Merit-based Incentive Payment System (MIPS)

2025 MIPS Value Pathways (MVPs) Data Submission User Guide

Quality Payment
PROGRAM

Table of Contents

Need More Help?

- File upload troubleshooting
- Contact the Quality Payment Program

Quality Payment
PROGRAM

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.

Return to Table of Contents

Click this icon (on the bottom left of each page) **to return to the table of contents**.

Hyperlinks

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

Quality Payment
PROGRAM

Getting Started

Getting Started

What to Expect During 2025 Submission

Reporting Update to CQM #510: First Year Standardized Waitlist Ratio (FYSWR) for the Optimal Care for Kidney Health MVP

CMS has received several inquiries about technical challenges with reporting Quality Measure 510: First Year Standardized Waitlist Ratio (FYSWR), which is available only as a MIPS clinical quality measure (CQM). After assessing the issue, CMS determined that it's not technologically feasible to calculate both the 1st and 2nd performance rates using the existing submission JavaScript Object Notation (JSON) structure. As a result, only the 2nd submission criteria will be accepted when submitting the measure for the 2025 performance period.

Electronic Case Reporting Measure Suppression

The Centers for Disease Control and Prevention (CDC) temporarily paused electronic case reporting registration (learn more in this fact sheet) and onboarding of new health care organizations (HCOs) to establish a more efficient and automated onboarding process. As a result, some MIPS eligible clinicians may be unable to meet the electronic case reporting registration and onboarding requirements by the end of the 2025 performance period.

To avoid adverse consequences beyond the MIPS eligible clinicians' control, we're suppressing the Electronic Case Reporting measure for the 2025 performance period for the MIPS Promoting Interoperability performance category for the CY 2025 performance period/2027 MIPS payment year.

The measure must still be reported. MIPS eligible clinicians will meet the measure requirements by attesting either "Yes" or "No" to being in active engagement with a public health agency or claiming an applicable exclusion. MIPS eligible clinicians who report the suppressed Electronic Case Reporting measure will receive full credit for the measure.

Getting Started

What to Expect During 2025 Submission

As a reminder, we eliminated the Preliminary Score and preliminary category level scores from the submission experience beginning with the data submission period for the 2023 performance year. The increasing volume of scoring information that can change after the submission period made this information too unreliable.

What should we expect during submission?

When you sign into the QPP website during the submission period, you'll see:

- Measure-level scores for the quality measures you've submitted to date, and a sub-total of points earned for these measures.
  - NOTE: You **won't** see administrative claims measures or the CAHPS for MIPS measure during the submission period.
  - If applicable, these measures will be added to performance feedback when we release final scores in June 2026.
- Activity-level scores for the improvement activities you've submitted to date, and a sub-total of points earned for these activities.
- Measure-level scores for the Promoting Interoperability measures you've submitted to date, and a sub-total of points earned for these measures.
- The number of objectives you've reported completely for the Promoting Interoperability performance category.
- An indicator of any performance categories that will be reweighted (if applicable).

Getting Started

What to Expect During 2025 Submission (Continued)

What can change after the submission period?
Several things can change between the close of the submission period and the release of final scores, most of which affect the quality performance category. For example:

What Can Change	How This Can Affect Your Score
Ex. Administrative claims quality measures are calculated	If you can be scored on one of the population health measures, it will increase the number of measures your quality score is based on.
Ex. CAHPS for MIPS measure is submitted	If your practice administered the CAHPS for MIPS Survey measure, this measure will be added to your score after the submission period
Ex. Performance period benchmarks are calculated for quality measures without a historical benchmark	If a measure didn't have a historical benchmark and we can calculate a performance period benchmark, this will change the measure-level score. If you submitted more than 4 measures in your MVP, performance period benchmarks can change which measures count towards your quality score.

When will our 2025 final score be available?
Final scores will be available in summer 2026, and your payment adjustment information will be available approximately 30 days later.

Learn more about final scores, how your scores will be calculated, and what can change after the submission period in the Scoring Calculations section of this guide.

Getting Started

Accessing the System

In order to sign in to the QPP website and submit Performance Year 2025 data and/or view data submitted on your behalf, you need:

- An account (user ID and password)
- Access to an organization (a role)

Make sure you sign in during the submission period to review data submitted on your behalf.

You can't submit new or corrected data after the submission period closes.

If you don't already have an account or access, review the following documentation in the QPP Access User Guide (ZIP, 4MB) so you can sign in to submit, or view, data:

Once you sign in, you can select **Start Reporting** on the main page or **Eligibility & Reporting** from the left-hand navigation bar.

DISCLAIMER:

- All screenshots include fictitious patients and organizations. Screenshots were captured from a test environment, so there may be slight variations between the screenshots included in this guide (including dates) and the user interface in the production system.

Before You Begin

Make sure you are using the most recent version of your browser:

- Chrome
- Edge

Note: Internet Explorer, Safari, Firefox aren't fully supported by QPP.

Getting Started

Organization Type

From here, you'll see the organizations you have permission to access. Most users will only have access to one organization type:

- **Registry** (includes Qualified Registries and QCDRs) or
- **Practice** (**individual**, **subgroup** and/or **group** reporting, all performance categories) or

Learn how to connect to an organization as a practice.

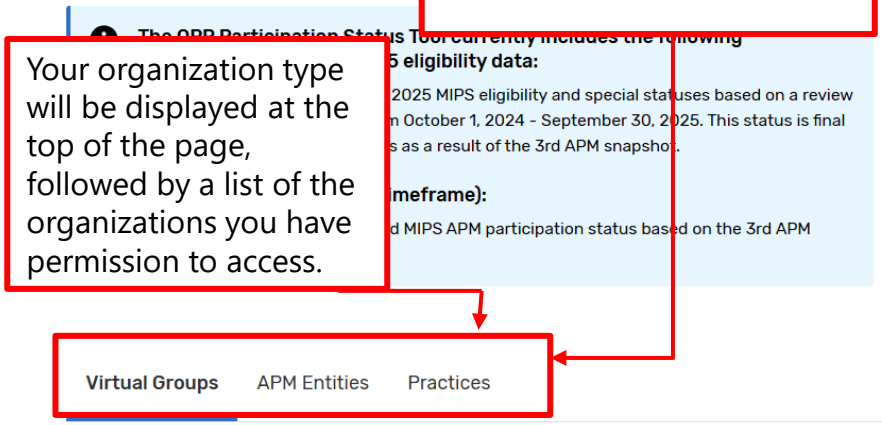
- **APM Entity** (APM Entity-level quality and improvement activities performance categories data submission) or

Learn how to connect to an organization as an APM Entity.

If you have access to multiple organization types, you will see them tabbed across the top of the page.

Click an organization type to view the list of associated organizations you can access.

Your organization type will be displayed at the top of the page, followed by a list of the organizations you have permission to access.



Helpful Hint

Click the links, or jump to Appendix B, to review what users associated with each organization type can and can't do and view during the submission period.

Getting Started

MVP Reporting FAQs

Do we have to report the MVP we registered for?

No. You can't report an MVP that you didn't register for, but you can report traditional MIPS (or the APM Performance Pathway, if applicable) instead.

Can we report traditional MIPS as a subgroup?

No. The subgroup participation option is only available for MVP reporting. MIPS eligible clinicians that registered to report as a subgroup would need to report traditional MIPS or the APP as individuals, as a group, or as an APM Entity (if applicable) if they don't report the MVP.

Can data we reported for traditional MIPS count for MVP reporting?

No. Data submitted for traditional MIPS will only be scored under traditional MIPS. MVP data must be submitted with the correct MVP identifier.

Our practice is reporting as a group, and we have clinicians registered to report an MVP as a subgroup. Do we need to submit our Promoting Interoperability data twice?

Yes. Even though you'll be submitting the same data, **there must be 2 distinct submissions**. One submission for the group and a separate submission for the subgroup (including the appropriate subgroup and MVP identifiers).

Quality Payment
PROGRAM

Reporting Option Selection

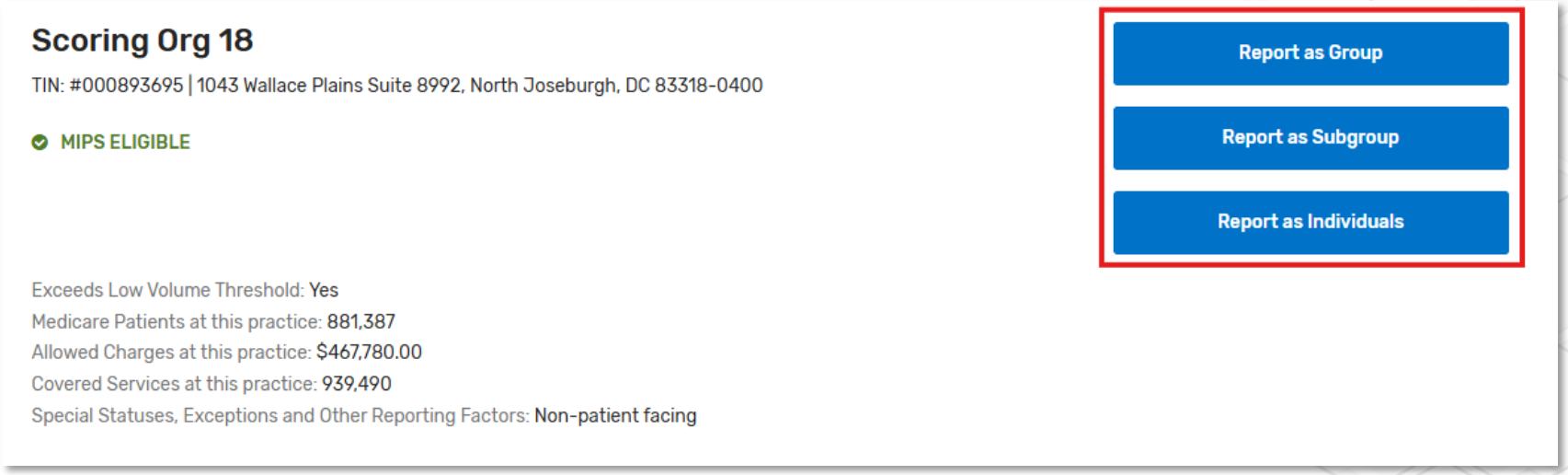
Reporting Option Selection

Quality Payment PROGRAM

Reporting Overview Page

From the **Eligibility & Reporting** page, select the appropriate option to match how your MVP registration was completed.

Note: Only practices that registered some of its clinicians to report an MVP as a subgroup will see **the Report as Subgroup** option.

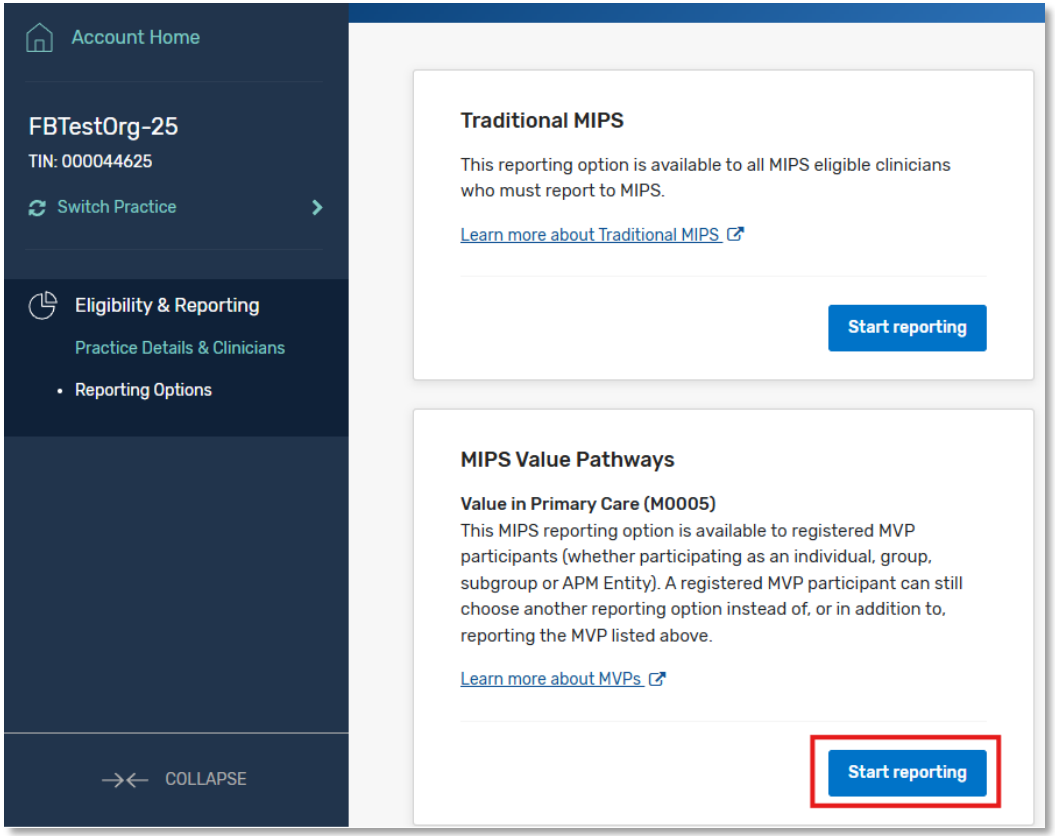


Reporting Option Selection

Quality Payment PROGRAM

Reporting Options

From the **Reporting Option** page, select **Start Reporting** under the MVP selected, during registration.



Only MIPS eligible clinicians and groups can report an MVP.

If you registered to report as an individual or group during the MVP registration period **but are no longer MIPS eligible** after final MIPS eligibility was released, **you won't see the MVP reporting option on this page**.

If you have questions, contact the Quality Payment Program (QPP) Service Center by emailing QPP@cms.hhs.gov, creating a QPP Service Center ticket, or calling 1-866-288-8292 (Monday through Friday 8 a.m. – 8 p.m. ET). Please consider calling during non-peak hours, before 10 a.m. and after 2 p.m. ET. People who are hearing impaired can dial 711 to be connected to a TRS Communications Assistant.

Reporting Option Selection

Quality Payment PROGRAM

Subgroup Reporting

If reporting as a subgroup, after selecting **Report as Subgroup** from **Eligibility & Reporting** page the you'll select the appropriate subgroup name you used during MVP registration, shown also, with the assigned Subgroup ID.

The subgroup name and ID will be displayed in the left navigation

The name and ID of the MVP you registered for will be displayed in the page header.

Quality Payment
PROGRAM

Submitting Data: MVP Identifiers

Submitting Data

MVP Identifiers (IDs) for PY 2025 Data Submission

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**.

MEDICARE PART B CLAIMS MEASURES (Quality)

- If you didn't append the MVP ID to at least one claim associated with your MVP quality reporting, your Medicare Part B claims measures will be attributed to a quality score in traditional MIPS (and not the MVP).
- Review the 2025 Part B Claims Measure Quick Start Guide (PDF, 2MB) for more information.

MANUAL ATTESTATION (Improvement Activities and/or Promoting Interoperability)

- Your data will be attributed to your MVP reporting when you select "MIPS Value Pathways" from the Reporting Options page.

FILE UPLOAD and API (All Categories)

You must include the appropriate MVP ID in every file you upload or API submission that includes MVP measure and/or activity data. 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 **2025 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 JSON file or API submission.

Submitting Data

MVP Identifiers (IDs) for PY 2025 Data Submission (Continued)

MVP ID	MVP Title
G0053	Advancing Rheumatology Patient Care
G0054	Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes
G0055	Advancing Care for Heart Disease
G0057	Adopting Best Practices and Promoting Patient Safety within Emergency Medicine
G0058	Improving Care for Lower Extremity Joint Repair
G0059	Patient Safety and Support of Positive Experiences with Anesthesia
M0001	Advancing Cancer Care
M0002	Optimal Care for Kidney Health
M0004	Quality Care for Patients with Neurological Conditions
M0005	Value in Primary Care
M1366	Focusing on Women's Health
M1368	Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV
M1367	Quality Care for the Treatment of Ear, Nose, and Throat Disorders
M1369	Quality Care in Mental Health and Substance Use Disorders

Submitting Data

MVP Identifiers (IDs) for PY 2025 Data Submission (Continued)

MVP ID	MVP Title
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

Quality Payment
PROGRAM

Submitting Data: File Upload

Submitting Data

Quality Payment PROGRAM

File Upload

You can upload a Quality Reporting Data Architecture Category III (QRDA III) or QPP JavaScript Object Notation (JSON) file with data for **any or all performance categories** by selecting **Upload File** on the **Reporting Overview**.

Having trouble uploading your file?

