



## 2025 Merit-based Incentive Payment System (MIPS) Performance Feedback FAQs for Small Practices

### Purpose

This document answers key questions about the MIPS performance feedback experience now available for small practices. MIPS defines a small practice as 15 or fewer clinicians (identified by National Provider Identifier, or NPI) who've reassigned their billing rights to a single Taxpayer Identification Number (TIN).

- These FAQs are intended to help you navigate the information within your performance feedback.
- **This resource doesn't provide detailed information about MIPS reporting requirements and scoring.**

Review the following resources on the Quality Payment Program (QPP) Resource Library for detailed scoring information:

- [2025 Traditional MIPS Scoring Guide \(PDF\)](#)
- [2025 MVPs Implementation Guide \(PDF\)](#)
- **2025 APP Scoring Guide**, available in the [2025 APP Toolkit \(ZIP\)](#)
- [2025 Facility-based Quick Start Guide \(PDF\)](#)

**PLEASE NOTE:** Third party representatives such as **Qualified Clinical Data Registries (QCDRs)** and **Qualified Registries** can't access **your performance feedback**.

**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.

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## Fast Facts About Performance Feedback

### What Is Performance Feedback?

Performance feedback is a summary of the data you've submitted to us and that we collected on your behalf. Final performance feedback includes:

- Performance category-level scores and weights.
- Bonus points and improvement scoring.
- Measure-level performance data and scores.
- Activity-level scores.
- Payment adjustment information (available approximately one month after final scores are released).
- Supplemental reports for administrative claims' quality and cost measures.
  - Learn more in the [2025 MIPS Performance Feedback: Supplemental Reports Guide \(PDF\)](#).
- Comparative quality and cost feedback (MVP reporting only).

### Who Can Access MIPS Performance Feedback and Payment Adjustment Information?

MIPS performance feedback is accessible to clinicians and authorized representatives of practices, virtual groups, and APM Entities (including Shared Savings Program Accountable Care Organizations [ACOs]), whether they reported [traditional MIPS](#), [a MIPS Value Pathway \(MVP\)](#), or the [APM Performance Pathway \(APP\)](#).

- **Practice representatives** with the QPP Staff User or Security Official role can view MIPS final scores and payment adjustments from **individual, group, and subgroup participation**.

**REMINDER:** Third party representatives such as **Qualified Clinical Data Registries (QCDRs)** and **Qualified Registries** can't access your performance feedback.

### How Do I Access Performance Feedback?

1. [Sign in to the Quality Payment Program website](#).
2. Click "**View PY 2025 Final Performance Feedback**" on the "home" page or select "Performance Feedback" from the left-hand navigation.
3. Select your organization (Practice, APM Entity, Virtual Group).

## General Questions

### Can I Print or Download Feedback Reports?

Yes, you can print performance feedback using the **Print** button accessible on each page within performance feedback. (This feature uses your browser's native print functionality.) You can also download a spreadsheet with your submitted data (submission.csv), even if it didn't count towards your final score.

### How Can I Learn More about 2025 MIPS Reporting Requirements and Scoring?

These FAQs are intended to help you navigate your performance feedback. This resource doesn't provide detailed information about MIPS reporting requirements and scoring. Review the following resources on the QPP Resource Library for detailed information:

- [2025 Traditional MIPS Scoring Guide \(PDF\)](#)
- [2025 MVPs Implementation Guide \(PDF\)](#)
- **2025 APP Scoring Guide**, available in the [2025 APP Toolkit \(ZIP\)](#)
- [2025 Facility-based Quick Start Guide \(PDF\)](#)

### What if We Find an Error with our Payment Adjustment/Performance Feedback?

If you believe an error has been made in your final score, you have approximately 60 days to request a targeted review. Targeted review will close 30 days after the release of MIPS payment adjustments.

### What's a Targeted Review?

A targeted review is a process through which QPP participants can request that the Centers for Medicare & Medicaid Services (CMS) review the calculation of their MIPS payment adjustment factor. For more information on the targeted review process, please review the [2025 Targeted Review User Guide \(PDF\)](#).

We continue to listen to you and make improvements to the system based on your feedback.

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.

Contact the QPP Service Center if you have questions about a discrepancy.

## Accessing Final Score (Performance Feedback)

### Before You Begin

If you don't already have a Health Care Quality Information Systems (HCQIS) Authorized Roles and Profile (HARP) account or access to your organization on [QPP website](#), you'll need to create an account, request access, and wait to be approved.

- More information is available in the [QPP Access User Guide \(ZIP, 4MB\)](#).

Please note that due to a mandatory federal-wide security update, you'll need a CMS-supported version of Microsoft Edge or Chrome to access the [QPP website](#). You may encounter errors if you use a different web browser.

- Please update your browser to the latest version of [Microsoft Edge](#) or [Chrome](#).

### How Can I Access My/Our MIPS Performance Feedback?

You can access your performance feedback through the [QPP website](#) by signing in with the same credentials that allowed you to submit and view data during the submission period.

If you don't have an account or role for your organization, refer to the [QPP Access User Guide \(ZIP\)](#) for information on creating an account and requesting a role for your organization.

After signing in, select **View Feedback** or **Performance Feedback** in the left-hand navigation pane.

The screenshot shows the QPP website interface. On the left is a dark blue navigation pane with a list of menu items: Account Home, Registration, Eligibility & Reporting, Performance Feedback (highlighted with a red box), APM Incentive Payments, Doctors & Clinicians Preview, Exceptions Application, and Targeted Review. The main content area is white and contains two sections. The top section is titled 'CAHPS for MIPS Survey and MVP Registration Information' and includes a 'Go to registration portal' button. The bottom section is titled 'View PY 2025 Final Performance Feedback' and includes a 'View feedback' button (highlighted with a red box).

### I'm a Clinician. What's the Best Way for Me to Access My Performance Feedback?

The **Clinician role** will let you view your performance feedback for all your associated practices without requesting access to each practice or gaining access to information about other clinicians in your practice.

If you're a clinician in a MIPS APM, this role also lets you directly access performance feedback based on your APM Entity's reporting via [traditional MIPS](#), an [MVP](#), and/or the [APP](#).

Please review the **Register for a HARP Account** and **Connect as a Clinician** documents in the [QPP Access User Guide \(ZIP\)](#).

## Can Third Party Intermediaries Access Performance Feedback?

Only authorized practice representatives can access the practice's performance feedback. CMS doesn't grant direct access to performance feedback for third party intermediaries (QCDRs and Qualified Registries) because it contains sensitive information, including payment and patient information.

**Third party intermediaries** with an account and a role for their Registry (or QCDR) organization can still access their dashboard and view the measures and activities they submitted on behalf of their clients, and the related scoring information. However, they **can't access**:

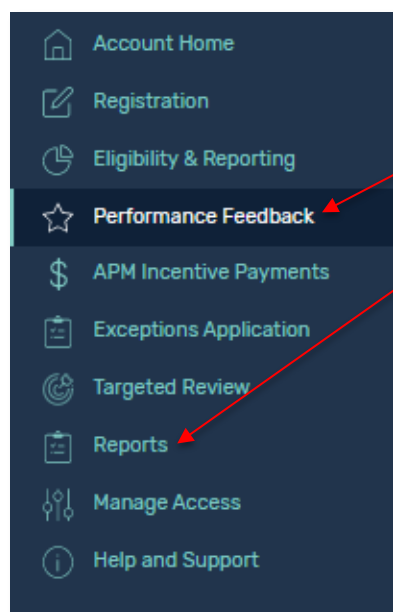
- Data submitted directly by their client or by another third party intermediary.
- Quality or cost measures that CMS calculates from administrative claims.
- Supplemental (including patient-level) reports for administrative claims measures.
- Final score and payment adjustment information.

To view their clients' performance feedback, third party intermediaries need to submit a request for a role for each practice (identified by Taxpayer Identification Number, or TIN) they represent.

- The Security Official for each organization will decide whether to approve the request.
- If approved, the third party intermediary is authorized to access performance feedback and all other information available for the organization once signed into the QPP website.

## What's the Difference Between the Performance Feedback and Reports Tabs?

Some users may notice the **Reports** tab in their left-hand navigation panel.



You'll access your 2025 MIPS performance feedback through the **Performance Feedback** tab.

The **Reports** tab is where some users will find:

- 2025 Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey Detail Reports.
- Historical CMS Web Interface reports for groups and APM Entities that have reported quality measures through the CMS Web Interface in previous years.
- Historical payment adjustment reports.
- Quarterly Items & Services data (learn more in [Items and Services FAQs](#) (PDF))

## Navigating Into Performance Feedback



This section assumes you have either the QPP Staff User or QPP Security Official role for a **Practice** organization.

- Practice representatives can view feedback for individual clinicians and the group (if the practice participated as a group).

Select **View Practice Details** to access group-, or clinician-level performance feedback.

