Quality Payment
PROGRAM

Small Practices Guide: Getting Started with Merit-based Incentive Payment System (MIPS) Clinical Quality Measure (CQM) Reporting

Table of Contents

Table of Exhibits

Purpose

This resource walks through the steps needed for small practices to report **Merit-based Incentive Payment System (MIPS) clinical quality measures (MIPS CQMs)** under MIPS, whether participating as an individual clinician, group, subgroup, or Alternative Payment Model (APM) Entity.

A **small practice** is defined as a group that has 15 or fewer clinicians identified by National Provider Identifier (NPI), billing under the group's Taxpayer Identification Number (TIN). To see if you have the small practice designation, visit the Quality Payment Program (QPP) Participation Status Lookup Tool.

This resource is intended to be broadly applicable, not specific to a particular performance year. Refer to Appendix A for links to the resources referenced throughout this guide that are specific to the 2025 performance year and Appendix B for links to resources specific to the 2026 performance year.

Background

This resource focuses on **MIPS CQMs**, one of several collection types available for reporting quality measures.

Collection type refers to the way you collect data for a MIPS quality measure. An individual MIPS quality measure may be collected in multiple ways (i.e., may be available through multiple collection types). Each collection type has its own specification (instructions) for reporting that measure. Follow the measure specifications that correspond with how you choose to collect your quality data.

- **Electronic clinical quality measures (eCQMs)** – Measure data are collected at the point of care in electronic health record (EHR) technology that's been certified by the Assistant Secretary for Technology Policy (ASTP)/Office of the National Coordinator for Health Information Technology (ONC). Data are collected for all patients that qualify for the measure, not just Medicare patients.
- **Medicare Part B claims measures** – Measure data are reported on Medicare Part B claims when they're submitted for reimbursement. Medicare Part B claims measures can only be reported by solo practitioners and small practices (15 or fewer clinicians). Data are only reported for Medicare patients. To learn more about these measures refer to the **Medicare Part B Claims Reporting Quick Start Guide (PDF)** (links provided in Appendix A (2025 performance year) and Appendix B (2026 performance year)).
- **MIPS CQMs** – Measure data may be gathered from different data sources including paper and/or electronic charts. A third party intermediary may be brought in for assistance with collecting and reporting data. Data are collected for all patients that qualify for the measure, not just Medicare patients.
- **Qualified Clinical Data Registry (QCDR) measures** – QCDRs are CMS-approved entities with the flexibility to develop and track their own quality measures. Because many QCDRs are specialty-based, QCDR measures may be more meaningful and applicable to your practice. Data are collected in a manner specified by the QCDR for all patients that qualify for the measure, not just Medicare patients.

It's important to differentiate between **MIPS CQMs** and **Medicare CQMs**. Make sure that you're using resources related to MIPS CQMs and not Medicare CQMs.

- **MIPS CQMs** are the focus of this resource. You can report MIPS CQMs via traditional MIPS, MIPS Value Pathways (MVPs), and Alternative Payment Model (APM) Performance Pathway (APP).

- **Medicare CQMs** are available only to Medicare Shared Savings Program ACOs reporting the APP Plus quality measure set.

MIPS Reporting Options

There are 3 reporting options available to MIPS eligible clinicians to meet MIPS reporting requirements. If you'd like more information, review the **MIPS Reporting Options At-A-Glance for Small Practices** (find the links to this resource in Appendix A (2025 performance year) and Appendix B (2026 performance year)).