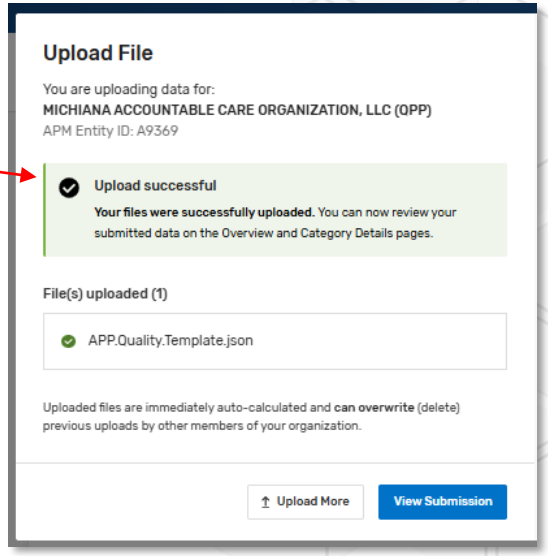
Please see the 2025 Data Submission Troubleshooting FAQs on the QPP Resource Library.

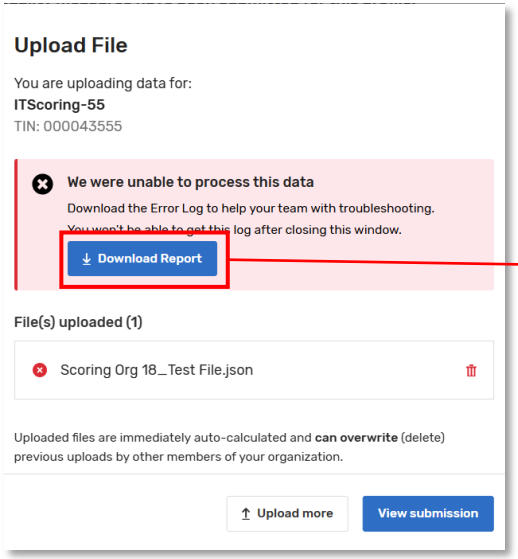
Submitting Data

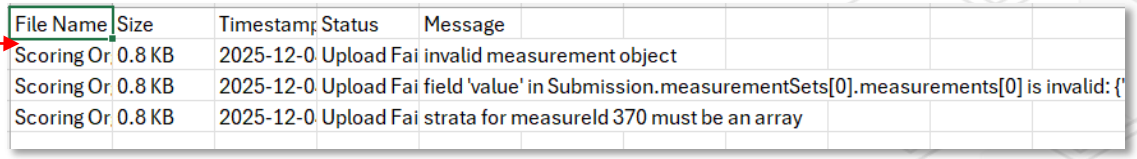
File Upload (Continued)

If your upload is successful, you will see an indicator of success.

If there's an error with your file, you'll see a message indicating that the data couldn't be processed and have access to a detailed error report. Click Download Report for details of the submission issue to send to your Third Party Intermediary. Work directly with your Third Party Intermediary to correct any errors and resubmit your file.







File Name	Size	Timestamp	Status	Message
Scoring Or	0.8 KB	2025-12-0	Upload Fai	invalid measurement object
Scoring Or	0.8 KB	2025-12-0	Upload Fai	field 'value' in Submission.measurementSets[0].measurements[0] is invalid: {'
Scoring Or	0.8 KB	2025-12-0	Upload Fai	strata for measureId 370 must be an array

If you continue to receive errors after working with your Third Party Intermediary, contact the QPP Service Center for assistance with your file. Contact the Quality Payment Program (QPP) Service Center by emailing QPP@cms.hhs.gov, creating a QPP Service Center ticket, or calling 1-866-288-8292 (Monday through Friday 8 a.m. – 8 p.m. ET). Please consider calling during non-peak hours, before 10 a.m. and after 2 p.m. ET. People who are hearing impaired can dial 711 to be connected to a TRS Communications Assistant.

Quality Payment
PROGRAM

Submitting Quality Data

Submitting Quality Data

Reporting Update to CQM #510: First Year Standardized Waitlist Ratio (FYSWR) for the Optimal Care for Kidney Health MVP

To report the data required for the 2nd submission criteria, you must continue to collect and calculate the 1st submission criteria to ensure reporting eligibility even though it won't be submitted.

For purposes of data submission, you must submit the measure as a single stratum, non-proportion measure with the numerator and denominator collected for submission criteria 2 only as outlined in the measure's specification. The measure has also been updated on the 2025 QPP Measures Repository on GitHub.

- **Scoring Impact:** The revised data submission requirements don't affect how the measure is scored; the measure's score is determined by the 2nd performance rate.

Submission criteria 2 measures the ratio of the observed number of waitlist events to the number of expected waitlist events:

- DENOMINATOR (SUBMISSION CRITERIA 2): The denominator for the First Year Standardized Waitlist Ratio (FYSWR) is the total number of patients under the age of 75 in the practitioner group according to each patient's treatment history for patients within the first year following initiation of dialysis.
- NUMERATOR (SUBMISSION CRITERIA 2): The ratio of the observed number of waitlist events in a practitioner group to the model-based expected number of waitlist events.

Your submission will be rejected for the 2025 submission period if:

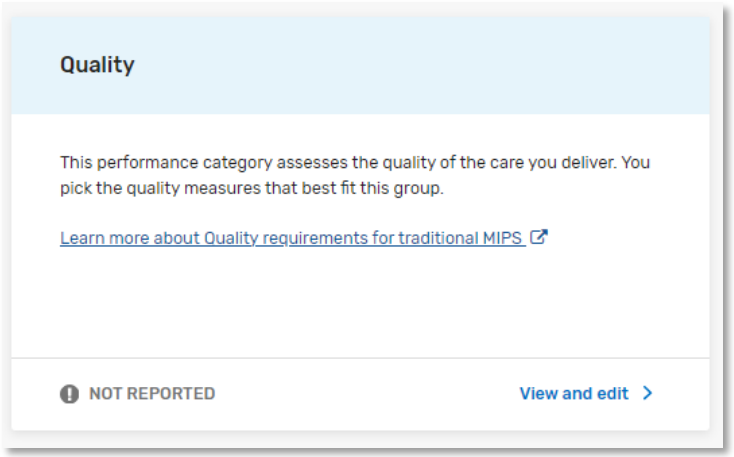
- You submit the measure with both submission criteria (stratum).

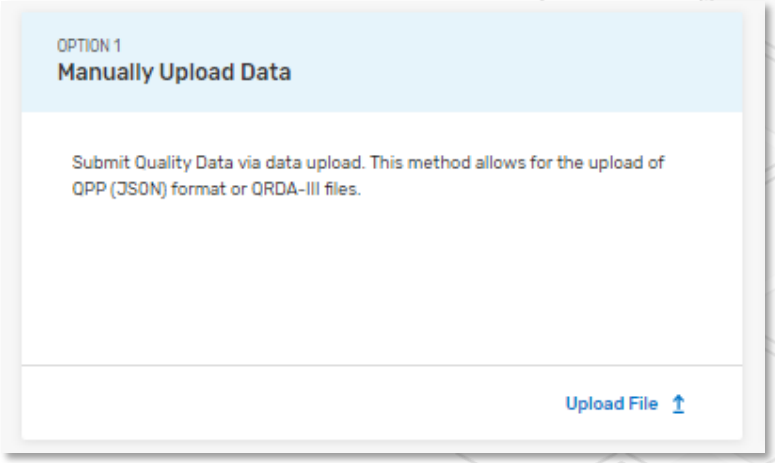
Submitting Quality Data (continued)

Quality Payment PROGRAM

Upload Your Quality Measures

You can upload your own QRDA III or QPP JSON file with your eCQMs or MIPS CQMs by clicking **View & Edit** in the Quality section of the Reporting Overview and then **Upload File**:





Having trouble uploading your file?

Please see the 2025 Data Submission Troubleshooting FAQs on the QPP Resource Library.

NEW for PY 2025: A CEHRT ID will now be required when submitting eCQM data for the quality performance category. For **detailed instructions on how to generate a CMS EHR Certification ID**, review pages 23-25 of the CHPL Public User Guide (PDF, 1.21MB).
A **valid** CMS EHR Certification ID for the 2025 performance period will include **"15C"** (as it did in PY 2024) **or "2025C".**

Quality Payment
PROGRAM

Attesting to Promoting Interoperability Data

Attesting to Promoting Interoperability Data

Electronic Case Reporting Measure Suppression

The Centers for Disease Control and Prevention (CDC) has temporarily paused electronic case reporting registration (learn more in this fact sheet) and onboarding of new health care organizations (HCOs) to establish a more efficient and automated onboarding process. As a result, some MIPS eligible clinicians may be unable to meet the electronic case reporting registration and onboarding requirements by the end of the 2025 performance period.

To avoid adverse consequences beyond the MIPS eligible clinicians' control, **we're suppressing the Electronic Case Reporting measure** for the MIPS Promoting Interoperability performance category for the CY 2025 performance period/2027 MIPS payment year.

The measure must still be reported. MIPS eligible clinicians will meet the measure requirements by attesting either "Yes" or "No" to being in active engagement with a public health agency or claiming an applicable exclusion. MIPS eligible clinicians who report the suppressed Electronic Case Reporting measure will receive full credit for the measure.

Note: Even though the Electronic Case Reporting measure is suppressed, MIPS eligible clinicians who don't report the Electronic Case Reporting measure (or claim an applicable exclusion) will earn zero points for the Promoting Interoperability performance category.

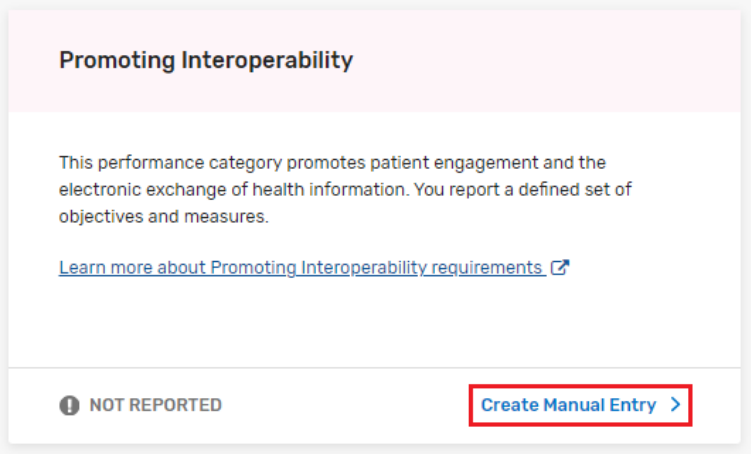
Attesting to Promoting Interoperability Data

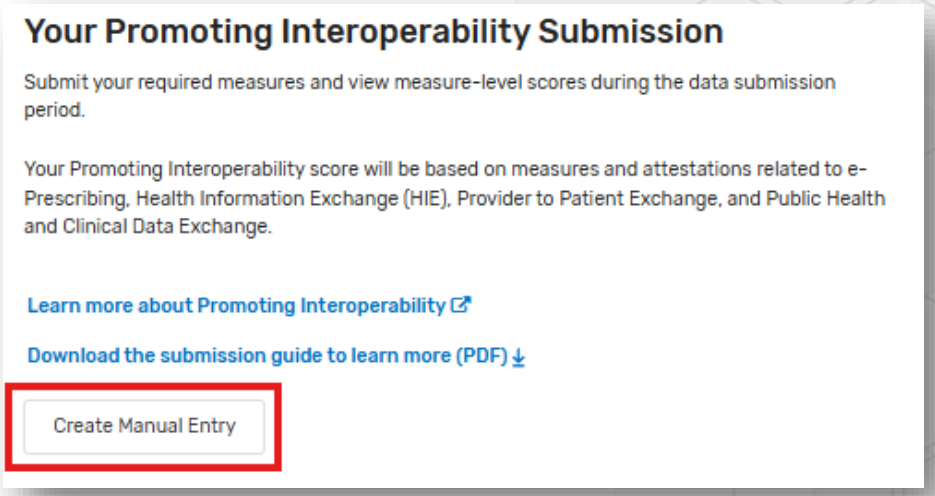
Quality Payment PROGRAM

Manual Entry (Attestation)

If you don't upload a file, you can also attest to your Promoting Interoperability data by manually entering numerators, denominators, and yes/no values as appropriate to the measure.

Click Create Manual Entry on the **Reporting Overview**, and then again on the **Promoting Interoperability** page.





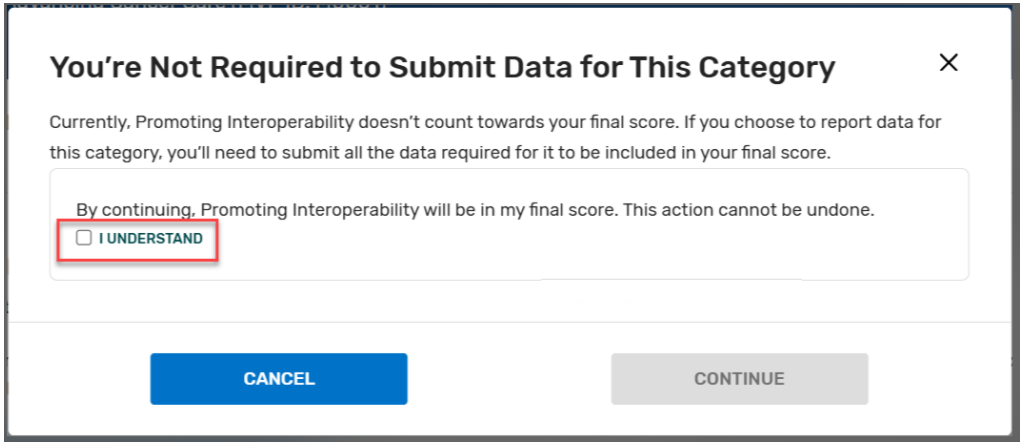
Attesting to Promoting Interoperability Data

Quality Payment PROGRAM

Manual Entry (Attestation) (Continued)

If your Promoting Interoperability performance category is currently weighted at 0%, you will be prompted to confirm that you wish to proceed (click **I Understand** then **Continue**).

- **If you click Continue and attest to all required data, you will receive a score in this performance category.**
- **A non-qualifying submission (submitting some but not all required data) WON'T override reweighting.**



Did you know?

Small practices have a different redistribution when **Promoting Interoperability** is reweighted to 0%

- **Quality:** 40%
- **Improvement Activities:** 30%
- **Cost:** 30%

As you provide the required information on the Manual Entry page, more fields will appear. For example, once you enter your performance period, the CEHRT ID field will appear. You must provide all required information (including measure data).

Attesting to Promoting Interoperability Data

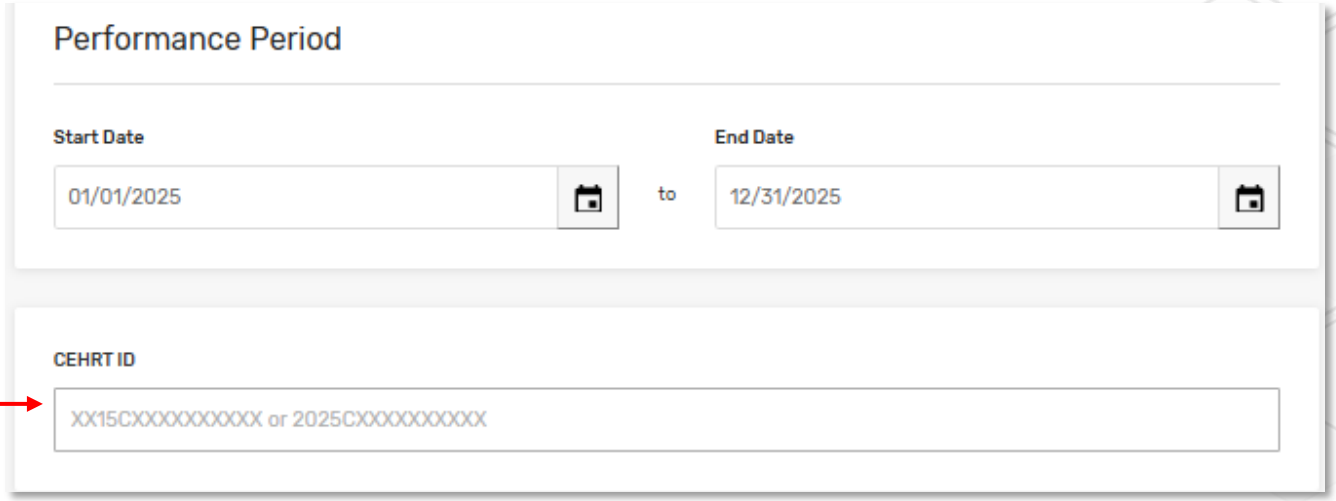
Quality Payment PROGRAM

Manual Entry (Attestation) (Continued)

Enter Your Performance Period and CMS EHR Certification ID ("CEHRT ID")

The CEHRT ID format was updated for 2025. A **valid** CMS EHR Certification ID for the 2025 performance period can include "**15C**" or "**2025C**".

For **detailed instructions on how to generate a CMS EHR Certification ID**, review pages 23-25 of the CHPL Public User Guide (PDF, 763KB).