Account Home  
Registration  
Eligibility & Reporting  
**Performance Feedback**  
APM Incentive Payments  
Exceptions Application  
Targeted Review  
Reports  
Manage Access  
Help and Support

APM Entities **Practices**

**Practices**  
Select one of the Practices below to view its performance details.

SEARCH  
Search by full or partial TIN

Showing 1 - 3 of 3 Practices

**Malave, Mascareñas and Jiménez**  
TIN: 000007280 | 303 Dach Avenue, Suite 303, West Dorian, ME 287413508

[View practice details](#)

[Download Data](#) ▾

**Malave, Mascareñas and Jiménez**  
TIN: 000007280 | 303 Dach Avenue, Suite 303, West Dorian, ME 287413508

[View practice details](#)

[Download Data](#) ▴

- ↓ Score Submission.CSV
- ↓ Connected Clinician List.CSV
- ↓ Payment Adjustment.CSV

You can also select **Download Data** to access:

- Score Submission CSV (data submitted for your entire practice, which may or may not contribute to your final score).
- Connected Clinician List.
- Payment Adjustments for each clinician in the practice.**

Click **View practice details** to access performance feedback.

If you have access to multiple types of organizations (such as an APM Entity and a practice), make sure to select the **Practices** tab.

## Group Feedback

Select **View group feedback** to the right of the practice name to access performance feedback based on **group participation** (aggregated data submitted on behalf of all clinicians in the practice).

**Pfeffer Group**

TIN: 000839403 | 01712 Amy Well Apt. 337, Suite 5150, Douglasburgh, NM 693839346567033

View group feedback

## Individual Feedback

Under **Connected Clinicians**, you can see the final score attributed to the individual clinician beneath their name. You can also filter this list by the reporting and participation options the practice implemented to show which final score clinicians are receiving.

**Pfeffer Group**

TIN: 000839403 | 01712 Amy Well Apt. 337, Suite 5150, Douglasburgh, NM 693839346567033

View group feedback

**Connected Clinicians**

Select one of the clinicians below to view their performance details.

FILTER

All Clinicians (25)

All Clinicians (25)

Receiving Group MIPS Score (25)

SEARCH

Search by full or partial NPI

Download Data (Page 1) ▾

The blue alert below the clinician's name will identify the participation option (individual, group, or subgroup) associated with their final score.

- **Please note that you won't see information about final scores from virtual group or APM Entity participation.**

Select **View Individual Feedback** to the right of the clinician's name to access more details about their final score.

#### Clinician Roles

Select one of the Clinician Roles below to view its performance details.

Showing 1 - 2 of 2 Clinician Roles

#### Twenty Scoring-20 at ITScoring-00

TIN: 000043500 | NPI: 0043520020

[View individual feedback](#)

[Download all data](#) ▾

| Final Score<br>MIPS Value Pathways | Final score ⓘ<br>MIPS Value Pathways | Total Payment<br>Adjustment | Payment<br>Adjustment Date |
|------------------------------------|--------------------------------------|-----------------------------|----------------------------|
| 75.80 / 100                        | Group                                | + 0.09%                     | Jan. 1, 2026               |

**i** This clinician scored lower than what the group scored. They will receive the group Final Score instead.

Continue with these [Frequently Asked Questions](#) or skip ahead to the [Final Score Overview section](#).

## Our Practice Participated in Multiple Ways. Can I Easily See Which Final Score Was Attributed to the Clinicians in Our Practice?

Yes, there are 2 ways to do this:

1. **Under Connected Clinicians** on the “Practice Details” page, you can filter your clinicians by the final scores attributed to the clinicians in your practice based on the reporting and participation options your practice implemented.

In the screenshot below, all MIPS eligible clinicians are getting the group’s traditional MIPS score. However, there would be additional options in the filter if any clinicians had received their final score from individual traditional MIPS reporting, individual MVP reporting, or subgroup MVP reporting.

**Pfeffer Group**  
TIN: 000839403 | 01712 Amy Well Apt. 337, Suite 5150, Douglasburgh, NM 693839346567033

**View group feedback**

**Connected Clinicians**  
Select one of the clinicians below to view their performance details.

**FILTER**  
All Clinicians (25)  
All Clinicians (25)  
Receiving Group MIPS Score (25)

**SEARCH**  
Search by full or partial NPI

[Download Data \(Page 1\)](#)

2. Before you get into the “Practice Details,” you can **download the Payment Adjustment CSV** (once available) to see the final score, performance category scores, and associated payment adjustment earned by each clinician in the group.

**Davis Inc**  
TIN: 000549237 | 73440 Bridges Cliff Apt. 204, Suite 2777, New Nicole, MN 660778514593281

**View practice details**

**Download Data**  
↓ Score Submission.CSV  
↓ Connected Clinician List.CSV  
↓ Payment Adjustment.CSV

Help shape the future of QPP. Participate in a user feedback session. [Sign up now](#)

## **Our Practice Didn't Participate/Submit Data as a Group (or Subgroup). What Will We See in Performance Feedback?**

If your practice didn't submit data as a group (or subgroup) for the 2025 performance year, you'll see a message indicating that your clinicians only reported as individuals.

You can **View Individual Feedback** for each connected clinician.

We'll also make administrative claims quality measure scores available for informational purposes if they can be calculated.

## **What's a "Connected Clinician" and Who's Included in This List?**

Connected clinicians are all clinicians, identified by their NPI, who are associated with your practice (TIN) through Medicare Part B claims billed October 1, 2024 – September 30, 2025, regardless of their individual MIPS eligibility. Your connected clinicians are displayed on the "Practice Details" page of performance feedback.

- Clinicians who started billing claims under your TIN for services furnished on or after October 1, 2025 through December 31, 2025, will appear in the Payment Adjustment CSV.

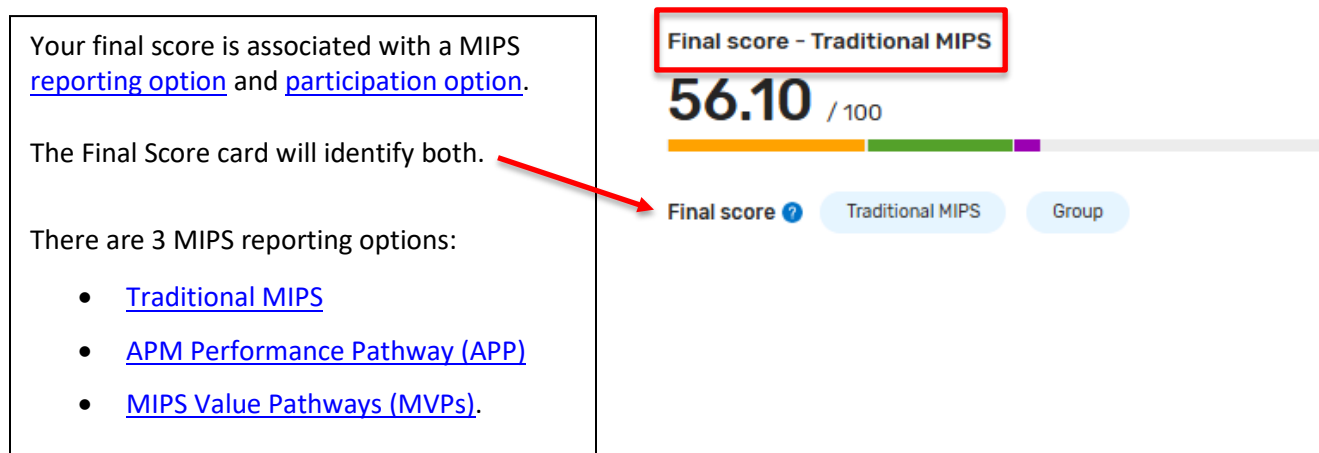
## Overview: Final Score and Payment Adjustment

When you navigate into “feedback”, you’ll land on the **Overview** page. From here, you can view:

- Your final score.
- Your score and the weight for each MIPS performance category.
- Your payment adjustment information once available. (Payment adjustments are released approximately one month after final scores; we’ll send an announcement through the QPP listserv once payment adjustments are available in your performance feedback.)

### How Is Our Final Score Determined?

Your final score is the sum of your performance category scores, and any points awarded for the [complex patient bonus](#).



If a clinician [participated in MIPS multiple ways](#) — for example, your practice reported traditional MIPS at the group level and the clinician also reported an MVP as an individual — we’ll assign the highest score that could be attributed to the clinician under that TIN/NPI combination.

Users with access to a practice (TIN) can access performance feedback and the final scores from individual, group, and subgroup participation. They won’t see if clinicians in their practice have a higher score from APM Entity or virtual group participation.

## We Participated in Multiple Ways. How Did You Determine Which Final Score and Payment Adjustment to Attribute to Our Clinicians?

While clinicians can participate in multiple ways under a single TIN/NPI combination, they'll only have one final score and associated payment adjustment under that TIN/NPI combination.

When a clinician has multiple final scores that can be attributed to their TIN/NPI combination, we apply the following hierarchy when determining which final score will determine payment adjustments:

| Scenario                                                                                                     | Final Score Used to Determine Payment Adjustments                                                    |
|--------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|
| TIN/NPI is part of a virtual group <b>and</b> reported as an individual, group, subgroup, and/or APM Entity. | Virtual group's final score. (All other reporting is considered voluntary.)                          |
| TIN/NPI has a score from individual, group, subgroup and/or APM Entity reporting.                            | The highest of these final scores, from either APM Entity, group, subgroup, or individual reporting. |

For group, subgroup, virtual group and MIPS APM participation, **MIPS eligible clinicians** include clinicians who didn't exceed the low-volume threshold as individuals but are otherwise eligible for MIPS based on their:

- Clinician type/ specialty
- Medicare enrollment date
- Not reaching QP thresholds if they're in an Advanced APM

## We Reported an MVP. Why Can't I Find Our MVP Feedback?

There are 2 reasons why you may not see your MVP feedback.