Exhibit 1. Overview of MIPS Reporting Requirements

Traditional MIPS	MIPS Value Pathways (MVPs)	APM Performance Pathway (APP)
• The original reporting option for MIPS. • Visit the QPP website to learn more about traditional MIPS.	• This reporting option offers clinicians a more meaningful and reduced grouping of measures and activities relevant to a specialty or medical condition. • Visit the QPP website to learn more about MIPS Value Pathways (MVPs).	• A streamlined reporting option for **clinicians who participate in a MIPS Alternative Payment Model (APM).** • Visit the QPP website to learn more about APM Performance Pathway.
• 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 traditional MIPS.	• You select an MVP that's applicable to your practice. • Then you choose from the quality measures and improvement activities available in your selected MVP. • You'll report a reduced number of quality measures and improvement activities as compared to traditional MIPS.	• You'll report a predetermined set of quality measures. • MIPS APM participants currently receive full credit in the improvement activities performance category, though this is evaluated on an annual basis
• You'll report the complete P	• You'll report the complete Promoting Interoperability measure set (the same as reported in traditional MIPS).	• You'll report the complete Promoting Interoperability measure set (the same as reported in traditional MIPS).
• We collect and calculate data for the cost performance category and any applicable administrative claims measures for you.	• We collect and calculate data for the cost performance category and population health measures for you.	• Cost isn't evaluated under the APP.

Learn more

For 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.

For detailed information for each performance year:

Refer to the Traditional MIPS Scoring Guide, APP Scoring Guide, and MVPs Implementation Guide. These resources are updated annually and posted on the QPP Resource Library.

Small Practice Flexibilities – Quality Performance Category

We remain committed to identifying flexibilities and options to help clinicians in small practices meaningfully participate and succeed in MIPS. These flexibilities apply to all 3 MIPS reporting options (traditional MIPS, MVPs, and the APP) unless otherwise specified.

Small practices receive:

- 3 points for submitting quality measures without an available benchmark (historical or performance period) – all other clinicians receive zero points.

- 3 points for submitting measures that don't meet the case minimum or data completeness requirements – all other clinicians receive zero points.

- 6 bonus points added to the quality performance category score when at least 1 quality measure is submitted (applies to individual clinician, group, subgroup, and APM Entity participation, but not to clinicians or groups who are scored under facility-based scoring).

Get Started with MIPS CQM Reporting

Step 1. Understand the Resources Available to Help You

The following resources are available for reporting MIPS CQMs. These resources are updated annually; search the Quality Payment Program Resource Library and make sure to choose the right performance year. Refer to Appendix A for links to these resources for the 2025 performance year and Appendix B for links to resources for the 2026 performance year.

- **MIPS Clinical Quality Measure Specifications and Supporting Documents (ZIP)** – Provides comprehensive descriptions of the MIPS CQMs for the MIPS quality performance category.

- **MIPS Quality Measures List (XLXS)** – A detailed list of the MIPS Quality Measures including applicable specialties and measures that may only be available for MVP reporting.

- **QCDRs Qualified Posting (XLSX)** – Provides a list of the QCDRs approved for a given performance year.

- **Qualified Registries Qualified Posting (XLSX)** – Provides a list of the Qualified Registries approved for a given performance year.

- **MIPS Guide to Using a QCDR or Qualified Registry (PDF)** – Guides clinicians, groups, and/or APM Entities with the selection of a QCDR and/or Qualified Registry to support participation in MIPS.

You can choose whether to collect and submit MIPS CQMs yourself or with the help of a QCDR and/or Qualified Registry. Step 3 reviews some factors to consider when making this decision.

- **QPP JavaScript Object Notation (JSON)** is the required file format for submitting MIPS CQMs.

- If you're submitting MIPS CQMs on your own, you'll want to review the **QPP JSON Templates and Instructions (ZIP).**

We update the template and instructions (ZIP) each year and post them in December (just before the data submission period opens).

Let's take a closer look at the contents of the 2025 MIPS Clinical Quality Measure Specifications and Supporting Documents (ZIP, 68MB). The zip file contains 5 types of files as described below.

1. **MIPS Clinical Quality Measures Guide (PDF)** offers general guidance for the Measure Specifications and Measure Flows for the MIPS CQM collection type for that performance year.

2. **MIPS Clinical Quality Measures Release Notes (PDF)** details changes to existing measures made since the release of the prior year's measure specifications.

   See the example below of specification updates for **Quality ID#008: Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD) MIPS CQM** for the 2025 performance year.