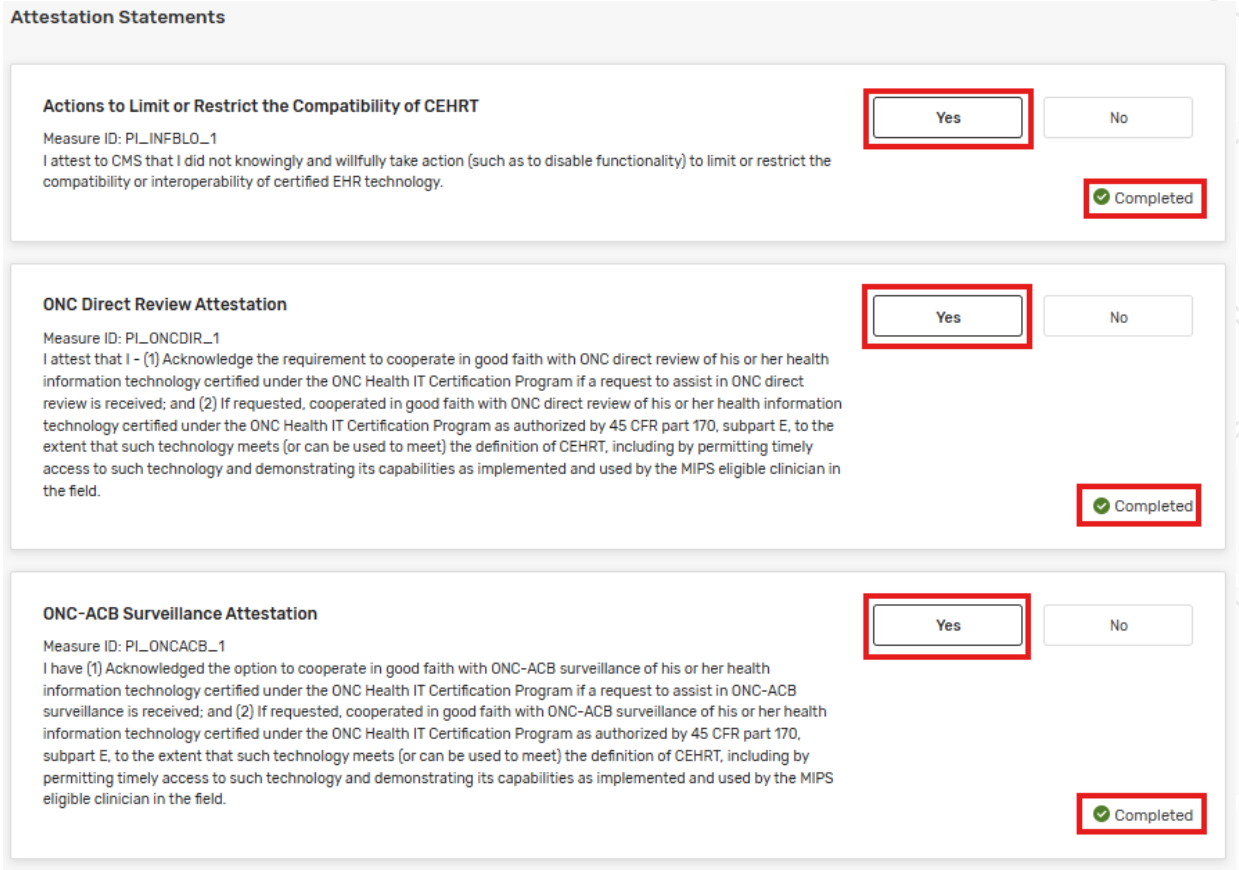
Attesting to Promoting Interoperability Data

Quality Payment PROGRAM

Manual Entry (Attestation) (Continued)

Complete Required Attestation Statements and Measures

You must select **Yes** for the 3 required attestations before you can begin entering your measure data. As you move through the required information, you will see an indicator as each requirement is **completed.**

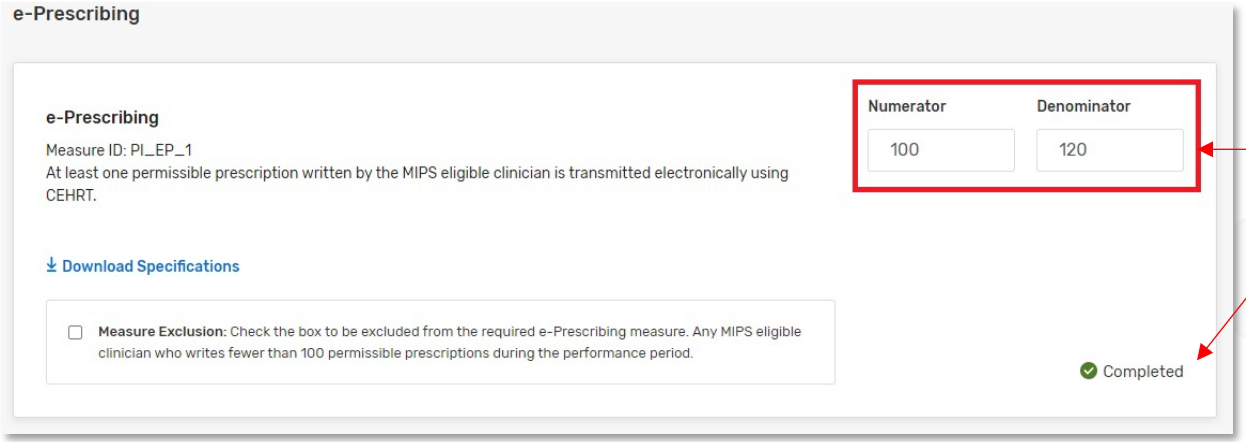


Attesting to Promoting Interoperability Data

Quality Payment PROGRAM

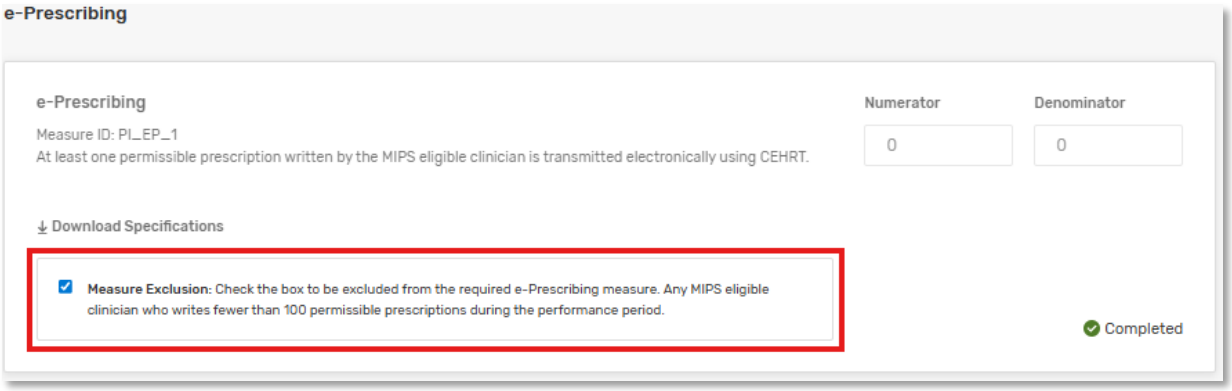
Manual Entry (Attestation) (Continued)

Numerator/Denominator Example



The numerator and denominator values for all Promoting Interoperability measures must be greater than 0 for the measure to be marked as completed.

Exclusion Example



Attesting to Promoting Interoperability Data

Quality Payment PROGRAM

Manual Entry (Attestation) (Continued)

Health Information Exchange Objective

There are 3 options for meeting the Health Information Exchange (HIE) objective:

Option 1:

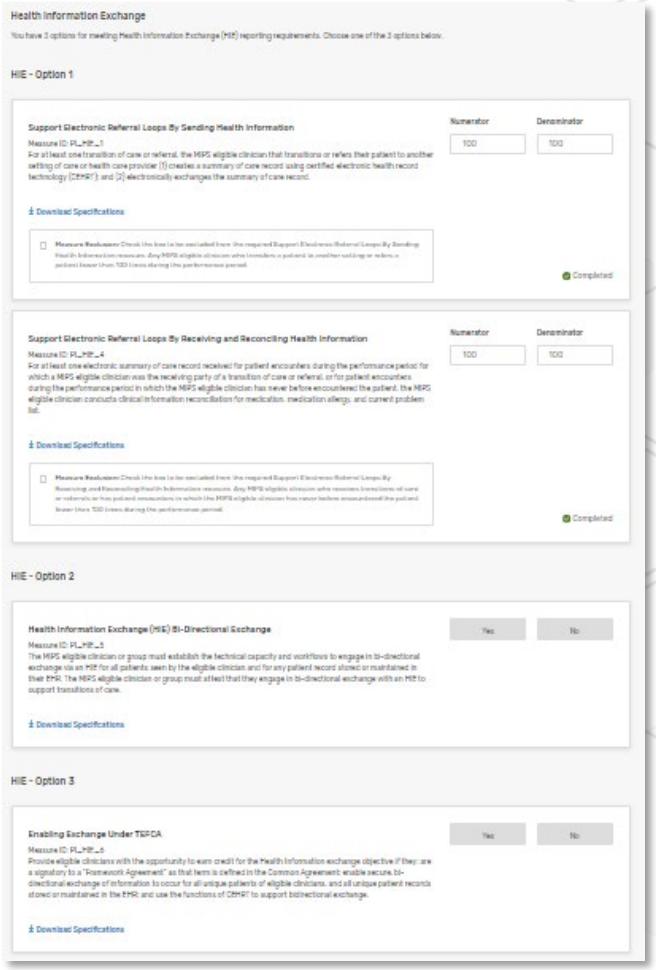
- Support Electronic Referral Loops by Sending Health Information - requires numerator and denominator values
- Support Electronic Referral Loops by Receiving and Reconciling Health Information - requires numerator and denominator values

Option 2:

- Health Information Exchange: Bi-Directional Exchange

Option 3:

- Enabling Exchange Under TEFCA

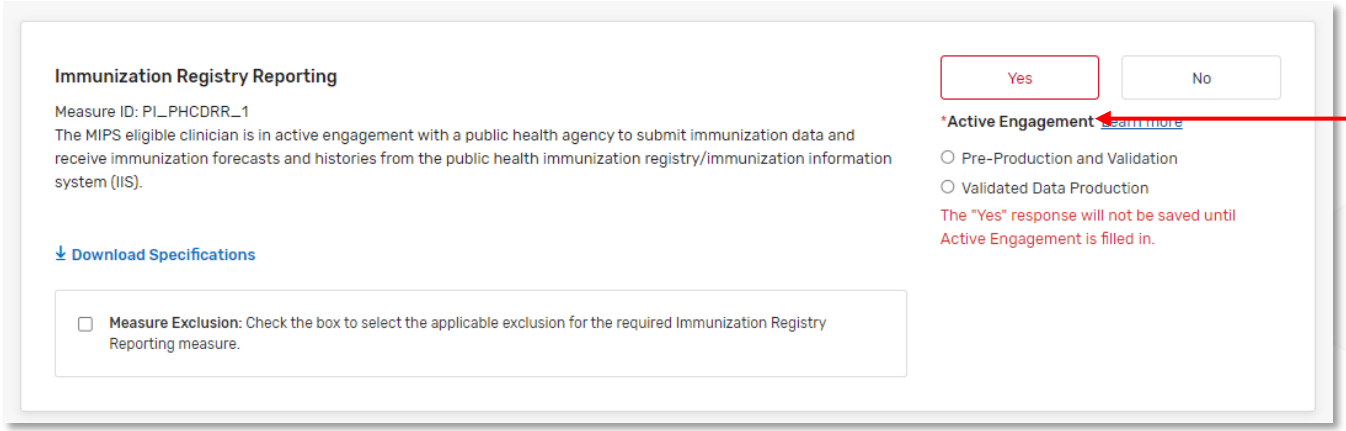


Attesting to Promoting Interoperability Data

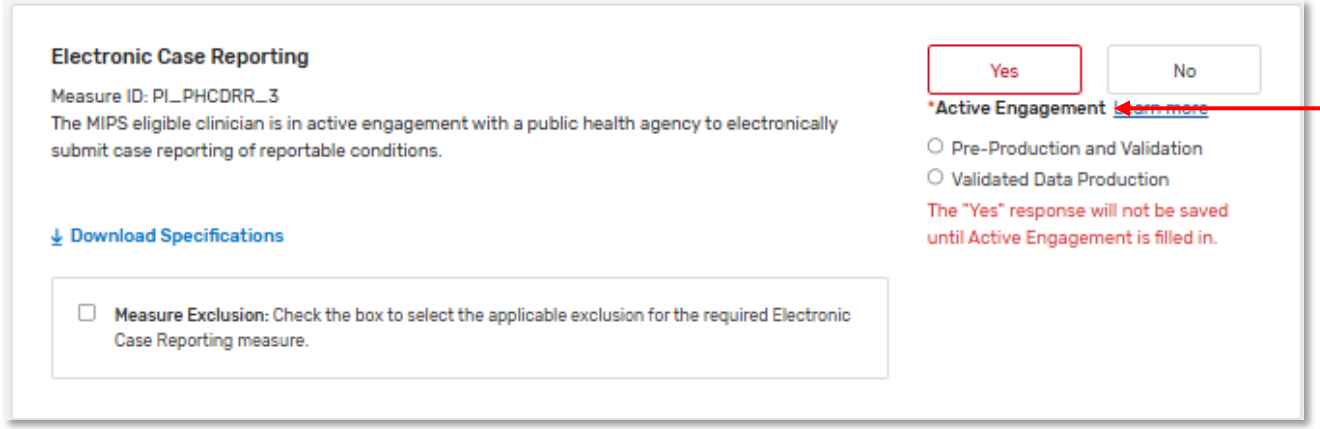
Quality Payment PROGRAM

Manual Entry (Attestation) (Continued)

Complete Required Attestation Statements and Measures – Public Health and Clinical Data Exchange



Choose one of the options for Active Engagement. A "Yes" response will not be saved until filled in.



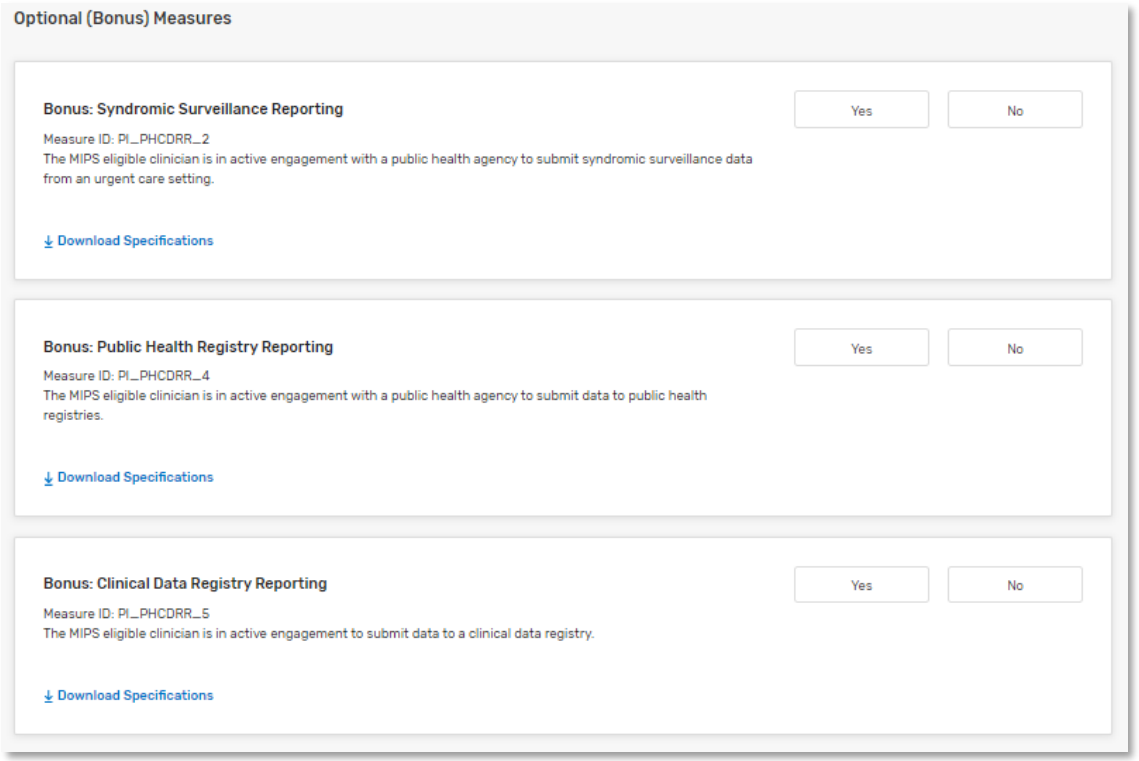
Choose a "Yes" or "No" for this measure OR claim an exclusion. Even though this measure is suppressed for PY 2025, the measure is still required to be reported.