1. To report an MVP, you needed to register in advance AND your data must have included the correct MVP identifier.
  - a. You wouldn't have been able to submit data with an MVP identifier if you hadn't registered for that MVP.
  - b. Data submitted without an MVP identifier was attributed to traditional MIPS.
2. If you reported both traditional MIPS and an MVP, only one of these will count for your final score. When your traditional MIPS score is higher, it will show as your final score and you can view your MVP feedback by selecting "Other Score". (Refer to the next question.)

## Why do I see both a Final Score and “Other Score”?

Your final score determines your MIPS payment adjustment. If you have the option to view an “Other Score”, that means you submitted data for an MVP that wasn’t used for your final score. This data has always been available through the downloadable “Score Submissions.CSV”, but now we’re providing a formatted version in performance feedback to help you more easily compare your performance between your MIPS reporting options.

### Let’s look at an example.

Your practice reported both an MVP and traditional MIPS as a group.

- You earned 78 out of 100 points for your MVP submission.
- You earned 83 out of 100 points for your traditional MIPS submission.

We selected the traditional MIPS submission for your group’s final score because it received the higher score. When you select “Other score” from your group feedback dropdown, you’ll see a formatted version of your MVP submission data and scores.

**FBTestOrg-25**  
TIN: 000044625 | 550 Graves Run, Suite 9262, Port Rachel, IA 829872597660887

**Final score** ⓘ Traditional MIPS Group

**Connected Clinicians**  
Select one of the clinicians below to view their performance details.

**FILTER** Search full or partial NPI number

All Clinicians (1) [Search Icon]

Showing 1 - 1 of 1 Clinician

**View group feedback** ^

**Final score:** Traditional MIPS >

**Other score:** MIPS Value Pathways >

You’ll be asked to confirm that you understand the “Other Score” is informational only.

**Other Score - MIPS Value Pathways**

**24.21** / 100

**Other Score**  
This isn't the final score. This is the score associated with a data submissions for another reporting option that received a lower score. This feedback is for informational purposes only.

|                            |            |
|----------------------------|------------|
| Quality                    | 1.37 / 55  |
| Promoting Interoperability | 0.00 / 30  |
| Improvement Activities     | 15.00 / 15 |
| Cost                       | --         |
| Complex Patient Bonus      | 7.83       |

**MIPS Payment Adjustment**

Total Adjustment --

Adjustment Starting January 1st, 2027

[How are payment adjustments calculated?](#)

## How Does My MIPS Final Score Determine My Payment Adjustment?

Your MIPS final score will be between 0 and 100 points. Each final score will correlate to a payment adjustment, **but in most cases, we can't project what this correlation will be (exceptions noted in the table below).**

**Why?** MIPS is required by law to be a budget-neutral program, which generally means that the size of payment adjustments depends on the overall participation and performance of clinicians in the program for that year.

| Final Score                             | Payment Adjustment                                                                                    |
|-----------------------------------------|-------------------------------------------------------------------------------------------------------|
| 0.00 – 18.75 points                     | -9% payment adjustment                                                                                |
| 18.76 – 74.99 points                    | Negative payment adjustment (greater than -9% and less than 0%)                                       |
| 75.00 points<br>(Performance threshold) | Neutral payment adjustment (0%)                                                                       |
| 75.01 –100.00 points                    | Positive payment adjustment (scaling factor applied to meet statutory budget neutrality requirements) |

- When more MIPS eligible clinicians have a final score above the performance threshold, we see **lower positive adjustments** because there are fewer MIPS eligible clinicians receiving a negative adjustment and relatively more MIPS eligible clinicians receiving a positive MIPS payment adjustment.
- When more MIPS eligible clinicians have a final score below the performance threshold, we see **higher positive adjustments** because there are more MIPS eligible clinicians receiving a negative MIPS payment adjustments and relatively fewer MIPS eligible clinicians receiving positive MIPS payment adjustments.

## Is There a Way for Me to See a List of the Final Scores and Payment Adjustments for All the MIPS Eligible Clinicians in My Practice (Identified by TIN)?

Yes, once payment adjustments are released. From the **Performance Feedback** tab, select “**Payment Adjustment CSV**” from the **Download Data** menu under the **View Practice Details** button.

**Note: This downloadable file won’t be available until MIPS payment adjustments are released at the end of October.**

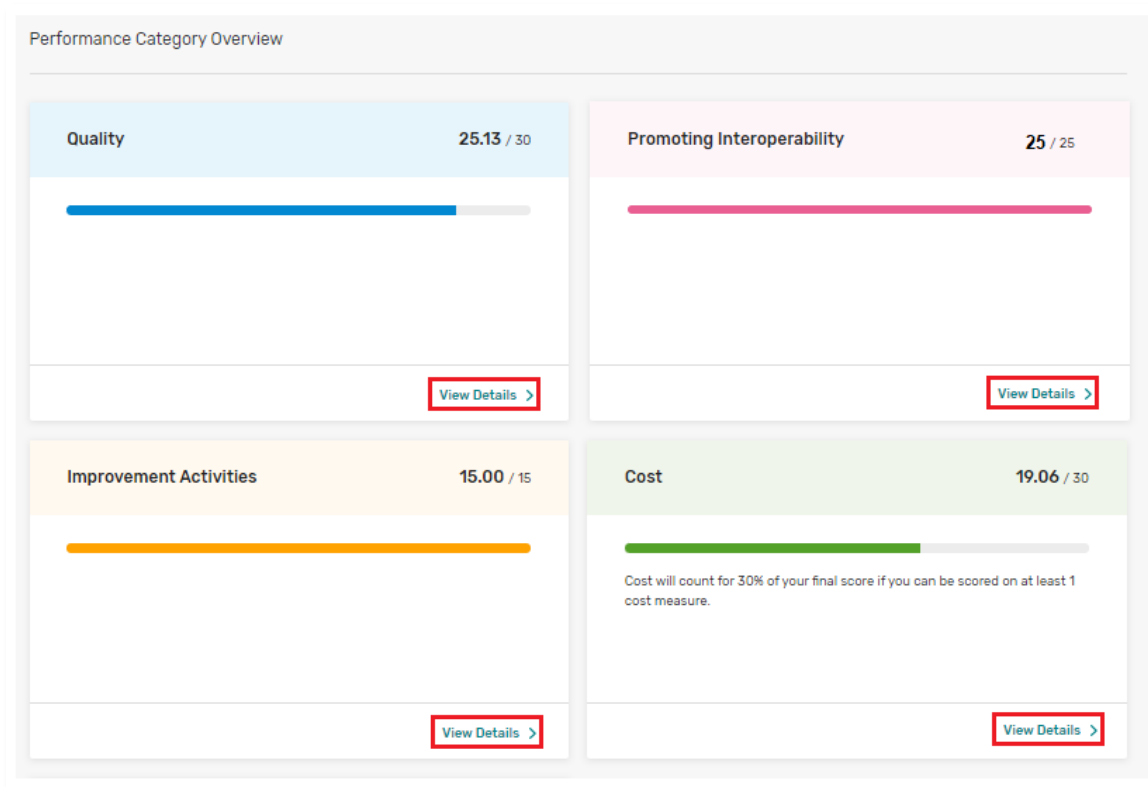
The screenshot shows a dashboard for an 'Example Group Practice' with TIN: 000043553 | 842 Marisa Terrace, Suite 7960, Ricardochester PA 16324. On the right, there are buttons for 'View group feedback', 'View practice details', and 'Download all data ^'. The 'Download all data ^' button is highlighted with a red box. Below it, a dropdown menu shows two options: 'Score Submission.CSV' and 'Payment Adjustment.CSV', with the latter highlighted by a red box. The main dashboard area displays performance metrics: 'Final Score Traditional MIPS' (100.00 / 100), 'Final Score' (with a question mark icon) showing 'Traditional MIPS' and 'Group' tabs, 'Total Payment Adjustment' (+1.11%), and 'Payment Adjustment Date' (Jan 1, 2027).

You can also filter your Connected Clinicians list by final score information once you’ve clicked **View Practice Details**. The list defaults to showing **All Clinicians**. There are multiple reports you can choose from (not all are shown in the image below).

The screenshot shows the 'Connected Clinicians' section with the instruction 'Select one of the clinicians below to view their performance details.' Below this is a 'FILTER' dropdown menu. The 'All Clinicians (138)' option is highlighted with a red box. Other options visible are 'Receiving Group MIPS Score (81)' and 'Individual Not Eligible (57)'. To the right of the filter is a 'SEARCH' box with the placeholder text 'Search by full or partial NPI' and a magnifying glass icon. Below the search box is a link that says 'Download Data (Page 1) v'.

## How Can I See More Information About the Different Performance Categories?

You can access the scoring details for each performance category by clicking “**View Details**” on the Performance Category Overview cards below.



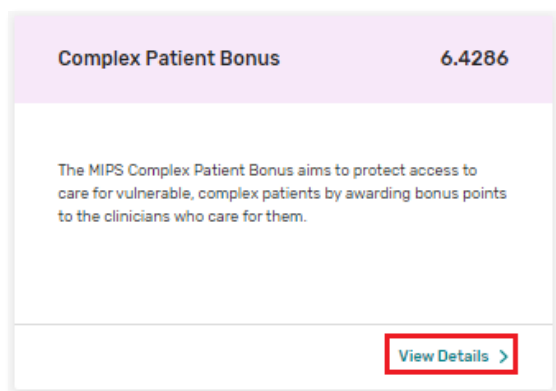
## What Is the Complex Patient Bonus?