Exhibit 2. Release Notes Example

Quality ID #008: Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)

- Updated Instructions to clarify telehealth
- Added Denominator Coding (Submission Criteria 1), CPT: 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016
- Updated Denominator Criteria (Submission Criteria 1 and Submission Criteria 2): G8923

3. **MIPS Clinical Quality Measure Specifications and Supporting Documents Version History (PDF)** identifies any changes to the measure specifications or single source files contained in the MIPS Clinical Quality Measure Specifications and Supporting Documents (ZIP).

4. **Individual Measure Specification (PDF) files** for each of the MIPS CQMs are available for the performance year. The individual measure specifications outline criteria for each measure component and detail how the measure is intended to be reported for the purposes of MIPS (see Exhibit 3).

   Each measure specification includes a measure flow with the associated measure calculation algorithm as a resource. This information assists users with understanding quality measure logic related to data completeness and measure performance. The measure flow shouldn't be used as a substitute for the MIPS CQM specification but used as an additional visual resource.

Exhibit 3. MIPS CQM Specification Overview

MIPS Clinical Quality Measure Specification Format: Each MIPS CQM conforms to a standard format. The measure format includes the following fields.

The measure header includes: Quality ID, Consensus-Based Entity (CBE) ID (if applicable), and Measure Title.

The body of the document includes the following sections:

- Collection Type
- Measure Type
- Measure Description
- Instructions on submitting including frequency, timeframes, and applicability
- Denominator Statement, Criteria, Exclusion(s), Exception(s), Instructions, Notes, and Definition(s) of terms where applicable
- Numerator Statement, Options (Performance Met, Denominator Exception, Performance Not Met), Instructions, Notes, and Definition(s) of terms where applicable
- Rationale
- Clinical Recommendation Statements

The Rationale and Clinical Recommendation Statement sections provide clinical guidelines and references supporting the quality actions described in the measure. Please contact the Measure Steward for section references and further information regarding the clinical rationale and recommendations for the described quality action. Measure Steward contact information is located on the "Measure Steward Contacts" tab of the 2025 MIPS Quality Measures List, which can be found on MIPS Explore Measures webpage (select Performance Year 2025).

Did you know? Each year when the measure specifications are released, you will need to ensure your system(s) are coded and able to capture all denominator eligible encounters for the applicable performance year for the MIPS CQMs you choose to report.

5. **MIPS Clinical Quality Measures Single Source (XLSX files)** - each MIPS CQM can be found in one of the three spreadsheets. Eligible clinicians can use these spreadsheets to search MIPS CQMs by measure number for the codes associated with each MIPS CQM, such as Healthcare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10), that map to the denominator and numerator information in the measure specification.