Attesting to Promoting Interoperability Data

Quality Payment PROGRAM

Manual Entry (Attestation) (Continued)

Optional/Bonus Measures – Public Health and Clinical Data Exchange



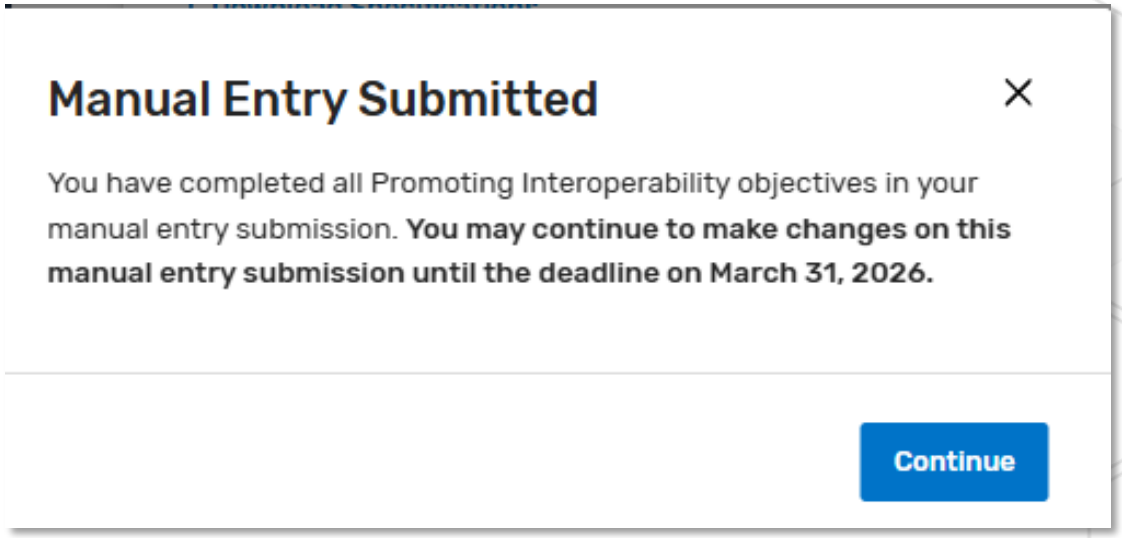
To earn an additional 5 bonus points in this performance category, you can choose to report 1 or more of the remaining, optional measures. There are a total of 5 bonus points available whether you report 1, 2, or all 3 of the optional measures.

Attesting to Promoting Interoperability Data

Quality Payment PROGRAM

Manual Entry (Attestation) (Continued)

Once all required data have been reported, the system will notify you and allow you to view your measure-level scores.



Quality Payment
PROGRAM

Attesting to Improvement Activities Data

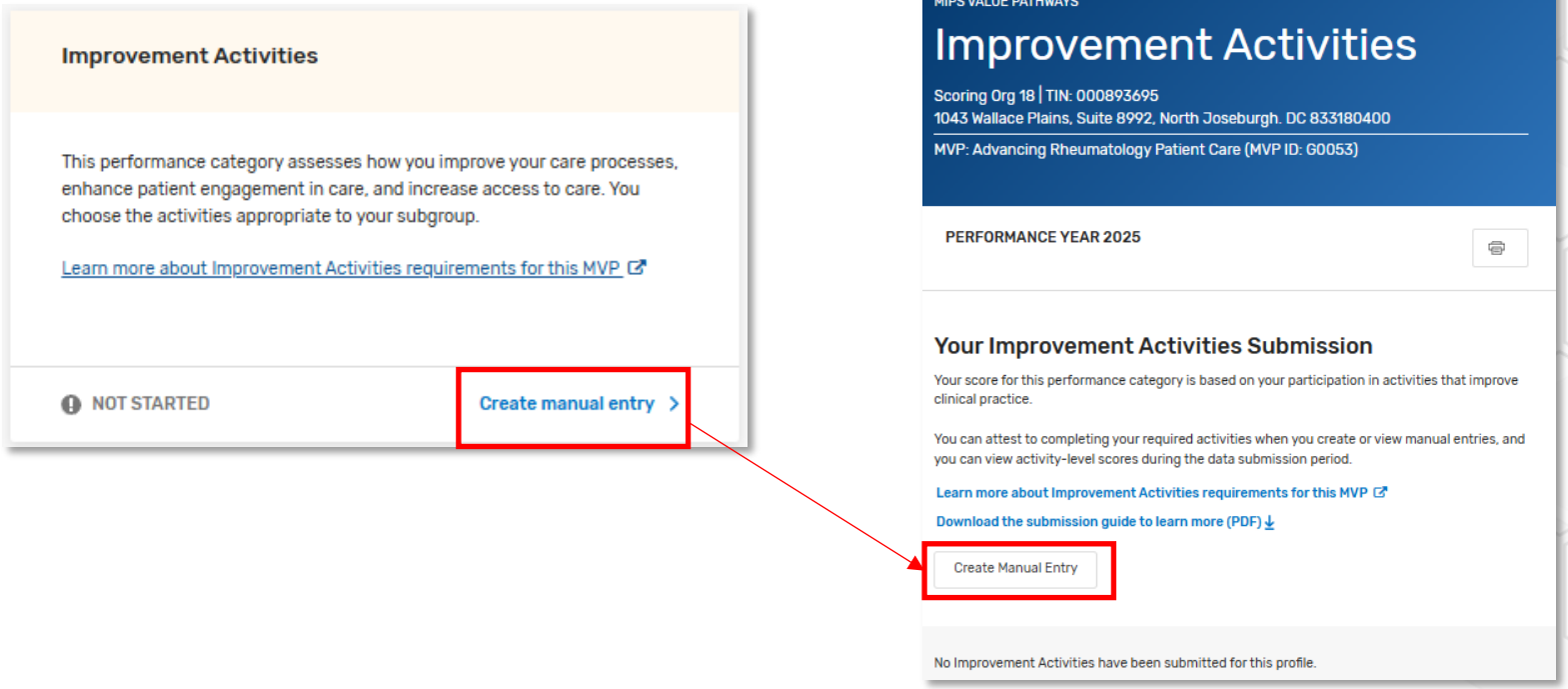
Attesting to Improvement Activities Data

Quality Payment PROGRAM

Manual Entry (Attestation)

If you don't upload a file, you can attest to your Improvement Activities data by manually entering yes values to indicate you've completed the activity.

Click Create Manual Entry on the **Reporting Overview**, and then again on the **Improvement Activities** page.

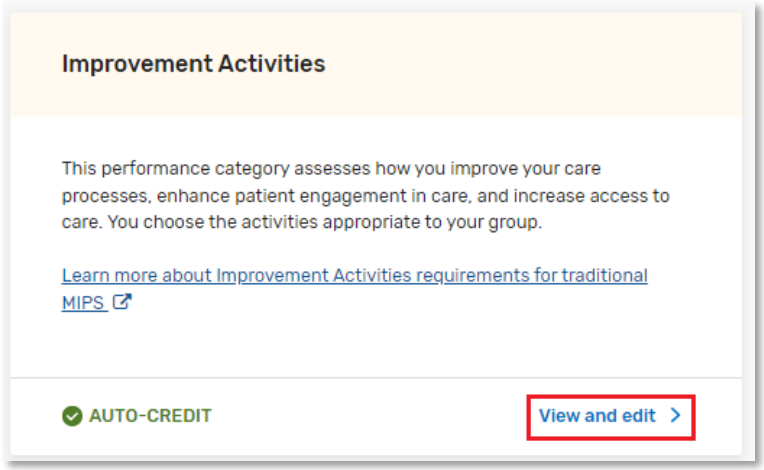


Attesting to Improvement Activities Data

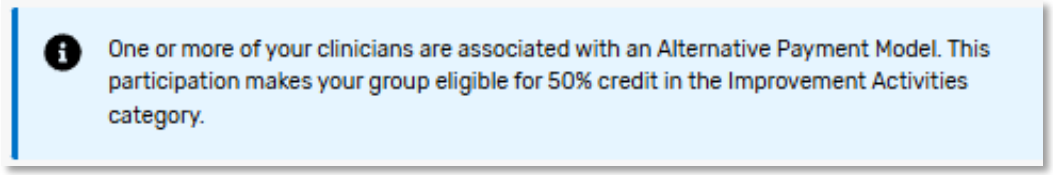
Manual Entry (Attestation) (Continued)

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.

Clinicians in an APM reporting an MVP will automatically receive 50% credit in the Improvement Activities performance category as long as some MIPS data is submitted, regardless of performance category.



Once you select Create Manual Entry, you will see a message that 20 (out of 40 possible) points have been awarded based on your APM participation (or for Group reporting, based on having at least one clinician who participates in an APM).

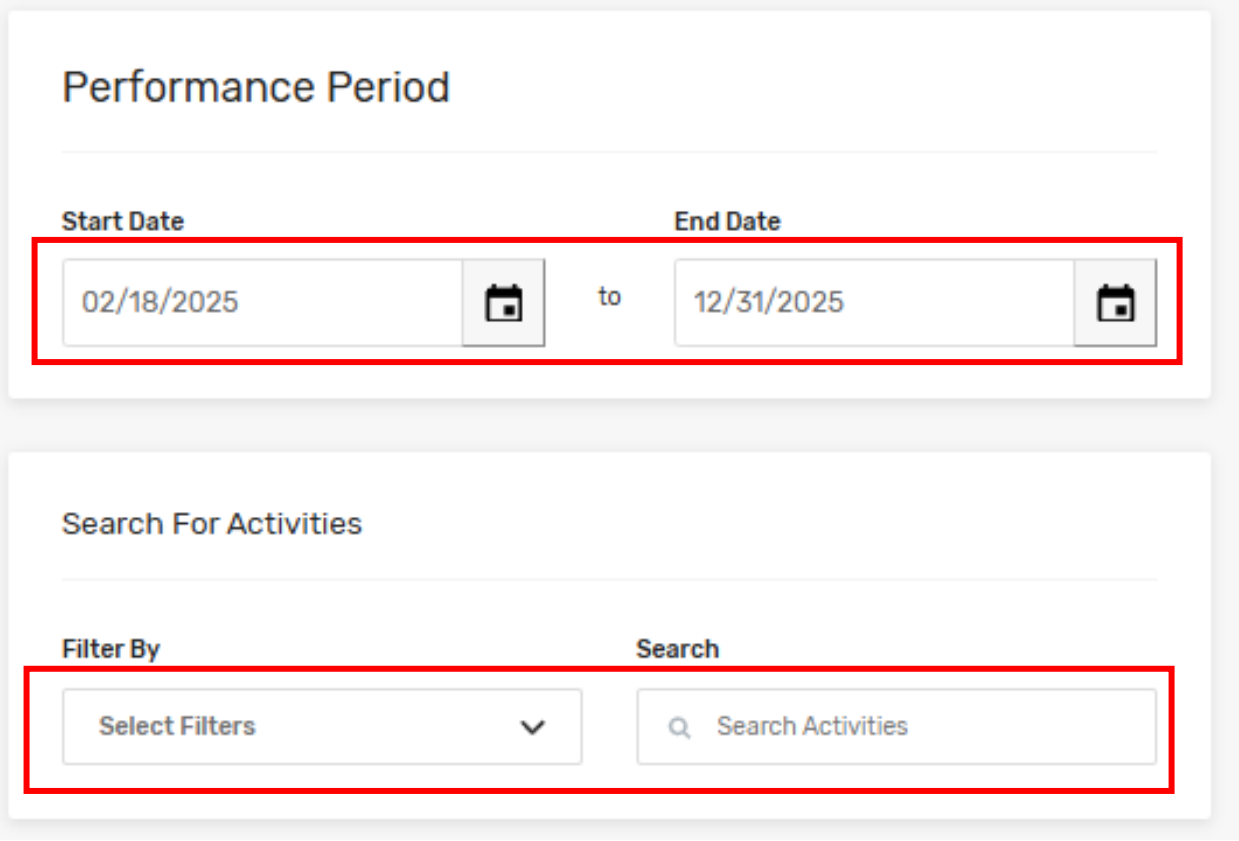


Attesting to Improvement Activities Data

Quality Payment PROGRAM

Manual Entry (Attestation) (Continued)

Once you enter your performance period, you can **search** for your activities by key term or **filter** by weight or subcategory. Check the box next to **Completed** to attest that the activity was performed.



You can submit more than the 1 required improvement activity, but you can't earn more than 40 points for the performance category.

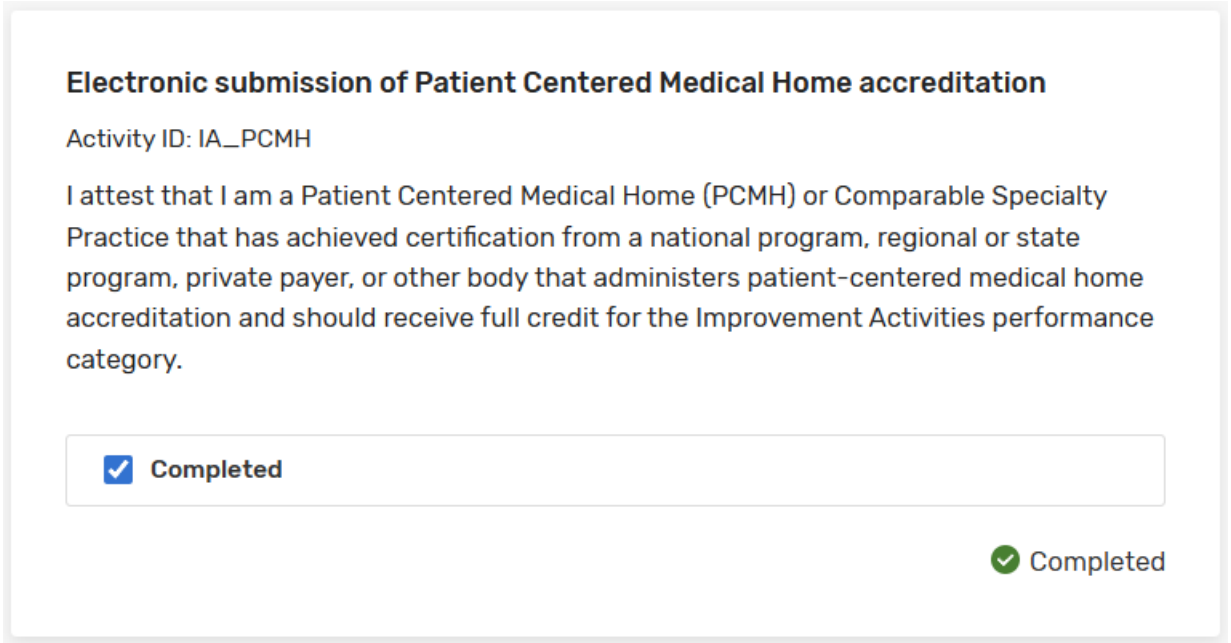
Each *activity* has a continuous 90-day performance period (or as specified in the activity description) but multiple activities don't have to be performed during the same 90-day period. If your improvement activities are performed at different times during the year, your performance period at the category level:

- **Starts** on the first day in the year that any improvement activity was performed, and
- **Ends** on the last day in the year that any improvement activity was performed.

Attesting to Improvement Activities Data

Quality Payment PROGRAM

Manual Entry (Attestation) (Continued)



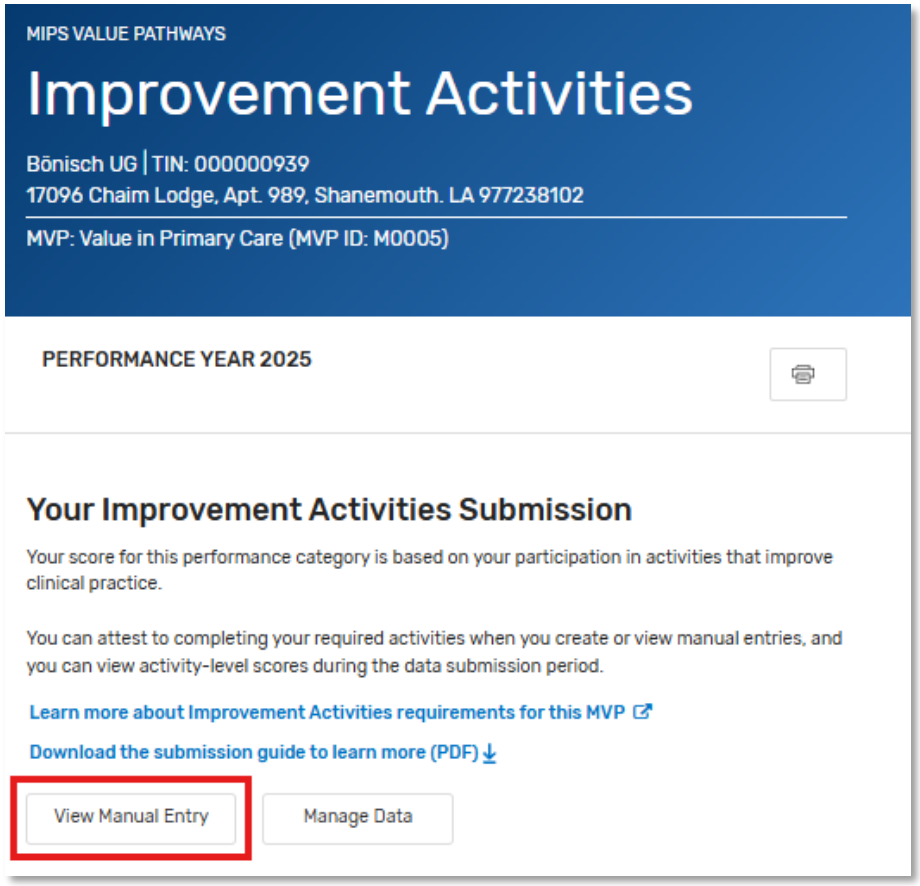
Helpful Hint:
The Patient Centered Medical Home attestation is the first activity listed if it's available within your selected MVP. You can attest to this activity if you Participate in a certified or recognized patient-centered medical home or comparable specialty society.