The MIPS Complex Patient Bonus aims to protect access to care for vulnerable, medically complex patients by awarding bonus points to the clinicians who care for them. This bonus is comprised of 2 components that are added together to form your score:

- **Medical Complexity.** This component uses the Hierarchical Condition Categories (HCC) Risk Scores of your patient population. These scores are assigned to each Medicare patient based on the severity of their acute or chronic conditions and are an indicator of medical complexity.
- **Social Risk.** This component uses the Dual Eligibility Ratio of your patient population. Dual Eligibility is a common indicator of social risk and refers to patients who are eligible for both Medicare and full- or partial-benefits under Medicaid.

## How Is the Complex Patient Bonus Calculated?

To learn about these calculations, click **View Details** on the Complex Patient Bonus card or review the [2025 Complex Patient Bonus Fact Sheet \(PDF\)](#).



## Why Am I Not Eligible for the Complex Patient Bonus?

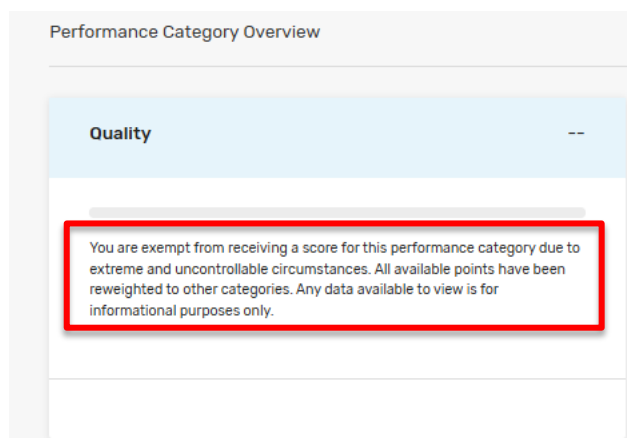
The complex patient bonus is **limited** to MIPS eligible clinicians, groups, virtual groups and APM Entities with at least one risk indicator (either average HCC risk score or dual eligibility ratio) at or above the median risk indicator calculated for all MIPS eligible clinicians, groups, virtual groups and APM Entities from the prior performance year.

From the “Overview” page, you’ll see a message indicating that you’re not eligible for this bonus. Click **View Details** to learn more about this calculation and why you’re not eligible.

## What Will Display When a Performance Category Is Reweighted?

When a category is reweighted due to extreme and uncontrollable circumstances, the performance category overview will display language stating that you’re exempt from receiving a score for that performance category.

- [Appendix A](#) reviews reweighting for individual clinicians under the automatic Extreme and Uncontrollable Circumstances (EUC) policy.
- [Appendix B](#) reviews the performance category weight redistribution when 1 or more performance categories are reweighted for any circumstances.



## Quality

### Quality Performance Category Requirements

Each of the MIPS reporting options have distinct measure reporting requirements for 2025 that are reflected on the “quality details” page of performance feedback.

- **[Traditional MIPS](#)**
  - You submit 6 measures (any available in the MIPS quality measure inventory) or a complete specialty set.
  - We automatically calculate 4 administrative claims measures; you’ll be scored on the measures for which you meet the requirements.

- **[MVPs](#)**
  - You submit 4 measures (selected from those available in the MVP you register for) or 3 measures (if you selected an outcomes-based administrative claims-based measure\* in your MVP registration) or all the Medicare Part B claims measures available in the MVP (even if fewer than 4).

Small practices generally aren’t eligible to be evaluated on the 2 available population health measures; these are limited to groups with 16 or more clinicians during the performance period. \*If you registered for an outcomes-based measure as 1 of your 4 required measures (separate from the population health measure), you’ll receive 0 points if you don’t meet the measure requirements.

- **[APP](#)**
  - **APP Plus Quality Measure Set (Required for Shared Savings Program ACOs):**
    - You submit the 4 required measures.
    - You administer the CAHPS for MIPS Survey.
    - Small practices generally aren’t eligible to be evaluated on the administrative claims’ measure in the APP Plus; these are limited to groups with 16 or more clinicians during the performance period.
  - **APP Quality Measure Set:**
    - You submit the 3 required measures.
    - You administer the CAHPS for MIPS Survey.

Small practices generally aren’t eligible to be evaluated on the administrative claims’ measures in the APP; these are limited to groups with 16 or more clinicians during the performance period.

### Small Practice Quality Performance Category Flexibilities

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, group, subgroup, virtual group and APM Entity participation, but not to clinicians or groups who are scored under facility-based scoring).

### Additional Scoring Factors

Additional Scoring Factors are any changes to your Quality Score outside of the base measures.



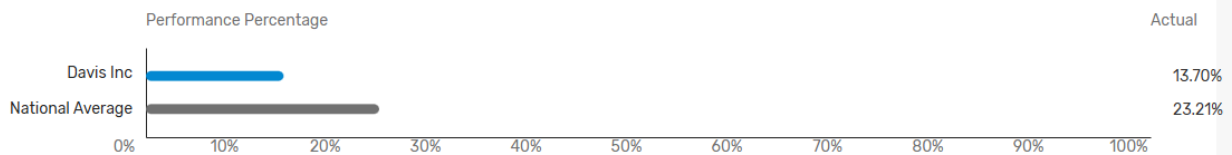
#### Small Practice Bonus

Your submission has met the requirements to be categorized as a small practice resulting in 6 bonus points added to your Quality score.

6.0

## Comparative Quality Feedback (MVP Reporting Only)

### Comparative Quality Performance Percentage



#### How You Compare

Davis Inc's Quality Performance of 13.70% is 10 points lower than the National Quality Performance Average of 23.21% of all who submitted for the Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV (M1368) MVP.

Individual clinicians, groups, and subgroups who received a final score from the MVP reporting option can see how their quality score compared to all other MVP participants who reported the same MVP.

## Submitted Measures

On the "quality" page, you may see your submitted quality measures displayed in up to 2 groups:

1. Measures whose performance points count toward your quality performance category score. The measure score will display the points earned based on comparison to its benchmark.

| Measures that count toward Quality Performance Score                                                                                     |                  |               |   |
|------------------------------------------------------------------------------------------------------------------------------------------|------------------|---------------|---|
| Your Measure Score includes both performance points and bonus points.                                                                    |                  |               |   |
| Measure Name<br><a href="#">Expand All</a>                                                                                               | Performance Rate | Measure Score |   |
| Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care<br>Measure ID: 141 | 100.00%          | 10.00         | ▼ |
| Intravesical Bacillus-Calmette Guerin for Non-muscle Invasive Bladder Cancer<br>Measure ID: 481                                          | 80.00%           | 7.00          | ▼ |

- Measures that don't count towards your quality performance category score. You'll see "N/A" in the measure score. Click the down arrow to open the measure details.

#### Measures That Don't Count Towards Your Score

The following measure(s) will not contribute to your final score.

| Measure Name<br><a href="#">Expand all</a>                                     | Performance Rate | Measure Score |
|--------------------------------------------------------------------------------|------------------|---------------|
| <b>Diabetes: Glycemic Status Assessment Greater Than 9%</b><br>Measure ID: 001 | 0.00%            | N/A           |

#### How Can I Access Details About the Measures I Submitted?

Click the arrow to the right of the measure score to expand and view the measure details, such as benchmark information, measure type, numerator, denominator, and data completeness.

|                                                                                |       |       |
|--------------------------------------------------------------------------------|-------|-------|
| <b>Diabetes: Glycemic Status Assessment Greater Than 9%</b><br>Measure ID: 001 | 0.00% | 10.00 |
|--------------------------------------------------------------------------------|-------|-------|

**Diabetes: Glycemic Status Assessment Greater Than 9%**  
 Measure ID: 001

0.00%

10.00

Lowest Benchmark

99.44 94.35 73.2 51.68 40.275 32.915 27.54 23.02 18.485 13.46

Highest Benchmark

Performance Rate: 0.00%

**Measure Info**  
 Percentage of patients 18-75 years of age with diabetes who had a glycemic status assessment (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) > 9.0% during the measurement period.  
  
 This measure is Inverse; a lower performance rate on this measure indicates better performance than a higher performance rate.