Exhibit 4. MIPS Clinical Quality Measures Single Source Example

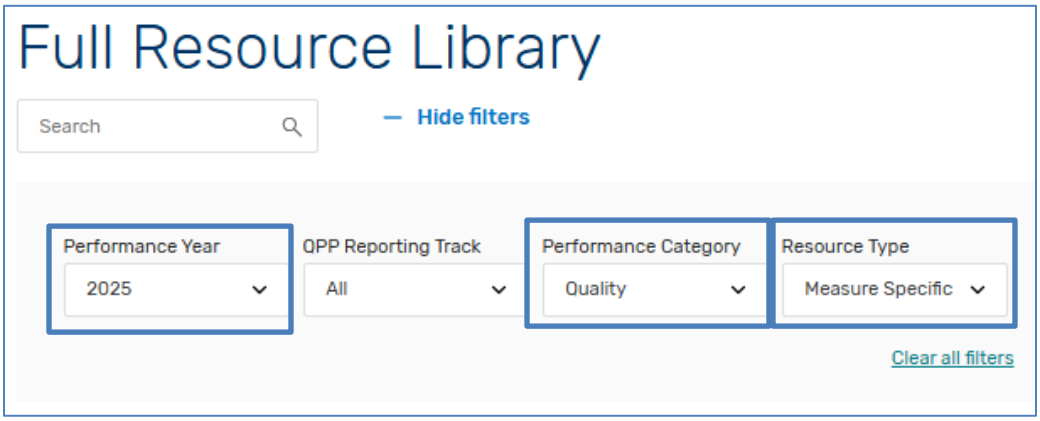
Table 1. Codes for CQM Measures

Measure ID	DATA ELEMENT NAME	CODING SYSTEM	CODE	MODIFIER	PLACE OF SERVICE	AGE	GENDER
1	CPT_II_PM_1	CPT_II	3046F	-	-	18 - 75	M, F
1	CPT_II_PM_2	CPT_II	3046F	8P	-	18 - 75	M, F
1	CPT_II_PNM_1	CPT_II	3044F	-	-	18 - 75	M, F
1	CPT_II_PNM_2	CPT_II	3051F	-	-	18 - 75	M, F
1	CPT_II_PNM_3	CPT_II	3052F	-	-	18 - 75	M, F
1	DX_CODE	I10	E10.10	-	-	18 - 75	M, F
1	DX_CODE	I10	E10.11	-	-	18 - 75	M, F
1	DX_CODE	I10	E10.21	-	-	18 - 75	M, F
1	DX_CODE	I10	E10.22	-	-	18 - 75	M, F
1	DX_CODE	I10	E10.29	-	-	18 - 75	M, F
1	DX_CODE	I10	E10.311	-	-	18 - 75	M, F
1	DX_CODE	I10	E10.319	-	-	18 - 75	M, F
1	DX_CODE	I10	E10.3211	-	-	18 - 75	M, F
1	DX_CODE	I10	E10.3212	-	-	18 - 75	M, F

Helpful Hint: You can also use the MIPS CQM Single Source Excel documents to find available measures by searching for the codes you commonly bill when treating patients.

Although the MIPS CQM Single Source documents may help you identify measures to report, please refer to the individual quality measure specifications as the source of truth for the purpose of reporting.

Need an Additional Resource? Be sure to visit the QPP Resource Library. Use the Search Feature to filter by “Performance Year” (i.e., 2025), “Performance Category” (i.e., quality) and “Resource Type” (e.g., Measure Specifications and Benchmarks).



Step 2. Select Measures

The number of measures you're required to report depends upon which reporting option you choose. Exhibit 5 below outlines the requirements for the quality performance category by reporting option.

Exhibit 5. MIPS Quality Performance Category Requirements by Reporting Option

Traditional MIPS	MIPS Value Pathway (MVP)	APM Performance Pathway (APP)
• Use the Explore Measures & Activities Tool to **select 6 measures** (including 1 outcome or high priority measure) from the complete MIPS quality measure inventory. **OR** **Report 1 complete specialty measure set**. — If the specialty set includes fewer than 6 measures, you'll meet reporting requirements if you report all the measures in the specialty set. • Collect data for each measure for the 12-month performance period (January 1-December 31). • We'll evaluate you on any applicable administrative claims-based measures based on data CMS collects.	• **Select 4 quality measures** within an MVP. • Collect data for each measure for the 12-month performance period (January 1-December 31). • An MVP may include outcomes-based administrative claims measures. If you wish to be evaluated on an administrative claims measure as 1 of your 4 required measures, you'll need to indicate this in your MVP registration.	• Collect data for the original APP quality measure set or the new APP Plus quality measure set for the 12-month performance period (January 1-December 31). • – Shared Savings Program ACOs must report the new APP Plus quality measure set. • Register for and administer the CAHPS for MIPS Survey measure. (Register April 1 – June 30, then collect data through December 31.) • We collect and evaluate data for 2 administrative claims-based measures if you meet the case minimum based on data CMS collects. • Learn more about the APP Quality Requirements.

Did you know? You can report a combination of collection types – Medicare Part B claims, eCQMs, MIPS CQMs, QCDR measures, and the CAHPS for MIPS Survey measure – to meet your quality reporting requirements.

