TEFCA**).