**Measure Type**  
 Intermediate Outcome

**Collection Type** Electronic clinical quality measures (eCQMs)

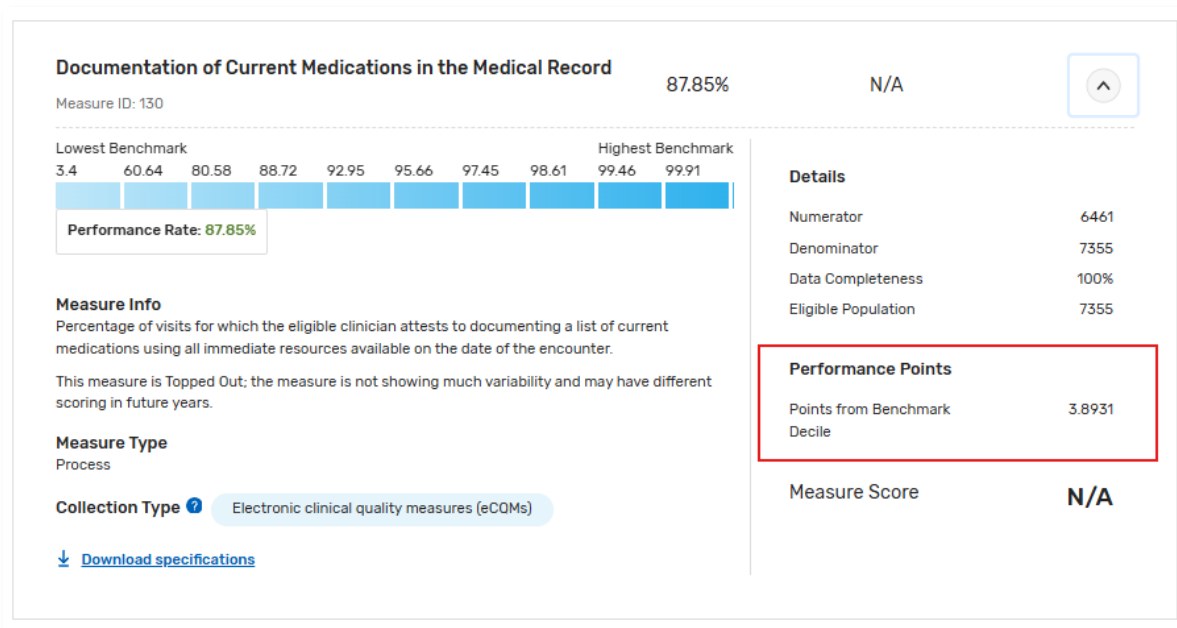
[Download specifications](#)

**Details**  
 Numerator 0  
 Denominator 100  
 Data Completeness 100%  
 Eligible Population 100  
  
**Performance Points**  
 Points from Benchmark Decile 10  
  
**Measure Score** 10.00

#### Note:

This screenshot shows an **inverse measure**, where a lower performance rate results in a higher measure score.

For measures that **don't** count towards your quality score, the measure details will allow you to see how many points you would have earned. These are found in the "Points from Benchmark Decile" in the Performance Points section of the measure card.



## We Submitted More Than the Required Number of Measures. How Did You Determine Which Ones Counted Towards Our Quality Performance Category Score?

If you submitted more than the required number of measures, only the required number will contribute measure achievement points to your quality performance category score.

There are 6 measures required for traditional MIPS and 4 measures required for MVP reporting.

When determining which measures are included:

- We'll select the highest scoring outcome measure.
- If you didn't have an outcome measure available, then we'll select the highest scoring high priority measure.
- We'll then select the next 5 (traditional MIPS)/3 (MVP) highest scoring measures.
- If you didn't submit an outcome or high priority measure, we select your next highest scoring measure, and you'll receive a score of 0/10 for the missing outcome or high priority measure.

When there are multiple measures with the same score, we select measures for the top based on the measure identification number (ID) (in ascending order).

**Example:** You submit 7 measures, and your 2 lowest scoring measures (after the outcome measure) were Measure 102 (Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients) and Measure 250 (Radical Prostatectomy Pathology Reporting), both earning 1 point. The Avoidance of Overuse of Bone Scan measure will be included in the top 6 because its measure ID (102) has a lower value than the Radical Prostatectomy Pathology Reporting measure (250).

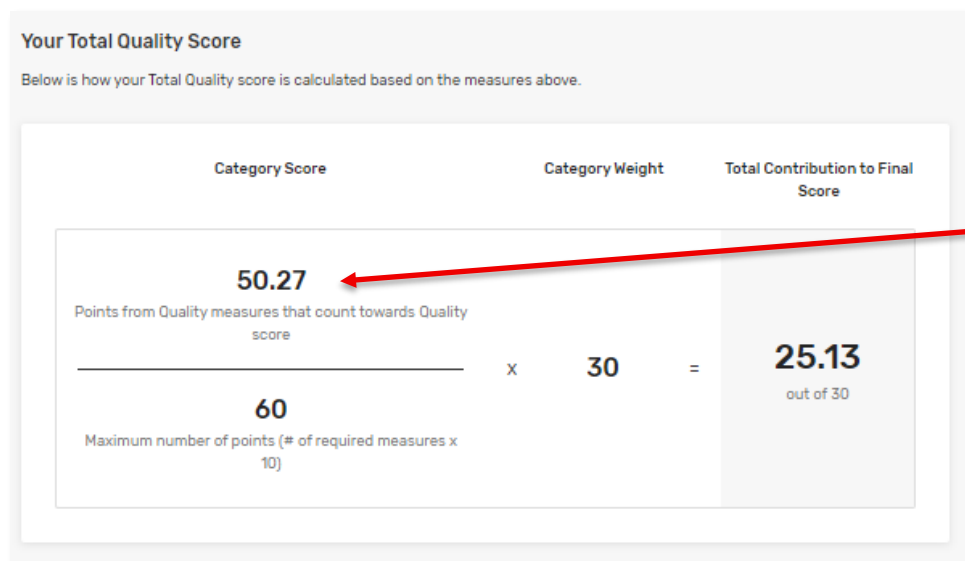
If you submit the same measure through multiple collection types; for example, as a Medicare Part B claims measure and as an electronic clinical quality measure (eCQM), we'll select the higher scoring version of the measure based on achievement points. Under no circumstances will 2 versions of the same measure count towards your quality performance category score.

### Why Are Measures with Higher Performance Rates Not Counted Towards My Quality Performance Category Score?

We included your **highest scoring** quality measures, not necessarily those with the highest performance rate. Scoring is determined by comparing the performance rate to the measure's benchmark. If you submit 2 measures, each with an 85% performance rate, 1 measure may earn 7 points while the other measure earns 10 points, based on the benchmarks for each measure.

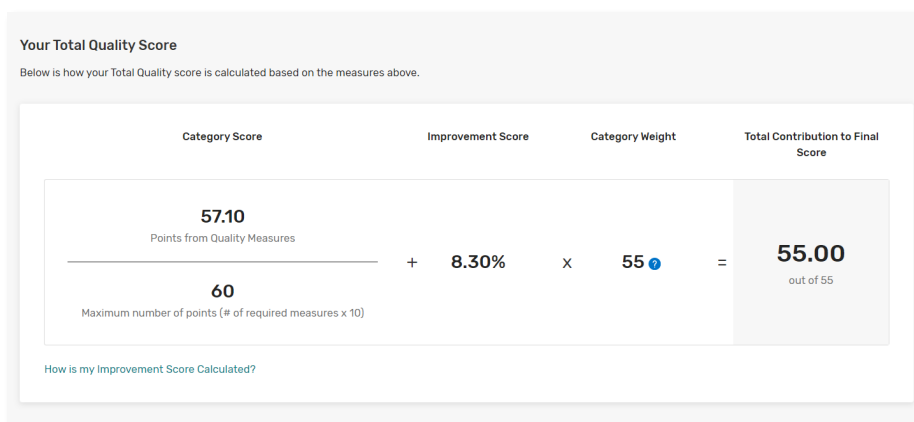
### How Do You Determine How Many Points Quality Contributes to Our Final Score?

At the bottom of the "quality" page, you can see how we arrived at the points contributing to your final score. In general, your score is calculated by dividing the total points you earned, including small practice bonus points, by the total available points (of required measures + # of administrative claims measures that are automatically calculated) multiplied by 10. That percentage is then multiplied by the category weight.



Small practice bonus points (6 points) are included here.

If you qualify for quality improvement scoring, we'll add that to your category score before multiplying by the category weight.



## What Is Quality Improvement Scoring?

MIPS eligible clinicians can earn up to 10 additional percentage points in the quality performance category based on the rate of their improvement from the previous year.

- The improvement score is calculated at the category level and represents improvement in achievement from one year to the next; it's capped at 10 percentage points.

If CMS can't compare data between 2 performance periods, or there's no improvement, the improvement score will be 0%.

- The improvement score can't be negative.

You'll see an indicator at the top of the "quality" page if you're receiving quality improvement scoring.

**Special Circumstances**  
Special circumstances are any changes to your Quality Score outside of the base measures.

*i* **Quality Improvement Score**  
You qualify for additional points based on your improvement from last year's quality score.  
[How is my Improvement Score Calculated?](#)

## How Is Quality Improvement Scoring Calculated?

Improvement scoring is calculated by comparing the quality performance category achievement score from the previous (2024) performance year to the quality performance category achievement score for the current (2025) performance year.

$$\text{Improvement Percent Score} = \frac{\text{Increase in Quality Performance Category Achievement Percent Score (From prior performance period to current performance period)}}{\text{Prior Performance Period Quality Performance Category Achievement Percent Score}} \times 10\%$$

## I Submitted All of the Medicare Part B Claims Measures (or MIPS Clinical Quality Measures [CQMs]) Available to Me. How Do I Know If the Eligible Measure Applicability (EMA) Process Was Applied to My Submission?

Clinicians reporting traditional MIPS who don't have 6 available quality measures and who report Medicare Part B claims measures or MIPS CQMs may qualify for the EMA process. This process checks for unreported, clinically related measures and can result in a denominator reduction in the quality performance category. EMA doesn't apply to any submissions containing eCQM or QCDR measures. Learn more about this process in the [2025 EMA and Denominator Reduction Guide \(PDF\)](#).