Helpful Hints and Reminders:

- Review your patient population to ensure you'll be able to meet the case minimum requirement (20 cases unless otherwise stated) on the quality measures you choose to report.
    - Small practices have some flexibility with the case minimum requirement, and will earn 3 points for measures that don't meet the required case minimum.
- Small practices also earn 3 points for measures that don't have a benchmark.
- If you report more than the required number of quality measures, we'll pick the highest scored outcome measure and then the next highest scored measures to reach a total of 6 (traditional MIPS) or 4 (MVPs) scored quality measures.
- You can report measures from multiple collection types to meet quality reporting requirements.
- If you submit the same measure through multiple collection types (e.g., as a Medicare Part B claims measure and MIPS CQM), we'll select the higher scoring collection type of the measure based on achievement points.
- You can report your quality measures through multiple submission formats (e.g., JSON and with the support of a QCDR or Qualified Registry).

Step 3. Decide If You'll Work with a QCDR and/or Qualified Registry

Decide if you have the capabilities to collect and submit data yourself, or if you need to work with a third party intermediary to support your data collection and submission.

We've identified several questions to consider when deciding whether to work with a third party intermediary (Exhibit 6). In addition to considering the below questions, there may be other factors or items to consider that are specific to your circumstances.

If you decide to collect and submit your own data, you will need to update your systems and workflows to capture data according to the current performance year's specifications for the MIPS CQMs you select.

Important: Prior to the start of a performance year, you must have completed updating your systems and workflows to ensure you're able to meet data completeness requirements. For the 2025 performance year, for example, data completeness is defined as capturing 75% of denominator eligible encounters, where the denominator eligible patient population is a complete representation of all available medical records, for each MIPS CQM you select to report.

Exhibit 6 offers information to consider when determining if you'll need help with your data collection and reporting. If you don't have the necessary systems, processes, or people in place, you may want to consider a third party intermediary that can work with you to collect and track your performance data throughout the year and can assist you with reporting to MIPS.

The table in Exhibit 6 uses **Quality ID #001: Diabetes: Glycemic Status Assessment Greater than 9%** as an example, where applicable.

Exhibit 6. Determine If Support is Needed for Data Collection & Reporting

Questions	Considerations
Do you use an EHR?	If so, you need to confirm whether your EHR supports your selected measures. • Contact your EHR vendor with a list of MIPS CQMs that you plan to collect and report before the performance period begins. If you previously collected Quality ID #001 as a Medicare Part B Claims measure, you'll need to verify that your EHR can capture this measure as a MIPS CQM and align to the measure specification accordingly. Check whether you can use reports generated by your EHR to ensure the data captured in the EHR aligns with the quality action(s) of the measures you select. • For example, your EHR might generate a report that highlights diabetic patients who haven't had a glycemic status assessment during the performance period. • You might be able to use this report to cross-check which patients meet the numerator criteria for Quality ID #001 (Glycemic Status Assessment Level is Missing or Was Not Performed). If you don't have an EHR, you'll need to determine if you have the systems, workflows, and people in place to track and aggregate required measure information.

Questions	Considerations

Do you have a system/process in place to track denominator-eligible encounters and confirm completion of the required quality actions for each selected measure?	While you may already gather denominator data through billing codes (e.g., ICD-10, CPT, HCPCS, etc.), you still need a method for tracking performance data for your chosen measures using that coding.
	
	For Quality ID #001, are you able to track the following patients based on the codes identified in the specification?
	
	• **Denominator:** All patients 18-75 years of age with diabetes with a visit during the measurement period
	
	• **Denominator Exclusions:**
	  ○ Hospice services provided to patient any time during the measurement period
	  ○ Palliative care services provided to patient any time during the measurement period
	  ○ Patients age 66 and older in Institutional Special Needs Plans (SNP) or residing in long-term care with a POS code 32, 33, 34, 54 or 56 for more than 90 consecutive days during the measurement period
	  ○ Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period
	  ○ Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND an advanced illness diagnosis during the measurement period or the year prior to the measurement period
	
	• **Numerator:** Patients whose most recent glycemic status assessment is >9%, is missing, or wasn't performed during the measurement period.