Attesting to Improvement Activities Data

Quality Payment PROGRAM

Manual Entry (Attestation) (Continued)

Click **View & Edit** from the Reporting Overview.



If you need to update your manually entered data click View Manual Entry

If a third party reported some but not all of the activities performed, you can manually enter any missing activities

If you haven't created a manual entry, you will see Create Manual Entry (instead of View Manual Entry.)

Quality Payment
PROGRAM

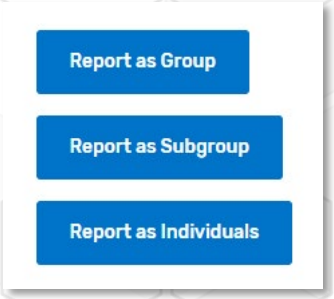
Reviewing Data

Reviewing Data

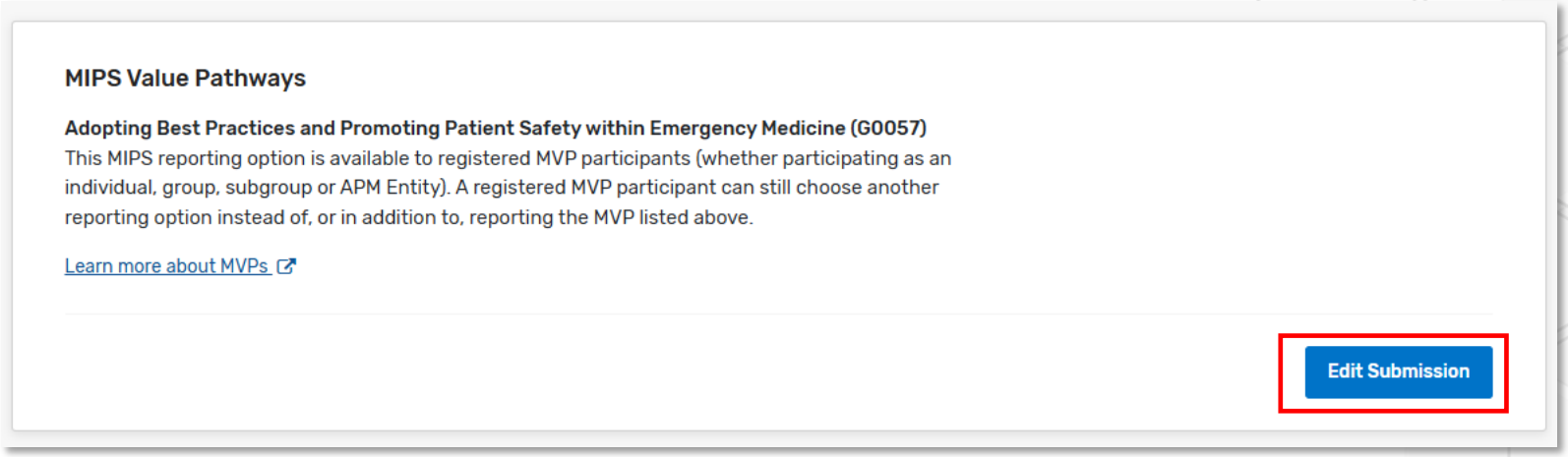
Quality Payment PROGRAM

Access Previously Submitted Data

1. Sign in
2. Navigate to the **Eligibility & Reporting** page
3. Select how you reported:
    a. Click **Report as Group** if you want to view data submitted by or for the group
    b. Click **Report as Subgroup** if you want to view data submitted by or for the subgroup
    c. Click **Report as Individuals** if you want to view data submitted by or for the individual



4. Click **Edit Submission** on the MIPS Value Pathways card.

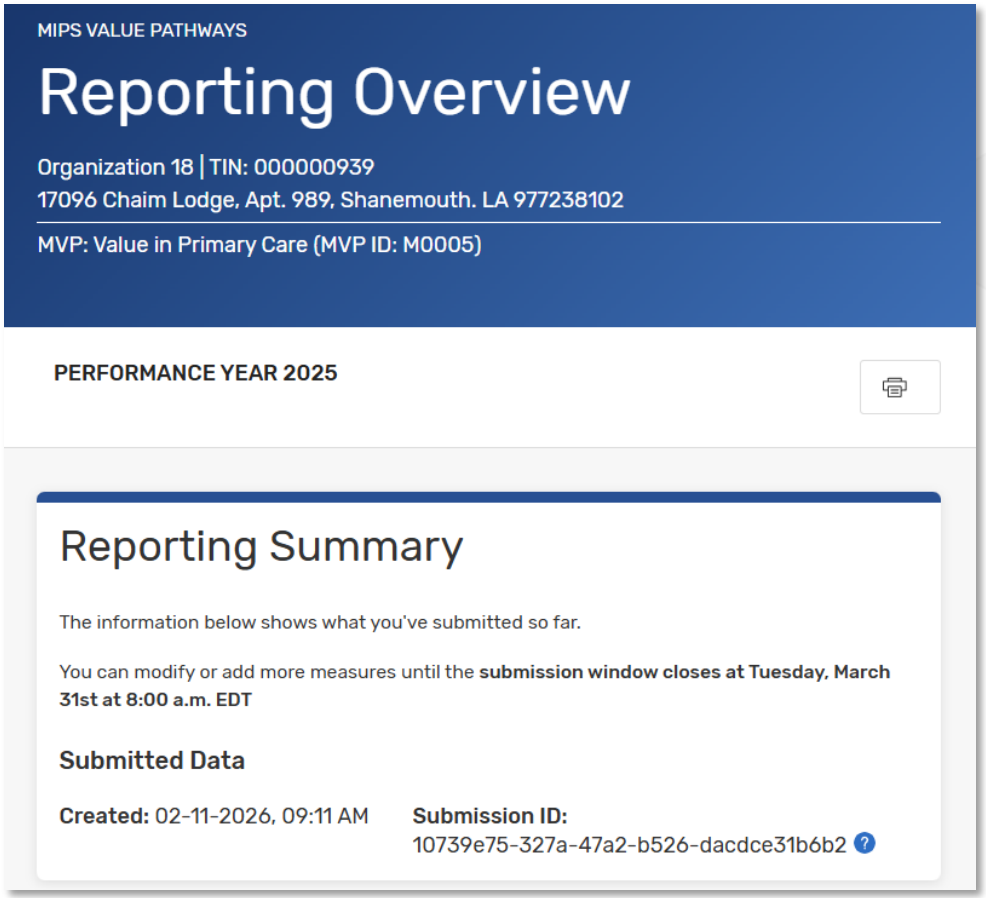


Reviewing Data

Quality Payment PROGRAM

Access Previously Submitted Data (Continued)

On the **Reporting Overview**, you'll see a reporting summary with the **Created Date** (the date that data was first submitted) and the Submission ID – these fields won't change with subsequent submissions.

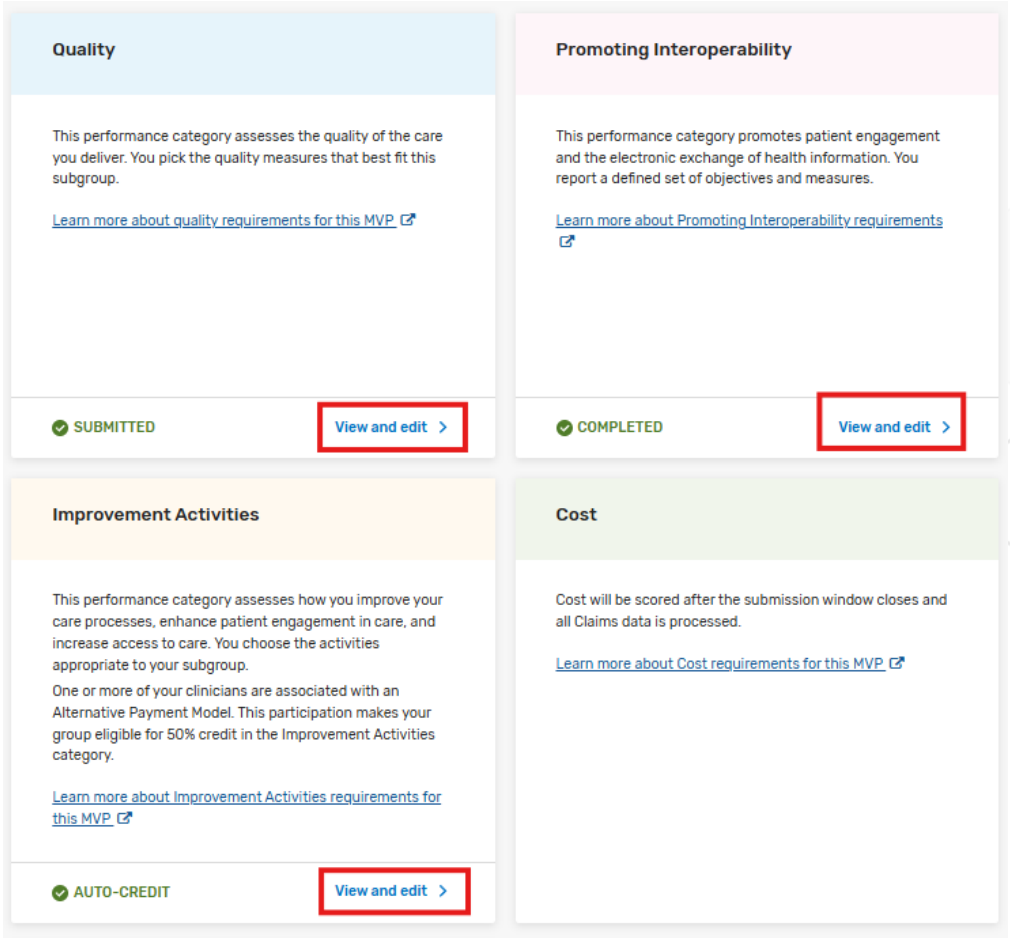


Reviewing Data

Quality Payment PROGRAM

Access Previously Submitted Data (Continued)

Scroll down and click **View & Edit** to access details about the data that's already been submitted for a performance category.



Quality Payment
PROGRAM

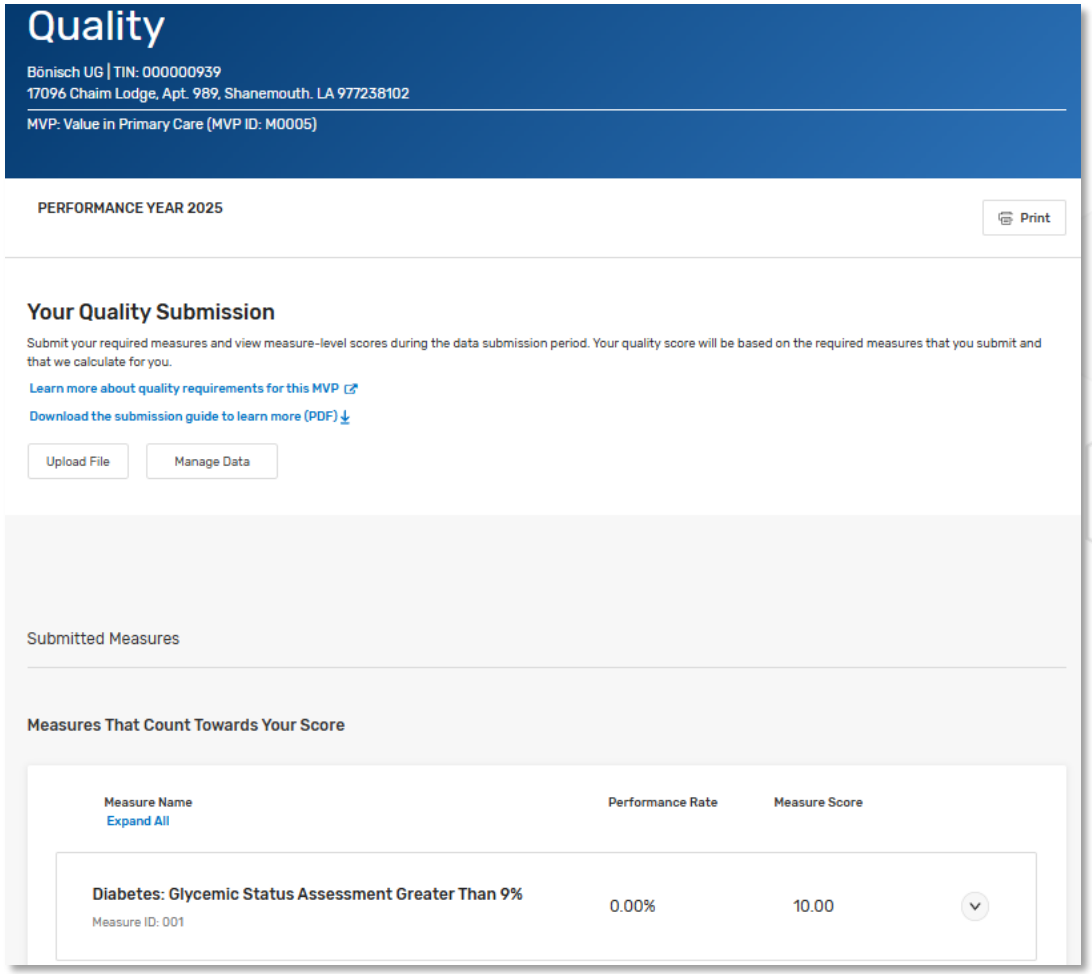
Reviewing Data: Quality

Reviewing Data: Quality

Quality Payment PROGRAM

Review Previously Submitted Data

Clicking View & Edit on the quality card will bring you to the Quality details page.



Reviewing Data: Quality

Quality Payment PROGRAM

Review Previously Submitted Data (Continued)

During the submission period, this page will reflect:

- ✓ Medicare Part B claims measures reported by clinicians in a small practice throughout the performance period (available by late January 2026), and
- ✓ eCQMs or MIPS CQMs that you have uploaded directly or were submitted by a third party (such as a Qualified Registry or QCDR), and
- ✓ QCDR measures submitted on your behalf by a QCDR

Medicare Part B Claims Measures

Only clinicians in small practices (fewer than 16 clinicians) can report Medicare Part B claims measures. If you don't see your preliminary scores for Part B claims measures, check the QPP Participation Status lookup tool to see if you have the small practice special status.

We'll only automatically calculate a quality score at the group level if the practice also submits data at the group level for another performance category.

We intend to update preliminary Part B claims measure scores on a monthly basis during the submission period (to account for the 60-day run out period for claims measure processing).

During the submission period, this page WON'T reflect:

- × Scoring for the CAHPS for MIPS Survey measure.
- × Scoring on your population health measure.
- × A preliminary score for the quality performance category.

Reviewing Data: Quality

Quality Payment PROGRAM

Multiple Quality Submissions from the Same Organization.

Please review the QPP Submissions Application Program Interface (API) documentation for detailed information about API submissions.

We'll keep the most recent data submitted when the data is **submitted the same way** (e.g., via file upload) AND **by the same organization** (e.g., the practice) AND **for the same**:

- ✓ **Performance category** (e.g., quality)
- ✓ **Collection type**
- ✓ **Participation option** (e.g., group)
- ✓ **Reporting option** (e.g., traditional MIPS)

This approach allows practices to correct and resubmit previously submitted data.

Reviewing Data: Quality

Multiple Quality Submissions from the Same Organization. (Continued)

Example 1.

John and Kathy are practice staff at Mountain Medical and support the group's MIPS reporting. Mountain Medical is reporting the Advancing Cancer Care MVP as a group.