If you submitted fewer than 6 Medicare Part B claims measures or MIPS CQMs, the "Quality Details" page will display a message indicating whether the submission qualified for EMA. Denominator reductions are reflected in the **Total Quality Score** calculation section. If you submitted all of the measures available to you and you don't see a denominator reduction, you can submit a targeted review. Refer to the [2025 Targeted Review User Guide \(PDF\)](#) for more information.

When you see this message, you should also see a reduced denominator (fewer measures required).

**Submission meets requirements for Eligible Measures Applicability (EMA)**  
Your submission has met the requirements for a clinical cluster resulting in a denominator reduction.

Submitted Measures

Measures That Count Towards Your Score

| Measure Name<br><a href="#">Expand All</a>                                                                                   | Performance Rate | Measure Score |
|------------------------------------------------------------------------------------------------------------------------------|------------------|---------------|
| Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy<br>Measure ID: 147 | 100.00%          | 7.00          |
| Radiology: Exposure Dose Indices Reported for Procedures Using Fluoroscopy<br>Measure ID: 145                                | 100.00%          | 6.32          |

Subtotal: **13.32**

**Your Total Quality Score**  
Below is how your Total Quality score is calculated based on the measures above.

| Category Score                                                                                                                                              | Category Weight | Total Contribution to Final Score |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|-----------------------------------|
| <div>13.32<br/>Points from quality measures that count towards quality score</div> <div>20<br/>Maximum number of points (# of required measures x 10)</div> | X 30            | = 19.98<br>out of 55              |

## Why Don't I See All the Part B Claims Measures That I Reported in My Feedback?

There are 2 reasons you may not see all of the quality measures you reported:

1. The measure was removed for the 2025 performance year. The measures removed for the 2025 performance year and future years include:
  - Quality #104 (MIPS CQMs) – Prostate Cancer: Combination Androgen Deprivation Therapy for High Risk or Very High Risk Prostate Cancer
    - Quality #137 (MIPS CQMs) – Melanoma: Continuity of Care – Recall System
    - Quality #254 (MIPS CQMs) – Ultrasound Determination of Pregnancy Location for Pregnant Patients with Abdominal Pain
    - Quality #260 (MIPS CQMs) - Rate of Carotid Endarterectomy (CEA) for Asymptomatic Patients, without Major Complications (Discharged to Home by Post-Operative Day #2)
    - Quality #409 (MIPS CQMs) - Clinical Outcome Post Endovascular Stroke Treatment
    - Quality #433 (MIPS CQMs) - Proportion of Patients Sustaining a Bowel Injury at the time of any Pelvic Organ Prolapse Repair
    - Quality #436 (Medicare Part B Claims) - Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques<sup>1</sup>
  - Quality #439 (MIPS CQMs) - Age Appropriate Screening Colonoscopy
  - Quality #452 (MIPS CQMs) - Patients with Metastatic Colorectal Cancer and RAS (KRAS or NRAS) Gene Mutation Spared Treatment with Antiepidermal Growth Factor Receptor (EGFR) Monoclonal Antibodies
    - Quality #472 (eCQMs) - Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture

Be sure to review the [QPP Policies Final Rule Fact Sheet and Policy Comparison Guide \(PDF\)](#) each rulemaking cycle to ensure that you're meeting current reporting requirements.

Full Resource Library

fact sheet  [Hide filters](#)

Performance Year: 2025 Reporting Track: All Performance Category: All Resource Type: Regulatory Resources

[Clear all filters](#)

Use the [Explore Measures & Activities Tool](#) to view current measure list by filtering by performance year.

2. You didn't accurately report at least 1 quality data code (QDC) required for the measure to be scored.

To add your quality measure performance data to your Medicare Part B claims, you must append a QDC to your originally submitted claim form.

<sup>1</sup> In the CY2024 Medicare Physician Fee Schedule final rule, Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques (Quality ID: 436) (Medicare Part B claim, MIPS CQM) was finalized for removal for the 2025 performance period and future years.

We encourage you to review your Medicare Part B claims for accuracy prior to submission for reimbursement and reporting purposes. It's important to confirm that you're using the current measure specifications to appropriately code your claims as they may change each year.

Refer to [2026 Part B Claims Quality Measure Reporting Quick Start Guide \(PDF, 2MB\)](#) for detailed instructions on how to attach and review QDCs to ensure correct reporting of 2026 performance year data. [Contact the Service Center](#) if you need additional assistance.

### **I reported Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention Quality Measure (Quality ID: 226) via Medicare Part B Claims. Why Wasn't It Scored?**

This measure has 3 submission criteria, and we've found that practices have requested help understanding which criteria are used for evaluation, when the measure will count for scoring, and how to report the measure's quality data codes (QDCs) correctly.

How we evaluate the measure for MIPS reporting:

1. We evaluate Submission Criterion 1 for data completeness and case minimum.
2. We evaluate Submission Criterion 2 for scoring; Submission Criterion 2 is a subset of the population reported for Submission Criterion 1.
3. We don't evaluate Submission Criterion 3 for scoring purposes. While encouraged, it isn't required for small practices reporting this measure by Medicare Part B claims; however, it is included in the data publicly reported in [downloadable files at data.cms.gov](#). (Submission Criterion 3 is a comprehensive look at overall tobacco screening and cessation intervention.)

For this measure to appear in your performance feedback:

- You must have a denominator-eligible population for Submission Criterion 2 (at least 1 patient you screened for tobacco use during the measurement period must have been identified as a tobacco user when you reported Submission Criterion 1). **AND**
- You must report at least 1 QDC for Submission Criterion 2.

If none of your patients are smokers, you should look for an alternative measure to report because non-smokers aren't evaluated for performance or scoring in Submission Criterion 2.

### **Why Don't I See All the Measures I Reported?**

If you reported more measures than the ones that appear in your feedback, please contact the QPP Service Center so we can investigate your specific circumstances.

## **Measure Spotlight: Quality #226**

The QPP Service Center frequently receives inquiries about the **Preventive Care and Screening: Tobacco Use Measure (Quality #226)** from small practices who reported the measure via Medicare Part B claims.

To understand scoring for the 2025 performance year and to ensure correct reporting of 2026 performance year data for Quality #226 via Medicare Part B Claims, review the newly added, Appendix G, in the [2026 Part B Claims Quality Measure Reporting Quick Start Guide \(PDF, 2MB\)](#).

Appendix G provides detailed reporting and scoring examples for this multi-strata measure.

## **Why Am I Seeing Scores for Medicare Part B Claims Measures?**

If you didn't intend to report measures by Medicare Part B claims but received a score for one or more Medicare Part B claims measures, this means that you're appending quality data codes (QDCs) appended to the Medicare Part B claims you submit.

Review your office workflows annually to determine if all measures your practice is intending to report have appropriate quality data codes (QDC) attached, and if your practice no longer intends to report a measure, you'll need to remove the QDC codes attached to your claims to avoid this measure receiving a score.

# Improvement Activities

## Improvement Activities Performance Category Requirements

- **Traditional MIPS:** You must select, perform, and attest (submit a “yes”) to one activity (any in the complete inventory)
- **MVPs:** You must select, perform, and attest to one improvement activity from the MVP you’re registered for.
- **APP:** – No reporting requirements for the 2025 performance year.

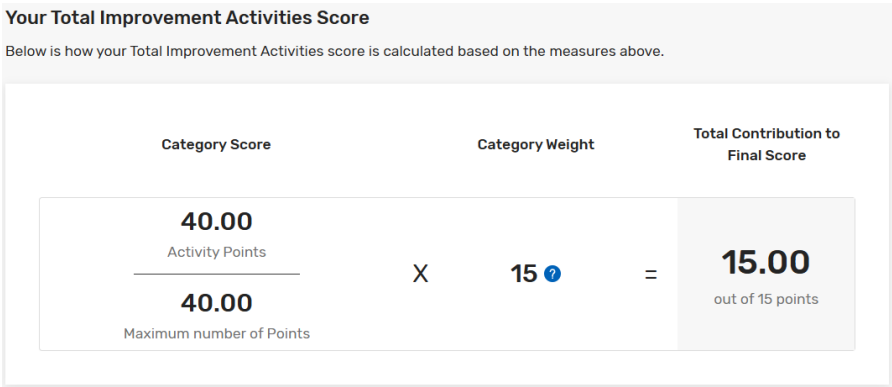
## Small Practice Improvement Activities Performance Category Flexibilities

Small practices, and those in rural locations and in health professional shortage areas receive full credit in this performance category when you perform and attest to one activity in traditional MIPS. (All clinicians must performance and attest to one activity when reporting an MVP, regardless of practice size or special status.)

## Performance Feedback

The “Improvement Activities” page will display the name and points received for each activity you attested to completing. At the bottom of the “Improvement Activities” page, you can see how we arrived at the points contributing to your final score.

We divide the sum of the points earned for your activities by 40 (the maximum number of points available). Then we multiply that number by the category weight.



## We’re a Certified Patient-Centered Medical Home. Why Didn’t We Receive Full Credit in the Improvement Activities Performance Category?

If you’re a MIPS eligible clinician practicing in a certified patient-centered medical home, including the medical home model, or a comparable specialty practice, **you earn full credit for the improvement activities performance category as long you attested to this participation (IA\_PCMH) during the submission period.** If you didn’t attest to participating in a certified, patient-centered medical home, then you didn’t receive the credit.