Is there a designated team or staff member responsible for reviewing specifications annually to update workflows and data collection processes based on changes?	Measure specifications are updated each year, including the codes that qualify a patient or encounter for the measure or indicate if the quality action was performed. Your EHR vendor might update your system each year to account for changes in measure specifications. If not, you'll need to incorporate this annual review into your processes for any measures you report year-over-year. The Release Notes (in the Measure Specifications and Supporting Documentation ZIP file) identify changes in the specification from the prior year.

Questions	Considerations
	For example, the 2025 MIPS CQM Release Notes include these updates for Quality ID 001: **Quality ID #001: Diabetes: Glycemic Status Assessment Greater Than 9%** • Updated Measure Title and Measure Description • Updated Instructions to clarify telehealth • Added Denominator Coding, ICD-10: E10.A2 • Added Denominator Coding, CPT: 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016 • Added Denominator Coding, HCPCS: G0402 • Updated Denominator Exclusion: G2091 • Updated Denominator Exclusion codes for identifying advanced illness • Updated Denominator Exclusion codes for identifying frailty • Updated Numerator Statement, Numerator Instructions, and Numerator Note • Updated Numerator Options: Performance Met (M1211, M1212), Performance Not Met (M1371, M1372, M1373
Are you in the process of switching to a different EHR?	If you transition from one or more EHR system(s) to another during the performance period, you'll need to aggregate the data from the previous EHR system(s) and the new EHR system into one report for the full 12-month performance period (identifying 100% of denominator-eligible instances) prior to submitting the data. Data completeness criteria must still be met (performance data – Performance Met, Performance Not Met, Exclusions – reported for at least 75% of the denominator-eligible patients/cases).

Step 4. Find a Third Party Intermediary (as applicable)

Working with a Third Party Intermediary

QCDRs and Qualified Registries are vetted and approved by CMS to support data collection and submission of quality measures on your behalf.

QCDRs and Qualified Registries are required to support all MIPS performance categories that require data submission, with some exceptions for the Promoting Interoperability performance category.

While reporting is retrospective, you can work with third party intermediaries to implement real time quality improvement throughout the performance year. QCDRs and Qualified Registries provide performance feedback at least 4 times throughout the performance year based on the data available to them at the time. The feedback can help drive practice improvement and alert you, your group or your APM Entity of the changes needed in workflows or processes to improve performance prior to submission.

Finding a Qualified Registry and/or QCDR

CMS publishes a list of approved organizations (with contact information, services offered, pricing, and the specific quality measures and/or QDCR measures they support) prior to the performance year.

In general, the population of approved QCDRs and Qualified Registries is fairly consistent from year to year. We encourage you to review the Qualified Postings for the current performance year to become familiar with the costs and services offered by approved QCDRs and Qualified Registries:

- **Qualified Clinical Data Registries (QCDRs) Qualified Posting (XLSX)**
- **Qualified Registries Qualified Posting (XLSX)**

The QCDR Qualified Posting and Qualified Registry Qualified Posting are updated on a monthly basis throughout the year to identify QCDRs and Qualified Registries that have been placed on remedial action and/or terminated. A QCDR or Qualified Registry can be placed on remedial action and/or terminated if CMS determines the organization isn't compliant with CMS requirements or has submitted inaccurate or otherwise unusable data. If placed on remedial

action, the QCDR or Qualified Registry must submit a corrective action plan addressing any deficiencies and outlining steps to prevent recurrence.

- If a QCDR or Qualified Registry is placed on remedial action, you don't need to take any action unless you wish to find another QCDR or Qualified Registry that isn't on a corrective action plan.

- If a QCDR or Qualified Registry is terminated, they're required to notify you that they won't be able to submit data for the terminated performance period. In this case, you would need to select another intermediary to submit your data or plan to submit your own data.

Best Practices for Finding a Third Party Intermediary

Start by searching for QCDRs and/or Qualified Registries that support your selected reporting option, performance categories, and participation option (i.e., individual, group, subgroup, or APM Entity).

Then review the MIPS CQMs you wish to report to confirm they are supported by the QCDR and/or Qualified Registry you're interested in working with. Note that not all third party intermediaries support data collection for all quality measures and specialties.