John uploaded a file with 2 measures (134 and 143) on Tuesday	Kathy uploaded a file with 2 measures (450 and 451) on Thursday
✓ Quality performance category	✓ Quality performance category
✓ MIPS CQM collection type	✓ MIPS CQM collection type
✓ Group reporting	✓ Group reporting
✓ Advancing Cancer Care MVP	✓ Advancing Cancer Care MVP

The group will be scored on the 2 MIPS CQMs that Kathy submitted on Thursday.

Why? Kathy submitted the most recent data by their organization, through the same submission method, for the same performance category, collection type, participation option, and reporting option.

Reviewing Data: Quality

Quality Payment PROGRAM

Multiple Quality Submissions from the Same Organization. (Continued)

Example 2.

Dr. Andrews is a solo practitioner reporting the Advancing Cancer Care MVP.

- She reported 2 quality measures through Medicare Part B claims throughout the performance period.
- She uploaded a file with 2 eCQMs (a report she extracted from her EHR) during the submission period.

Dr. Andrews reported 2 measures during the performance period:		Dr. Andrews submitted 2 measures during the submission period:	
✓	Quality performance category	✓	Quality performance category
×	Medicare Part B claims	×	eCQM collection type
✓	Individual reporting	✓	Individual reporting
✓	Advancing Cancer Care MVP	✓	Advancing Cancer Care MVP

Dr. Andrews will be scored on all 4 measures.

Why? The 2 measures submitted by file upload won't overwrite the 2 measures submitted through Medicare Part B claims because they were submitted through different methods and for different collection types.

Reviewing Data: Quality

Quality Payment PROGRAM

Multiple Quality Submissions from the Same Organization. (Continued)

Example 3.

Steven and Elise are assistant practice managers at Keaton's Oncology Center, which is reporting both traditional MIPS and the Advancing Cancer Care MVP at the group level. Steven oversees their traditional MIPS reporting and Elise oversees their MVP reporting.

Steven uploaded a file with 6 measures on Thursday:		Elise uploaded a file with 4 measures on Friday:	
✓	Quality performance category	✓	Quality performance category
✓	MIPS CQM collection type	✓	MIPS CQM collection type
✓	Group reporting	✓	Group reporting
×	Traditional MIPS	×	Advancing Cancer Care MVP

The group will receive a quality score in traditional MIPS (based on the 6 measures Steven submitted) and a quality score for the Advancing Cancer Care MVP (based on the 4 measures submitted by Elise).

- When a group reports both traditional MIPS and an MVP, the group will ultimately receive the higher MIPS final score, either from traditional MIPS reporting (based on traditional MIPS submissions for all categories) or MVP reporting (based on MVP submissions for all categories).

Why? Elise's data didn't overwrite Steven's data because they submitted data for different reporting options.

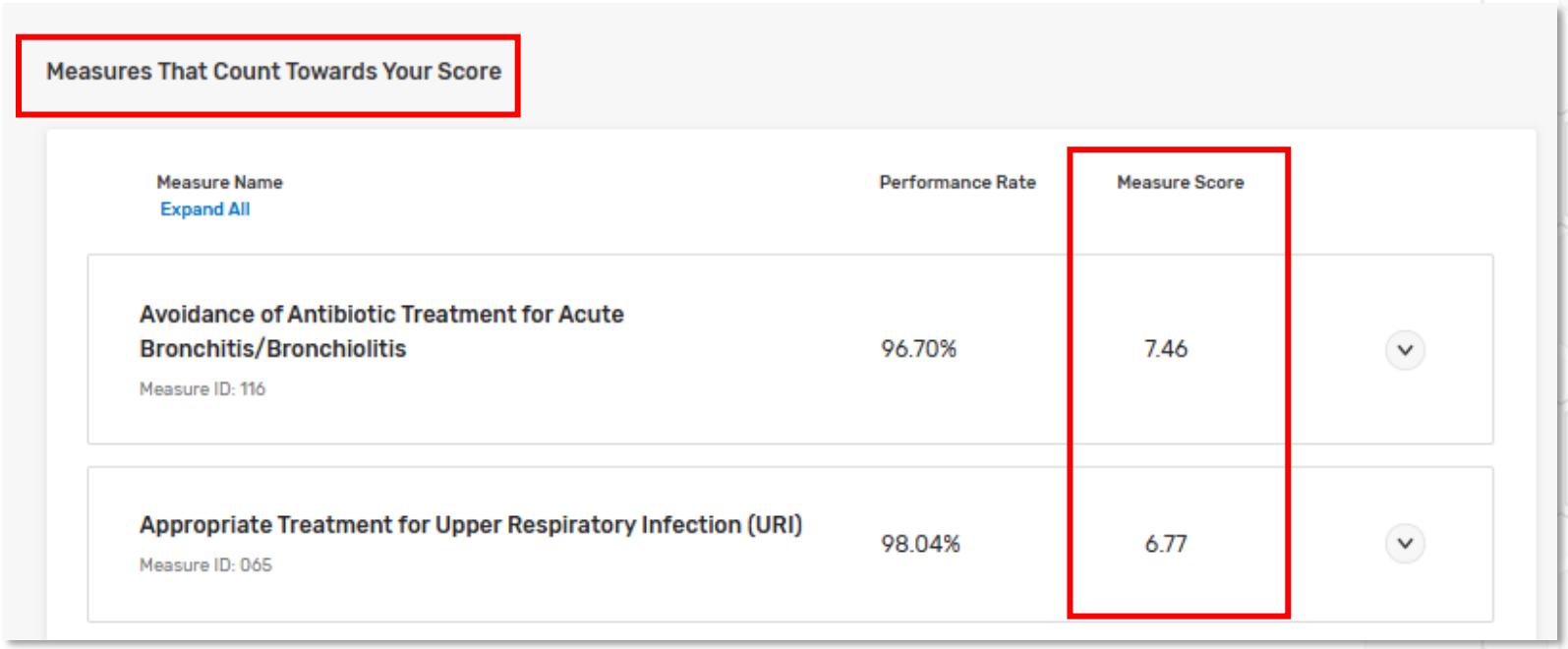
Reviewing Data: Quality

Quality Payment PROGRAM

Measure Information

Measures may be divided into 2 groups:

1. Measures whose performance points count toward your quality performance category score. The measure score will display your performance points (those achieved based on performance in comparison to the measure's benchmark).



Reviewing Data: Quality

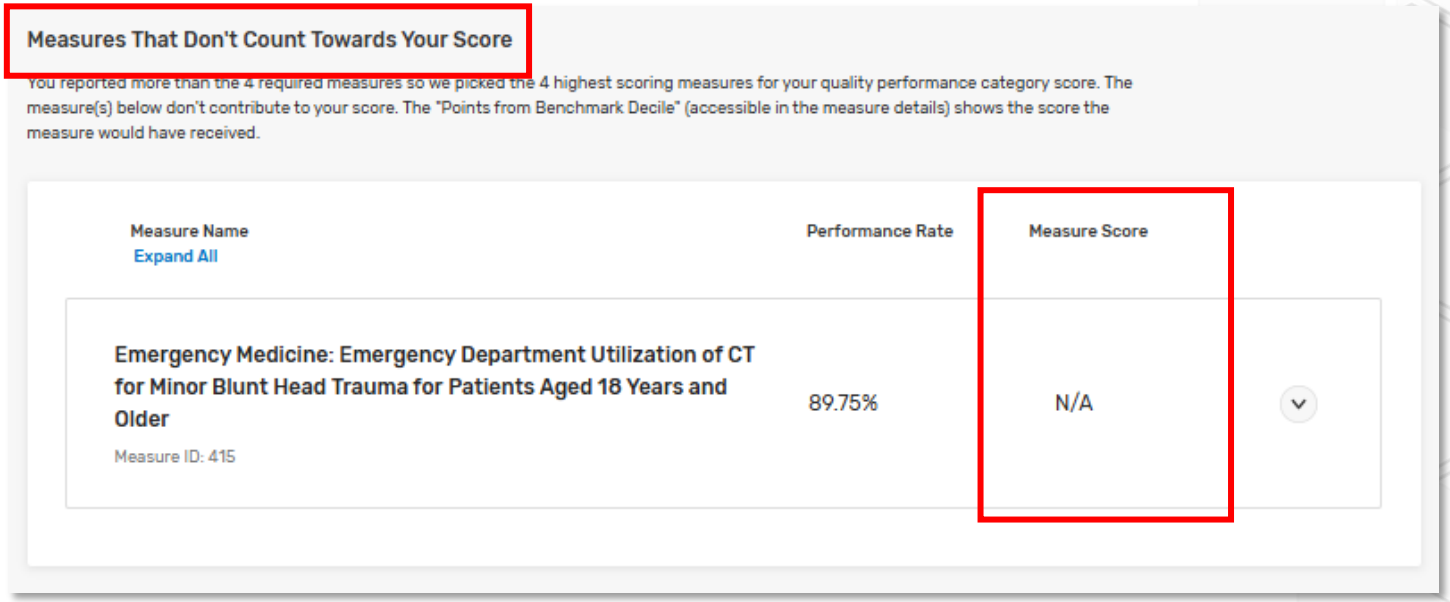
Quality Payment PROGRAM

Measure Information (Continued)

Measures may be divided into 2 groups (Continued):

2. Measures that contribute no points to your quality performance category score. You will see an "N/A" in the measure score.

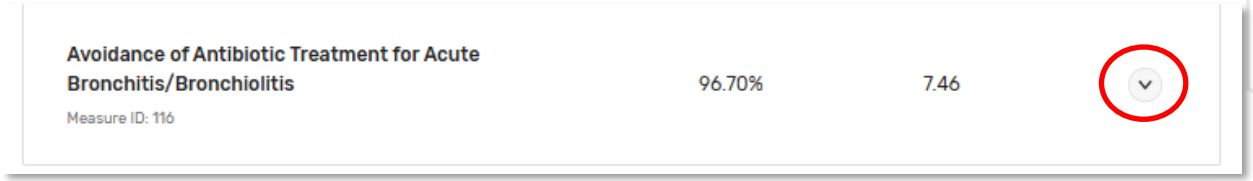
   This will occur if you submit more than 4 measures from the MVP

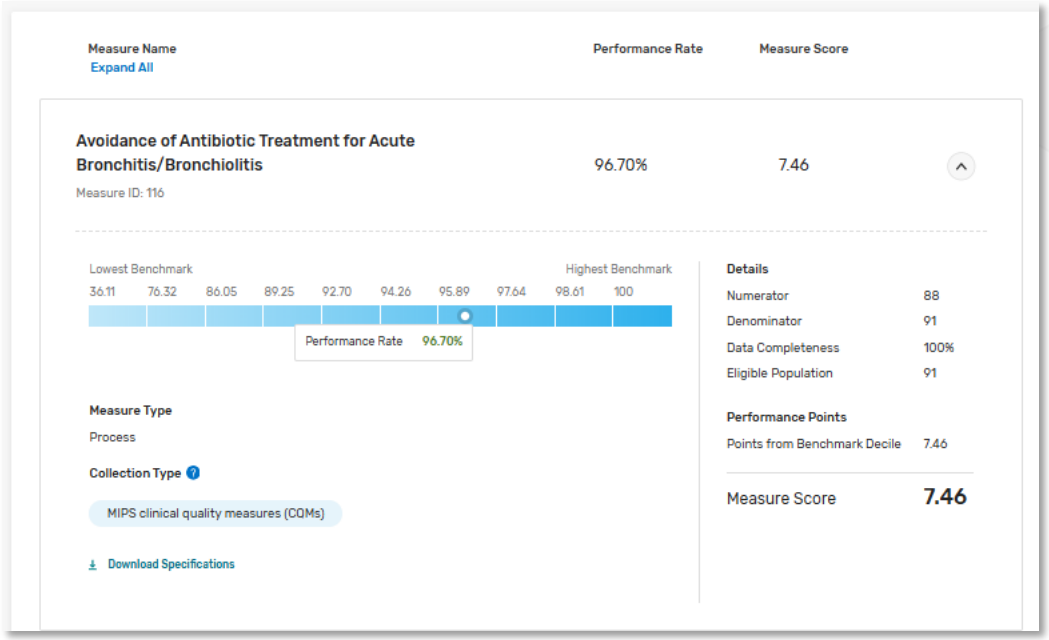


Reviewing Data: Quality

Measure Information (Continued)

To view measure details, click the down arrow on the right side of the measure information:





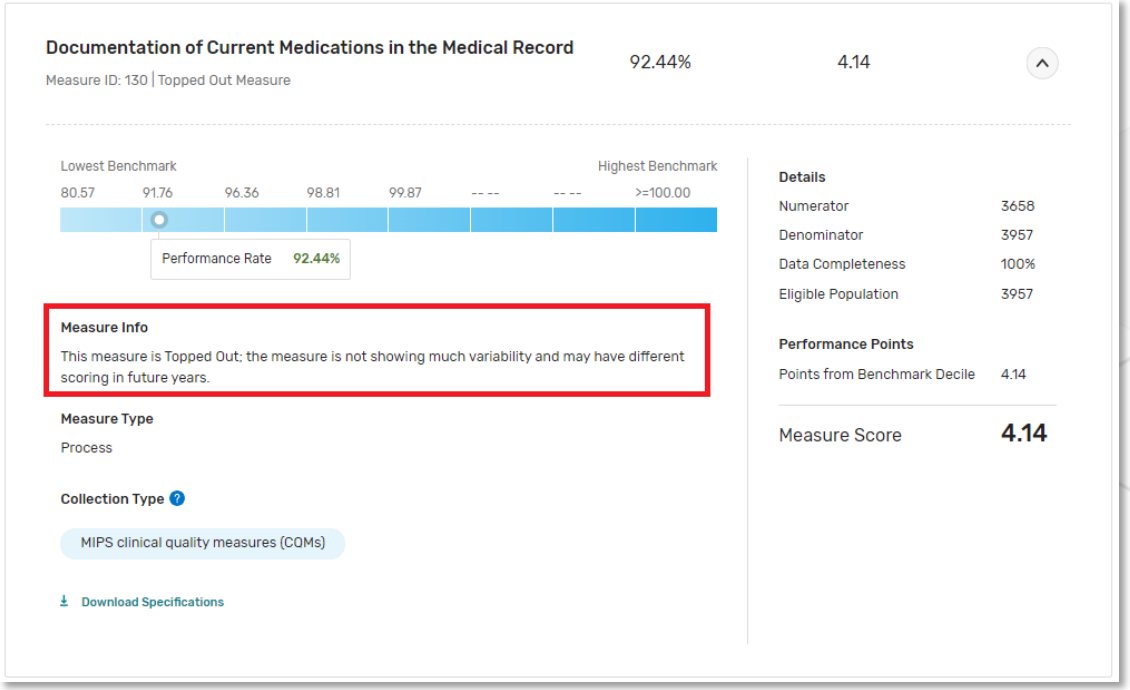
From here, you will see performance points (those earned by comparing your performance to a historical benchmark), and other scoring details about the measure.

Reviewing Data: Quality

Quality Payment PROGRAM

Topped-Out Measures

A topped-out measure is one where performance is high with little variation among those reporting the measure – a topped out **process** measure is defined as a measure with a **median** performance rate of 95% or greater (or 5% or less, for inverse measures).

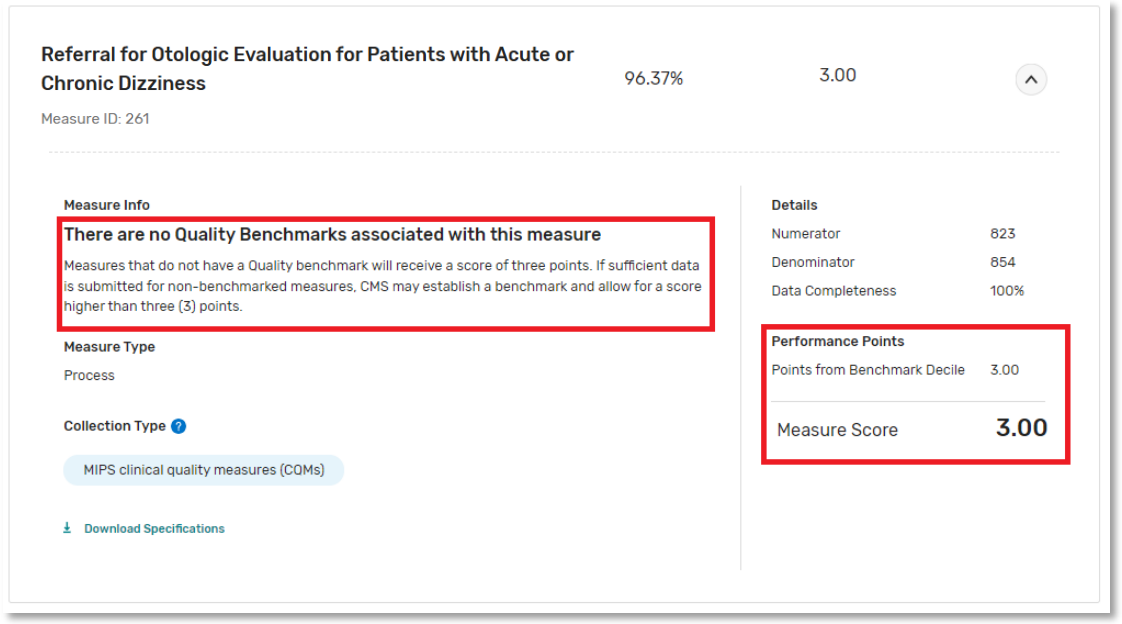


Did you know?
Not all topped out measures are capped at 7 points. To be capped at 7 points, a measure must be topped out for 2 or more consecutive years through the same collection type. Refer to "Seven Point Cap" column in the 2025 Quality Benchmarks file. Measures determined to be impacted by limited measure choice are not subject to the 7-point cap.