## Promoting Interoperability

### Promoting Interoperability Performance Category Requirements

The Promoting Interoperability performance category consists of a single set of measures required for all MIPS eligible clinicians, unless an available exclusion could be claimed. **All 3 MIPS reporting options have the same requirements for this performance category.**

### Small Practice Promoting Interoperability Performance Category Flexibilities

**Small practices (reporting individually or as a group) aren't required to report data for the Promoting Interoperability performance category; this performance category won't contribute to your final score unless you choose to report data for it.**

- Small practices qualify for this exception automatically; you don't need to submit a MIPS Promoting Interoperability Performance Category Hardship Exception application.

Choosing to submit Promoting Interoperability data voids reweighting of the performance category. CMS scores any qualifying Promoting Interoperability performance category data that's submitted. A qualifying submission includes all required performance data, required attestation statements, CEHRT ID, and the start and end date for the performance period.

### How Are Measures Scored?

Each measure is worth a specified number of points, though the maximum points per measure could change based on reporting exclusions for other measures. (Note: Some measures and attestations are required but don't receive points. They must be submitted to meet reporting requirements.)

For measures submitted with a numerator and denominator, we calculated a score for each measure by dividing the numerator you submitted by the denominator you submitted for the measure. Then we multiplied the performance rate by the maximum points available for the measure, after which we rounded the value to the nearest whole number.

### REMINDER: Electronic Case Reporting Measure Suppression

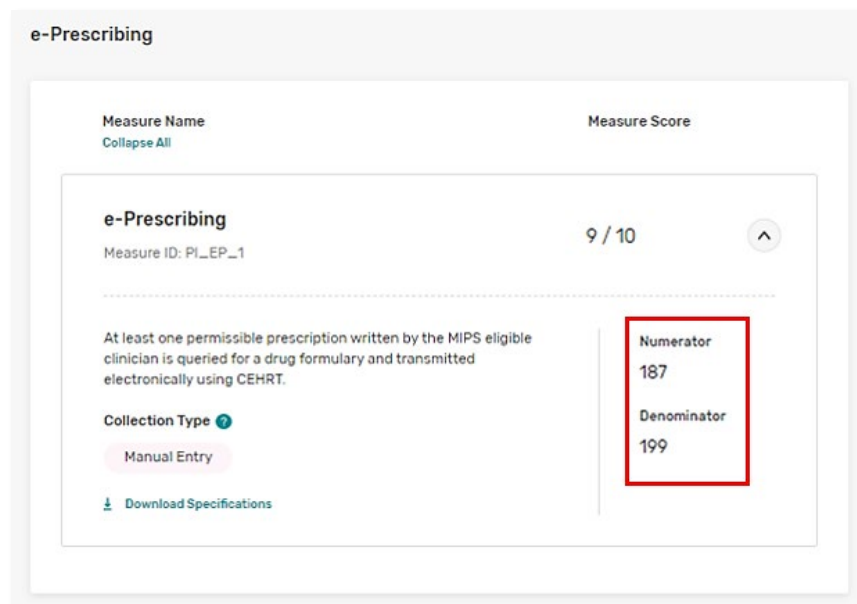
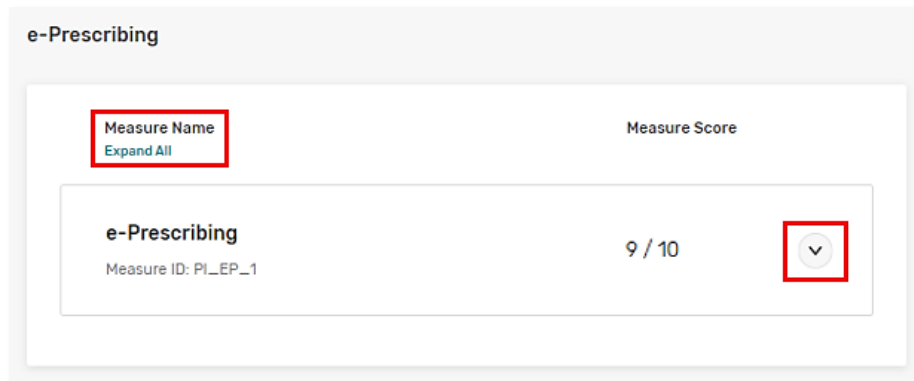
The Centers for Disease Control and Prevention (CDC) temporarily paused electronic case reporting registration (learn more in this fact sheet) and onboarding of new health care organizations (HCOs) to establish a more efficient and automated onboarding process. As a result, some MIPS eligible clinicians may have been 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 suppressed the Electronic Case Reporting measure in 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 met 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 reported the suppressed Electronic Case Reporting measure will receive full credit for the measure.

## How Do I Find Measure Details?

Click the 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.



## How Was Our Promoting Interoperability Score Calculated?

At the bottom of the “Promoting Interoperability” page, you can see how we arrived at the points contributing to your final score. We divided the points earned by 100 (the maximum number of points available); then we multiplied that number by the category weight.

### Your Total Promoting Interoperability Score

Below is how your Total Promoting Interoperability score is calculated based on the measures above.

| Category Score                     |   | Category Weight                                 | Total Contribution to Final Score |
|------------------------------------|---|-------------------------------------------------|-----------------------------------|
| 100.00<br>Base Score               | + | 5.00<br>Additional Performance and Bonus points |                                   |
| <hr/>                              |   | X                                               |                                   |
| 100.00<br>Maximum number of points |   | 25                                              | =                                 |
|                                    |   |                                                 | 25.00<br>out of 25                |

### Performance Category Overview

|                                                                                   |                                                                                                                                                                                                                                             |
|-----------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Quality<br>46.97 / 50                                                             | Promoting Interoperability<br>30.00 / 30                                                                                                                                                                                                    |
|  | <br><small>Promoting Interoperability score was aggregated to the APM Entity level based on the weighted average from all applicable submissions.</small> |
| <a href="#">View Details &gt;</a>                                                 | <a href="#">Download PI Scores</a>                                                                                                                                                                                                          |

## Why Did I Receive a Performance Category Score When I Wasn't Required to Report It?

If you had a qualifying submission for the Promoting Interoperability performance category, CMS scored the data submitted, and the category **WASN'T** reweighted to 0%.

- A qualifying submission includes all required data elements (performance period, CEHRT ID, all required attestations, all required measures, etc.), even if the data submitted didn't meet reporting requirements.

**Note:** If you didn't meet the criteria for a qualifying data submission and received a performance category score but should've qualified for reweighting based on your clinician type, special status, and/or exception status, please contact the [QPP Service Center](#) for assistance.

## Cost

### Cost Performance Category Requirements

The traditional MIPS and MVP reporting options have different cost measure options. Cost isn't measured under the APM Performance Pathway.

**Traditional MIPS** - We automatically calculate all cost measures in the MIPS inventory; you'll be scored on the measures for which you meet the case minimum.

- If you can't be scored on (don't meet the case minimum) for any cost measures, the performance category will automatically be reweighted to 0% and no cost information will be displayed.
- We'll attempt to calculate cost measures for individually eligible clinicians even if they didn't submit data for any other performance category.
- 

**MVPs** - We automatically calculate the cost measures in the MVP you registered for; you'll be scored on the measures for which you meet the case minimum.

- If you can't be scored on (don't meet the case minimum) for any cost measures within the MVP, the performance category will automatically be reweighted to 0% and no cost information will be displayed.
- You can see which cost measures are included in each MVP by viewing the [Explore MVPs](#) webpage.

### Why Don't I See Any Cost Measure Information?

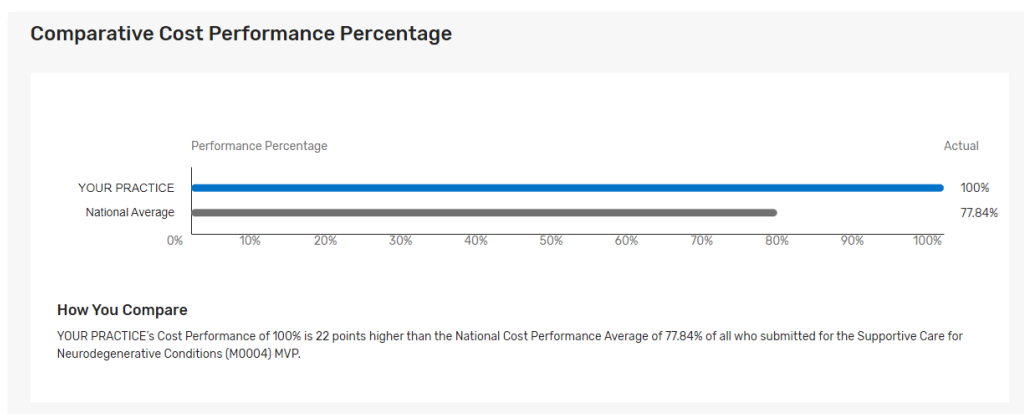
Only clinicians and groups who were scored on at least one measure will see cost measure information in performance feedback.

If you don't see any cost measure details and see a score of "--" then you didn't meet the case minimum for any cost measures and the weight for this performance category was reallocated to another category.

Clinicians and groups who were approved for reweighting in this performance category can still access measure-level and patient-level feedback if they met the case minimum for at least one cost measure.