Once you have identified the QCDRs and/or Qualified Registries that support the MIPS CQMs you've selected, you can evaluate such third party intermediaries based on cost and services offered, including how you'll get your quality data to them.

- For example, if your group or APM Entity has multiple EHR systems, you may need to search for QCDRs and/or Qualified Registries that offer data aggregation services.

Lastly, contact the QCDR(s) and/or Qualified Registry(ies) directly. Note that some QCDRs and Qualified Registries will accept new clients during the performance year and into the submission period; the Qualified Postings identify the last date that a QCDR or Qualified Registry will accept new clients.

Review the **MIPS Guide to Using a QCDR or Qualified Registry (PDF)** for more detailed guidance on selecting a third party intermediary.

Where Can I Get Help?

Contact the Quality Payment Program (QPP) Service Center by emailing QPP@cms.hhs.gov, 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 hearing impaired can dial 711 to be connected to a Telecommunications Relay Services (TRS) Communications Assistant.

Version History

Date	Change Description
11/17/2025	Original version
02/27/2026	Updated to include 2026 performance year resources.

Appendix A: Links to Resources for the 2025 Performance Year

- 2025 MIPS Clinical Quality Measure Specifications and Supporting Documents (ZIP, 68MB) – Provides comprehensive descriptions of the MIPS CQMs for the MIPS quality performance category.

- 2025 MIPS Quality Measures List (XLXS, 803KB) – A detailed list of the MIPS Quality Measures including applicable specialties and measures that may only be available for MVP reporting.

- 2025 QCDRs Qualified Posting (XLSX, 230KB) – Provides a list of the QCDRs approved for the 2025 performance year.

- 2025 Qualified Registries Qualified Posting (XLSX, 202KB) – Provides a list of the Qualified Registries approved for the 2025 performance year.

- 2025 MIPS Guide to Using a QCDR or Qualified Registry (PDF, 461KB) – Guides clinicians, groups, and/or APM Entities with the selection of a QCDR and/or Qualified Registry to support participation in MIPS for the 2025 performance year.

- 2025 QPP JSON Templates and Instructions (ZIP, 1MB) – This resource provides instructions for using the association QPP JSON templates to submit the data you've collected for MIPS CQMs during the 2025 performance year.

- 2025 Part B Claims Quality Reporting Quick Start Guide (PDF, 2MB) – Provides information about reporting quality measures through Medicare Part B claims (an alternative to MIPS CQM reporting).

- 2025 MIPS At-A-Glance Reporting Options for Small Practices (PDF, 436KB) – Provides information about the different requirements for the 3 MIPS reporting options.

Appendix B: Links to Resources for the 2026 Performance Year

- 2026 MIPS Clinical Quality Measure Specifications and Supporting Documents (ZIP, 41MB) – Provides comprehensive descriptions of the MIPS CQMs for the MIPS quality performance category.

- 2026 MIPS Quality Measures List (XLXS, 813KB)) – A detailed list of the MIPS Quality Measures including applicable specialties and measures that may only be available for MVP reporting.

- 2026 QCDRs Qualified Posting (XLSX, 220KB) – Provides a list of the QCDRs approved for the 2026 performance year.

- 2026 Qualified Registries Qualified Posting (XLSX, 223KB) – Provides a list of the Qualified Registries approved for the 2026 performance year.

- 2026 MIPS Guide to Using a QCDR or Qualified Registry (PDF, 426KB) – Guides clinicians, groups, and/or APM Entities with the selection of a QCDR and/or Qualified Registry to support participation in MIPS for the 2026 performance year.

- 2026 QPP JSON Templates and Instructions (ZIP) – **This resource will be available in December 2026.**

- 2026 Part B Claims Quality Reporting Quick Start Guide (PDF, 2MB) – Provides information about reporting quality measures through Medicare Part B claims (an alternative to MIPS CQM reporting).

- 2026 MIPS At-A-Glance Reporting Options for Small Practices (PDF, 436KB) – Provides information about the different requirements for the 3 MIPS reporting options.