Reviewing Data: Quality

Quality Payment PROGRAM

Measures Without a Historical Benchmark



If you report a measure without a historical benchmark, you will receive 0 performance points. **Small practices will continue to earn 3 points**, provided the measure meets data completeness and case minimum requirements.

If we can calculate a performance period benchmark, we will update the measure's performance points in your final performance feedback (available summer 2026).

Quality Payment
PROGRAM

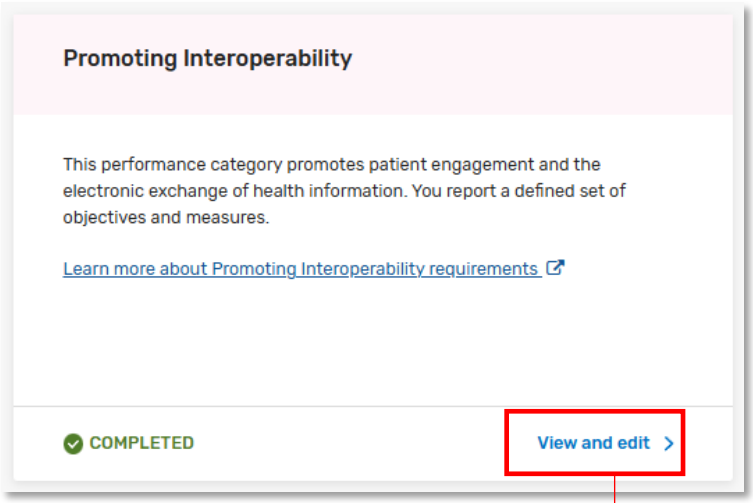
Reviewing Data: Promoting Interoperability

Reviewing Data: Promoting Interoperability

Quality Payment PROGRAM

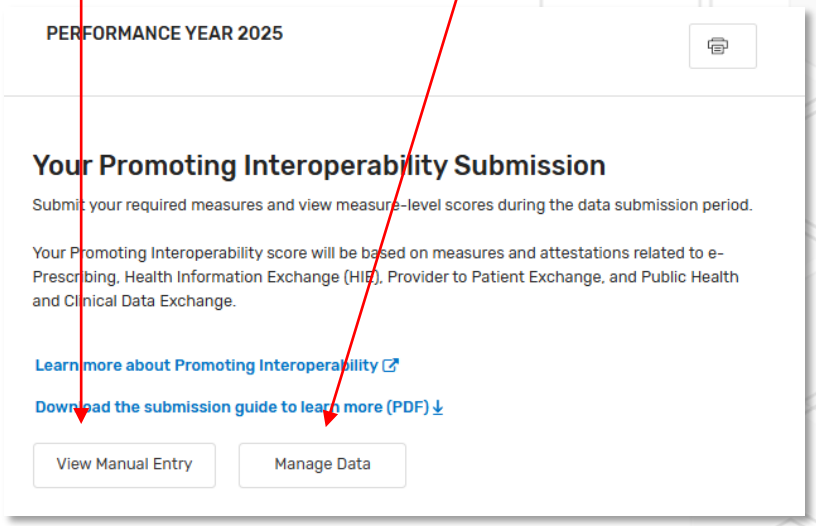
Review Previously Submitted Data

Scroll down the Reporting Overview page to the Promoting Interoperability card. Click **View and edit**. You will land on a read-only page, letting you review the preliminary measure scoring details of your submission.



If you need to update your manually entered data, click **View Manual Entry**.

If you need to delete data your organization has submitted, click **Manage Data**.



Reviewing Data: Promoting Interoperability

Quality Payment PROGRAM

Multiple Submissions

Please review the QPP Submissions Application Program Interface (API) documentation for detailed information about API submissions.

When there are multiple Promoting Interoperability submissions for an individual clinician, group, virtual group or APM Entity, we'll score all submissions and assign the highest score to the clinician, group, virtual group, or APM Entity.

A qualifying data submission includes all required performance data, required attestation statements, CEHRT ID, and the start and end date for the performance period. Only qualifying data submissions will override reweighting.

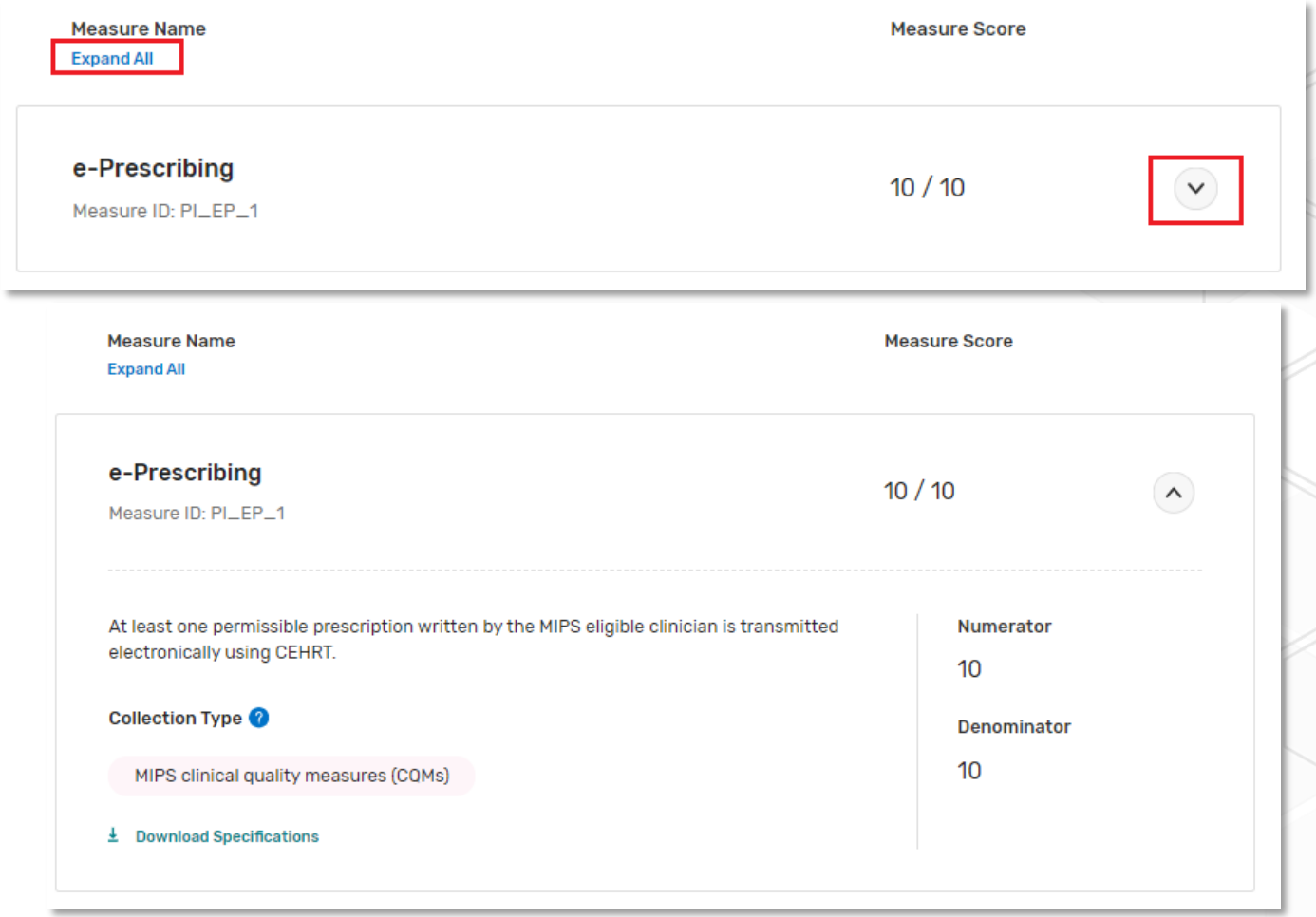
- **We'll no longer assign a performance category score of zero when there are conflicting submissions.**

Reviewing Data: Promoting Interoperability

Quality Payment PROGRAM

Access Previously Submitted Data (Continued)

Click the down arrow on the right-hand side of the measure information to see numerator/denominator details or click **Expand All** below Measure Name to see the details of all the measures in that objective.



Quality Payment
PROGRAM

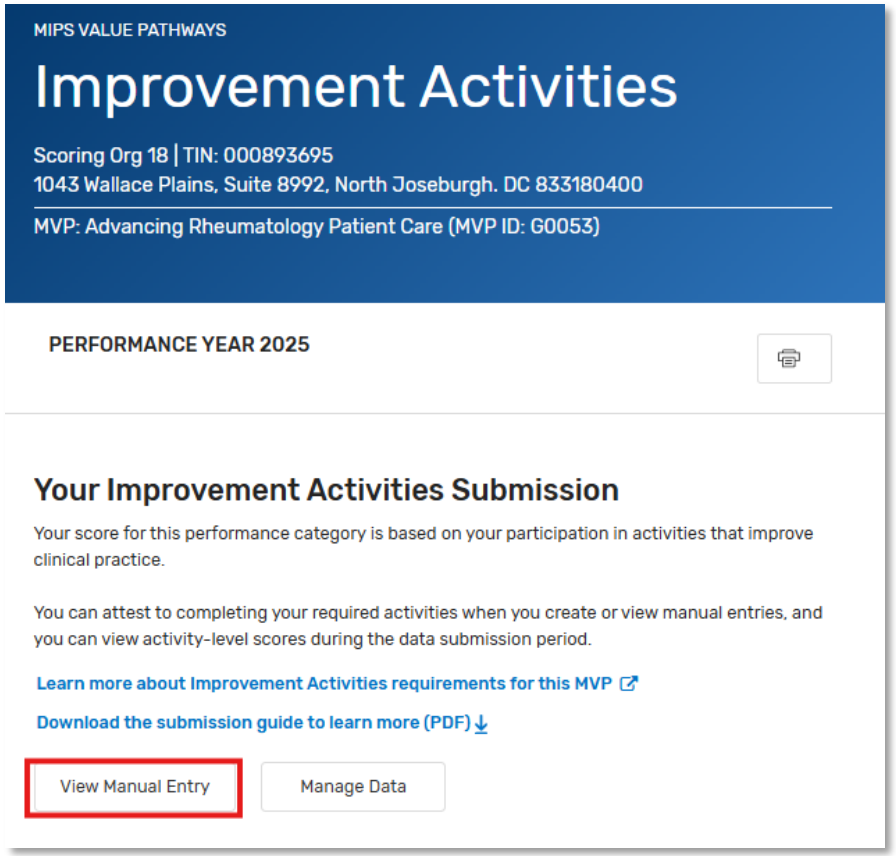
Reviewing Data: Improvement Activities

Reviewing Data: Improvement Activities

Quality Payment PROGRAM

Review Previously Submitted Data

Click **View & Edit** from the Reporting Overview.



If you need to update your manually entered data click View Manual Entry

If a third party reported some but not all of the activities performed, you can manually enter any missing activities

If you haven't created a manual entry, you will see Create Manual Entry (instead of View Manual Entry.)

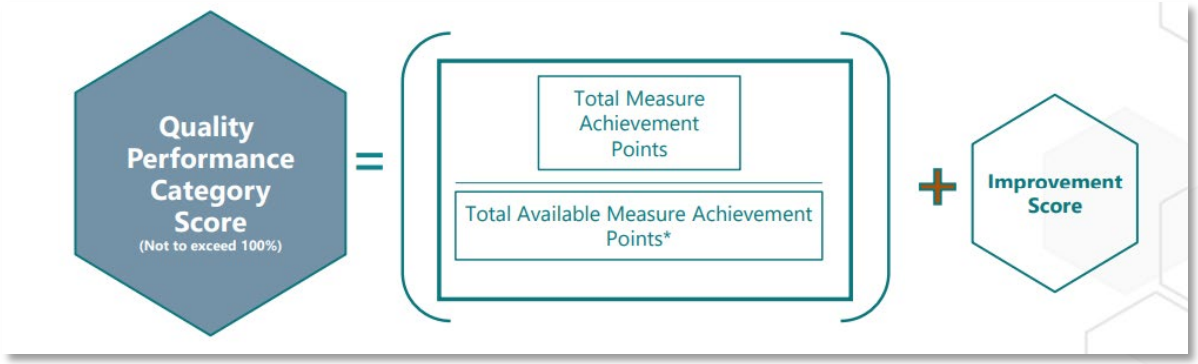
Quality Payment
PROGRAM

Scoring Calculation

Quality

Quality Score Calculation: How We'll Get There

We'll calculate your quality score after the data submission period, once we've received all required available data.



(Small practices that submit 1 quality measure qualify for 6 bonus points)

For more information about quality score calculations, refer to the 2025 MVPs Implementation Guide (PDF, 4MB).

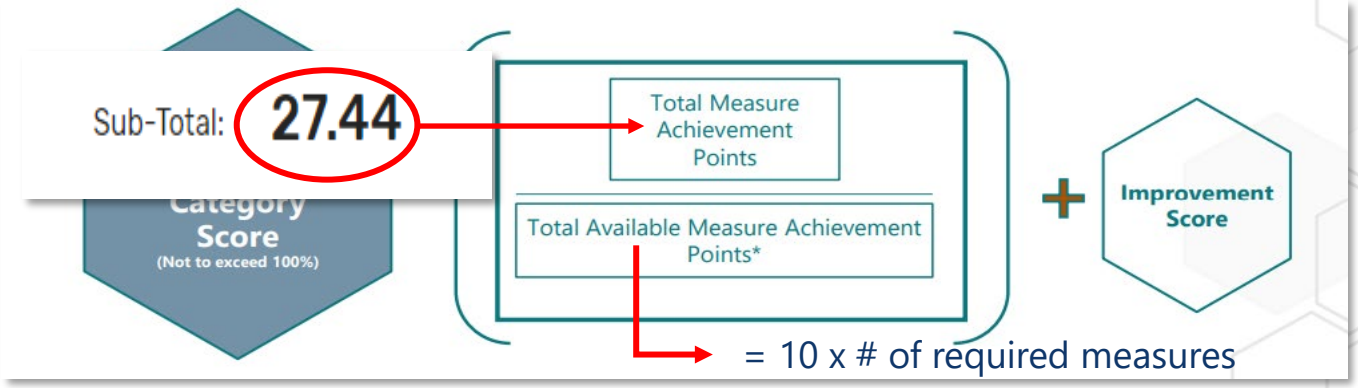
Quality

Quality Score Calculation

The **Sub-Total** displayed at the bottom of your submitted measures shows how many achievement points you've earned to date based on the measures you've submitted.

This number can change after the submission period.

- For example, this number would increase based on the achievement points earned for the population health measure.



In MVPs, you're required to submit **4 measures**, including one outcome measure which would mean **40 total points** available.

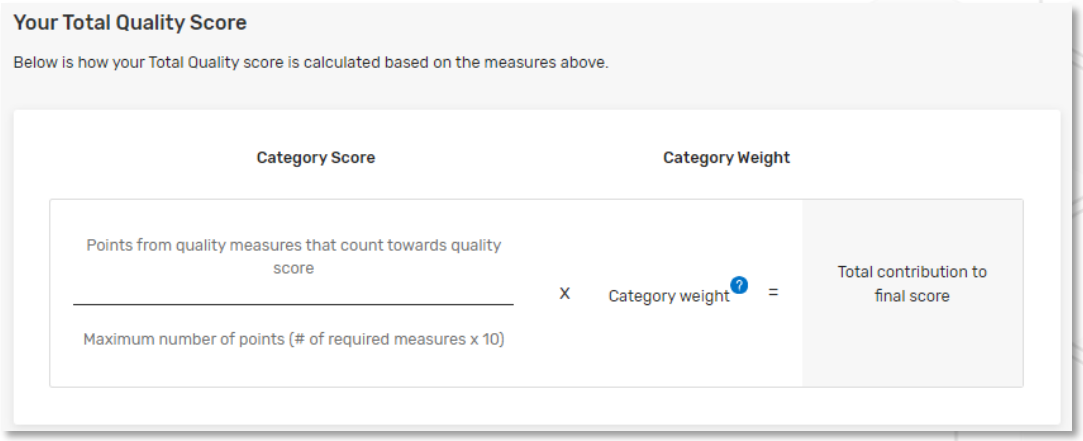
- This number will increase by 10 points after the data submission period if you can be scored on the population health measure.

Quality

Quality Score Calculation

Once we calculate your quality score, we'll multiply it by the category weight.

- The weight tells you the maximum number of points the performance category can contribute to your final score.
- Your final score will be between 0 and 100 points.

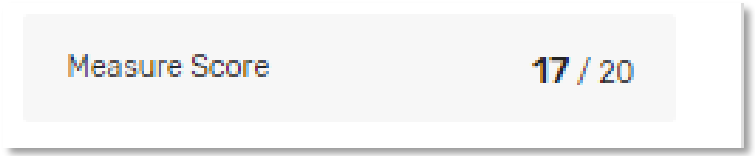


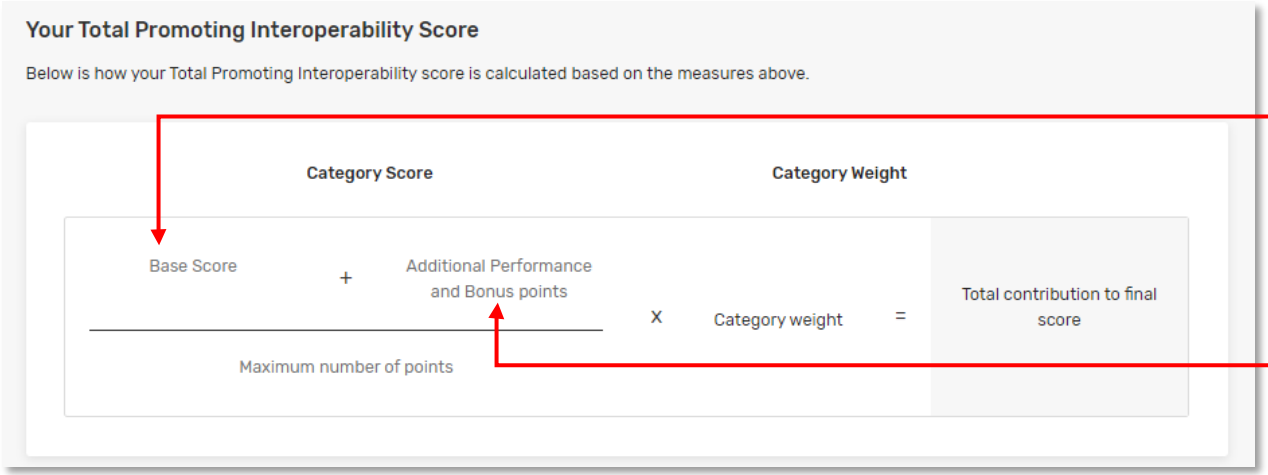
Example. When quality is **weighted at 30%**, quality can contribute **up to 30 points** to your final score.

Promoting Interoperability

Promoting Interoperability Score Calculation

We'll calculate your Promoting Interoperability score after the data submission period from the measure scores displayed during the submission period. Then we'll multiply that by the performance category weight to determine how many points the Promoting Interoperability performance category will contribute to your final score.





Sum of points earned for all required measures

Bonus points earned for reporting optional measures

We no longer display preliminary scores.

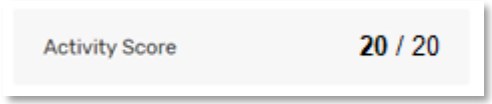
For more information about Promoting Interoperability score calculations, refer to the 2025 MVPs Implementation Guide (PDF, 4MB).

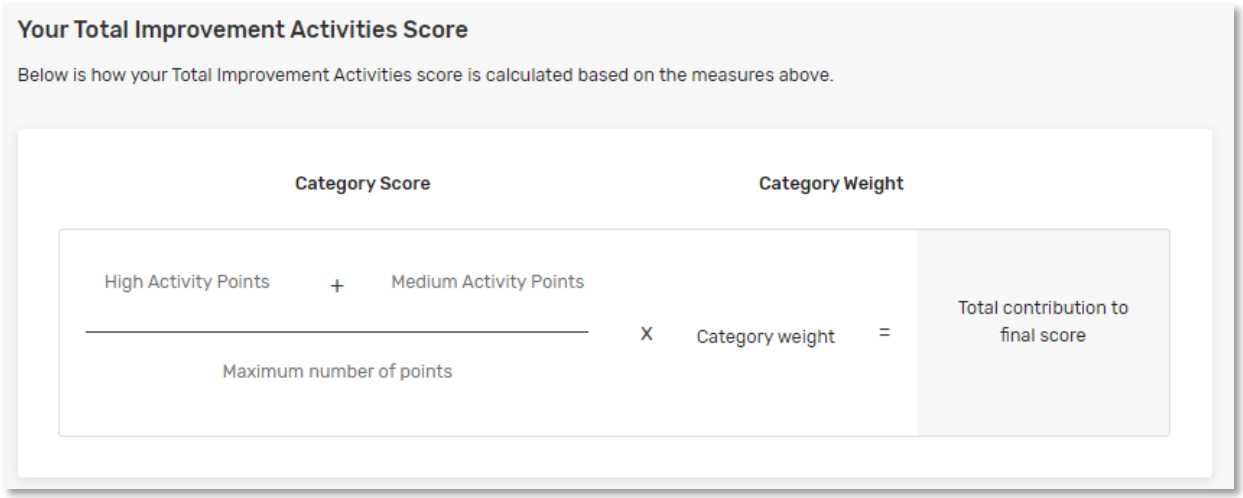
Promoting Interoperability

Quality Payment PROGRAM

Improvement Activities Score Calculation

We'll calculate your improvement activities score after the data submission period from the activity scores displayed during the submission period. Then we'll multiply that by the performance category weight to determine how many points the improvement activities performance category will contribute to your final score.





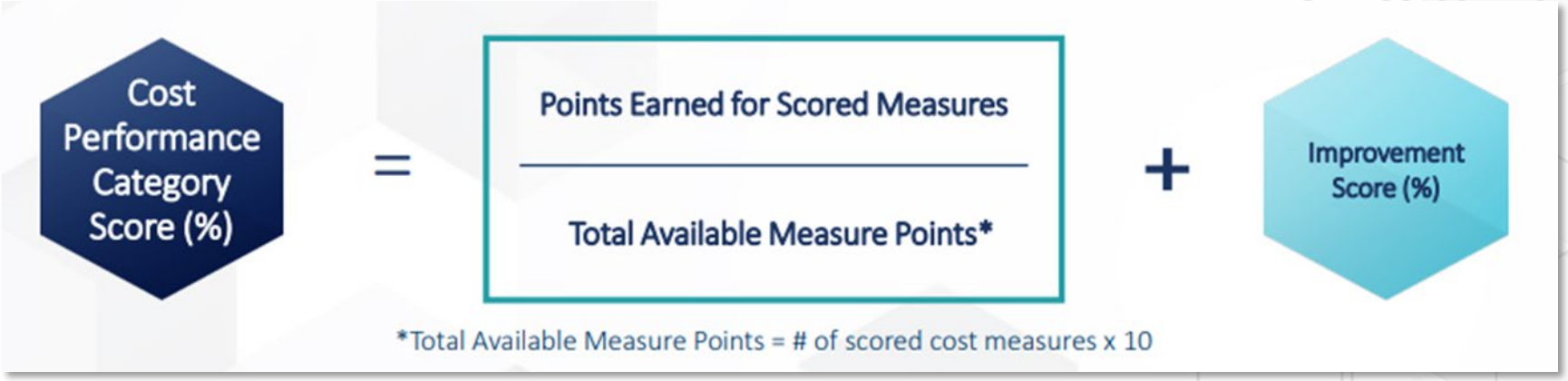
We no longer display preliminary scores.

For more information about improvement activity score calculations, refer the 2025 MVPs Implementation Guide (PDF, 4MB).

Cost

Cost Score Calculation

Cost measures and cost performance category scores are calculated after the data submission period. You'll receive a cost score if you can be scored on at least one cost measure in the MVP you're reporting. We'll only you on the cost measures included in your MVP.



Then we'll multiply your score by the performance category weight to determine how many points the cost performance category will contribute to your final score. It's generally weighted at 30% of your final score.

For more information about cost score calculations, refer to the 2025 MVPs Implementation Guide (PDF, 4MB).

Quality Payment
PROGRAM

Help and Version History

Help and Version History

Quality Payment PROGRAM

Where Can You Go for Help?

Contact the Quality Payment Program (QPP) Service Center by emailing QPP@cms.hhs.gov, creating a QPP Service Center ticket, or by phone at 1-866-288-8292 (Monday through 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 hearing impaired can dial 711 to be connected to a TRS Communications Assistant.

Visit the Quality Payment Program website for other help and support information, to learn more about MIPS, and to check out the resources available in the Quality Payment Program Resource Library.

Visit the Small Practices page of the Quality Payment Program website where you can **sign up for the monthly QPP Small Practices Newsletter** and find resources and information relevant for small practices.

Help, Resources, and Version History

Version History

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

Date	Description
12/30/2025	Original version.

Appendices

Appendix A

Quality Payment PROGRAM

Data Submission and the Automatic EUC Policy

The tables on the following slides illustrate the Performance Year 2025 MIPS performance category reweighting policies that CMS will apply under the MIPS automatic EUC policy to affected clinicians who submit MIPS data as individuals.

This policy was triggered by the following events for the 2025 performance year:

- Designated counties* in California for wildfires
- The designated counties in Texas for severe storms, straight-line winds, and flooding (Counties updated 08/06/2025)

Please refer to Appendix B (beginning on p. 8) of the 2025 MIPS Automatic Extreme and Uncontrollable Circumstances Policy Fact Sheet (PDF, 462KB) for a list of these designated counties and parishes.

Note: Participants in APMs are eligible to receive automatic credit in the improvement activities performance category; for these MIPS eligible clinicians, submitting data for the quality and/or Promoting Interoperability performance categories will initiate a score in the improvement activities performance category, which will override reweighting of this performance category.

Appendix A

Data Submission and the Automatic EUC Policy (Continued)

Table 1: Reweighting for Clinicians Not in a Small Practice

Data Submitted	Quality Category Weight	Promoting Interoperability Category Weight	Improvement Activities Category Weight	Cost Category Weight	Payment Adjustment
No data	0%	0%	0%	0%	Neutral
Submit Data for 1 Performance Category					
Quality Only[1]	100%	0%	0%	0%	Neutral
Promoting Interoperability Only[1]	0%	100%	0%	0%	Neutral
Improvement Activities Only	0%	0%	100%	0%	Neutral
Submit Data for 2 Performance Categories					
Quality **and** Promoting Interoperability[1]	70%	30%	0%	0%	Positive, Negative, or Neutral
Quality **and** Improvement Activities	85%	0%	15%	0%	Positive, Negative, or Neutral
Improvement Activities and Promoting Interoperability	0%	85%	15%	0%	Positive, Negative, or Neutral
Submit Data for 3 Performance Categories					
Quality and Improvement Activities and Promoting Interoperability	55%	30%	15%	0%	Positive, Negative, or Neutral

[1] APM participants are eligible to receive automatic credit in the improvement activities performance category; for these MIPS eligible clinicians, submitting data for the quality and/or Promoting Interoperability performance categories will initiate a score in the improvement activities performance category (40 out of 40 possible points), and they'll receive a final score based on the data submitted and available for scoring.

Appendix A

Data Submission and the Automatic EUC Policy (Continued)

Table 2: Reweighting for Clinicians in a Small Practice

Data Submitted	Quality Category Weight	Promoting Interoperability Category Weight	Improvement Activities Category Weight	Cost Category Weight	Payment Adjustment
No data	0%	0%	0%	0%	Neutral
Submit Data for 1 Performance Category					
Quality Only[2]	100%	0%	0%	0%	Neutral
Promoting Interoperability Only[2]	0%	100%	0%	0%	Neutral
Improvement Activities Only	0%	0%	100%	0%	Neutral
Submit Data for 2 Performance Categories					
Quality **and** Promoting Interoperability[2]	70%	30%	0%	0%	Positive, Negative, or Neutral
Quality **and** Improvement Activities	50%	0%	50%	0%	Positive, Negative, or Neutral
Improvement Activities and Promoting Interoperability	0%	85%	15%	0%	Positive, Negative, or Neutral
Submit Data for 3 Performance Categories					
Quality and Improvement Activities and Promoting Interoperability	55%	30%	15%	0%	Positive, Negative, or Neutral

[2] APM participants are eligible to receive automatic credit in the improvement activities performance category; for these MIPS eligible clinicians, submitting data for the quality and/or Promoting Interoperability performance categories will initiate a score in the improvement activities performance category (40 out of 40 possible points), and they'll receive a final score based on the data submitted and available for scoring.

Appendix B

Quality Payment PROGRAM

Submission Period: QPP Access and Permissions by Organization Type (Continued)

This table provides a snapshot of what you can and can't do/view regarding MVP reporting based on your access (role) and organization type during the submission period (January 2 – March 31, 2026).

With this Access	You CAN	You CANNOT
Staff User or Security Official for a **Practice** (includes solo practitioners)	✓ Access information about eligibility and special status at the individual clinician and group level ✓ View information about performance category reweighting (including from approved exception applications) ✓ Submit data on behalf of your practice (as a group, subgroup and/or individuals) ✓ Submit opt-in elections on behalf of your practice (as a group and/or individuals) ✓ View data submitted on behalf of your practice (group, subgroup and/or individual) ✓ View measure-level scoring for Part B claims measures reported throughout the performance period • This data will be updated during the submission period to account for claims received by CMS until March 1, 2025 ✓ View measure and activity-level scores and a sub-total of points for the group and individual clinicians	✗ View feedback or scores for administrative claims quality measures or the CAHPS for MIPS measure (if applicable) ✗ View your cost feedback (if applicable) • Cost data won't be available during the submission period ✗ Overall preliminary score or preliminary performance category score

Appendix B

Quality Payment PROGRAM

Submission Period: QPP Access and Permissions by Organization Type (Continued)

This table provides a snapshot of what you can and can't do/view regarding MVP reporting based on your access (role) and organization type during the submission period (January 2 – March 31, 2026).

With this Access	You CAN	You CANNOT
Clinician Role	*You can't do anything related to Performance Year 2025 submissions with this role* *This is a view-only role to access final performance feedback*	
Staff User or Security Official for a **Virtual Group**	✓ Access information about the practices (TINs) and clinicians participating in the virtual group ✓ View information about performance category reweighting (including from approved exception applications) ✓ Submit data on behalf of your virtual group ✓ View data submitted on behalf of your virtual group ✓ View measure and activity-level scores and a sub-total of points for the virtual group	✗ View feedback or scores for administrative claims quality measures or the CAHPS for MIPS measure (if applicable) ✗ View your cost feedback (if applicable) • Cost data won't be available during the submission period ✗ View data submitted by individuals or practices in your virtual group (such data wouldn't count towards scoring and would only be considered a voluntary submission) ✗ Overall preliminary score or preliminary performance category score
Staff User or Security Official for a **Registry** (QCDR or Qualified Registry)	✓ Download your API token (security officials only) ✓ Upload a submission file on behalf of your clients (groups and/or individuals) ✓ Submit opt-in elections on behalf of your clients ✓ View measure and activity-level scores and a sub-total of points for your clients based on the data you submitted for them	✗ View data submitted directly by your clients ✗ View data submitted by another third party on behalf of your clients ✗ View data collected and calculated by CMS on behalf of your clients ✗ Cost measures (if applicable) ✗ View preliminary category level scores

Appendix B

Quality Payment PROGRAM

Submission Period: QPP Access and Permissions by Organization Type (Continued)

This table provides a snapshot of what you can and can't do/view regarding MVP reporting based on your access (role) and organization type during the submission period (January 2 – March 31, 2026).

With this Access	You CAN	You CANNOT
Staff User or Security Official for an **APM Entity**	✓ Access a list of the practices (TINs) and clinicians participating in the APM Entity ✓ View information about performance category reweighting (including from approved exception applications) ✓ Submit quality data through the CMS Web Interface (Shared Savings Program, or other registered APM Entities) ✓ Upload a QRDA III file with your eCQM data (Primary Care First) ✓ Upload a file of APM Entity-level MIPS quality measure data (all APM Entities in a MIPS APM) ✓ View measure and activity-level scores and a sub-total of points on quality data submitted by or on behalf of the APM Entity ✓ View the automatic 50% reporting credit available to some APMs	✗ View feedback or scores for administrative claims quality measures or the CAHPS for MIPS measure (if applicable) ✗ View the Promoting Interoperability data reporting by clinicians and groups in your APM entity ✗ View quality data reported by clinicians and groups in your APM Entity ✗ View preliminary quality performance category score

Appendix C

Quality Measures with MIPS Scoring or Submission Changes

This slide will identify any measures affected by specification or coding issues, clinical guideline changes during the 2025 performance period, or specifications determined during or after the performance period to have substantive changes.