### Comparative Cost Feedback (MVP Reporting Only)

Individual clinicians, groups, and subgroups who received a final score from the MVP reporting option can see how their cost score compared to all other MVP participants who reported the same MVP.



## How is the Cost Performance Category Score Determined?

There's a graphic at the bottom of the "cost" page showing how we arrived at the points contributing to your final score.

- We sum up the points earned for each of the cost measures you could be scored on and divide that by the maximum number of points available (the number of measures you could be scored on x 10).
- We will add cost improvement scoring (if applicable).
- We then multiply that by the performance category weight.

We finalized a change to our cost scoring methodology in the CY 2025 Medicare Physician Fee Schedule Final Rule. This change was effective beginning with the 2024 performance period and is reflected in your 2025 performance feedback. For more information on this change, please see pages 48 and 51 of the [2025 Traditional MIPS Scoring Guide \(PDF\)](#) and pages 47 and 48 of the [2025 MVPs Implementation Guide \(PDF\)](#).

## What Is Cost Improvement Scoring?

You can earn up to 1 additional percentage point in the cost performance category based on your rate of improvement from the previous year.

The improvement score, calculated at the category level and representing improvement in achievement from one year to the next, may not total more than 1 percentage point. If CMS can't compare data between 2 performance periods, or there's no improvement, the improvement score will be 0%. The improvement score can't be negative.

- You'll see an indicator at the top of the "cost" page if you're receiving cost improvement scoring.

**Special Circumstances**

Special circumstances are any changes to your Cost Score outside of the base measures.

✓ **Cost Improvement Score**

Your submission has met the requirements for a specialty set resulting in a percent increase to the total Cost score. 0.15 %

[How is my Improvement Score Calculated?](#)

## How Is Cost Improvement Scoring Calculated?

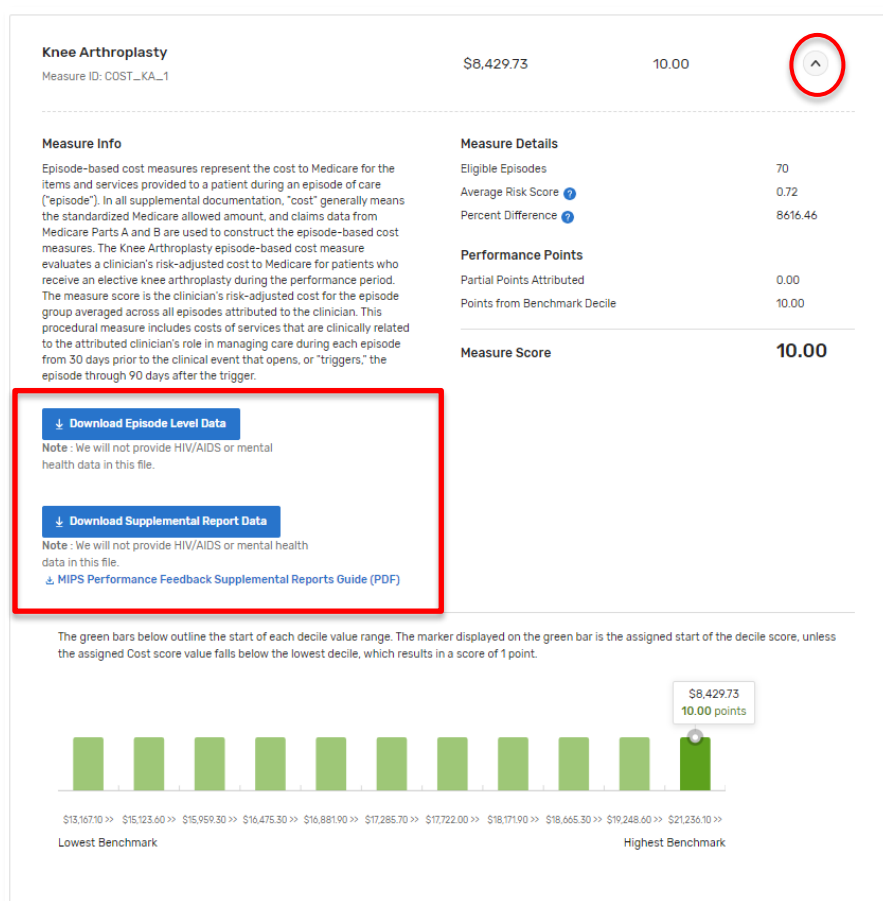
Cost improvement scoring is calculated by comparing the cost performance category score from the previous (2024) performance period to the cost performance category score for the current (2025) performance period.

- Cost improvement scoring is capped at one percentage point.

$$\text{Improvement Score (\%)} = \frac{\text{Increase in Cost Performance Category Score (From prior performance period to current performance period)}}{\text{Prior Performance Period Cost Performance Category Achievement Percent Score}} / 100$$

## Where Can I Find More Detailed Information about the Cost Measures I Was Scored on?

We've released supplemental cost measure reports. These reports are available for every cost measure on which you could be scored. Click the arrow to open the cost measure details and access these reports. Review the [2025 MIPS Performance Feedback Supplemental Reports Guide \(PDF\)](#) for more information about the data included in these reports and how to interpret this data.



## At a High Level, How Can I Interpret My Score (Expressed as a Dollar Value) on a MIPS Cost Measure?

A cost measure score represents how a clinician performs relative to their peers. A clinician or group receives more MIPS points on a cost measure if their average observed (i.e., actual) spending is lower than the expected spending (predicted through risk adjustment), compared to their peers.

- For episode-based cost measures and the MSPB Clinician measure, clinicians are scored based on their average cost per episode after applying adjustments.
- For the TPCC measure, clinicians are scored based on their average cost per beneficiary after applying adjustments.

All cost measures used standardized payment data, so factors such as geographic variation in reimbursement do not influence cost performance. All cost measures also use risk adjustment to help account for factors outside attributed clinicians' control that can influence the cost of care, such as the patient's age or preexisting comorbidities.

Risk adjustment factors include comorbidities derived from the CMS Hierarchical Condition Category (HCC) model, plus measure-specific factors tailored to the condition or procedure being assessed by that cost measure. For some measures, a specialty adjustment is also applied. The risk adjustment model predicts the cost for a given episode of care or beneficiary ("expected cost"), which is then compared to the actual ("observed") costs for an episode or beneficiary to get a ratio of observed to expected costs. This ratio is averaged across all episodes or beneficiaries attributed to a clinician during a performance period and is multiplied by the national observed mean cost to generate a dollar figure referred to as an average cost per episode or per beneficiary. This score is then translated into points in the cost performance category based on the measure's performance benchmarks.

Please see the [2025 MIPS Cost User Guide \(PDF\)](#), or the cost section of the [2025 Traditional MIPS Scoring Guide \(PDF\)](#) and the cost section of the [2025 MVPs Implementation Guide \(PDF\)](#) for a summary of how the cost measures are scored.

## How Can I Use My Performance Year Supplemental or Patient-level Cost Measure Reports to Address or Improve My Cost Category Performance in Future Performance Years?

Cost measures assess costs directly related to treatment choices, as well as the costs of other services such as costs associated with clinically related adverse outcomes or complications. Clinicians can consider the appropriate use of treatment services, such as office visits, testing and imaging, and medications. Additionally, clinicians can influence the costs of care by providing high-quality care, such as having an appropriate care plan, following clinical guidelines, conducting proactive monitoring, reconciling medications, engaging in care coordination, and providing patient education. These treatment choices can affect the likelihood and severity of costly adverse outcomes, like emergency department visits, hospitalizations and readmissions, post-acute care, and other treatment for complications, which can contribute to a clinician's cost performance score.

Clinicians could engage in the following activities/strategies after reviewing their supplemental or patient-level cost measure reports:

- Use the Hierarchical Conditions Categories (HCC) Percentile Ranking figure in the TPCC and Medicare Spending per Beneficiary (MSPB) Clinician patient-level reports and the HCC risk score figure in the episode-based cost measure patient-level reports to identify higher and lower risk patients attributed to you. Higher HCC percentile rankings and HCC risk score figures tend to be associated with more serious health conditions, including multiple chronic conditions. These patients may benefit from more intensive care coordination efforts. You may also look for opportunities to help patients at lower risk avoid the need for high-cost services (for example, outpatient emergency services). The HCC risk score figure included in the episode-based cost measure reports is provided for informational purposes only and is not used in cost measure calculations.
- To the extent possible, review attributed patients' clinical history and care decisions to inform future case and condition management.
- Identify patients that could benefit from targeted interventions that could result in avoiding unnecessary and costly services and procedures.
- Identify differences between the characteristics of the national average episode for the measure and their attributed episodes. Differences could signify billing and care patterns that warrant additional investigation.

### **What Can I Do During the Current Performance Year to Ensure My MIPS Cost Measure Performance Is Accurately Assessed?**

MIPS cost measures are calculated automatically using Medicare Parts A, B, and D administrative claims data, so it's important to submit Medicare claims accurately. For example, please ensure you fully document patient conditions in claims submitted to Medicare so that risk adjustment methodologies adequately capture patients' relative acuity.

You may also review the measure specifications to see which services and costs are included in the measure; this information is available in the [2025 MIPS Cost Measure Codes Lists \(ZIP\)](#) and the [2025 MIPS Cost Measure Information Forms \(ZIP\)](#), which are both available in the [QPP Resource Library](#).

While providers don't directly influence the costs of services paid for by Medicare, they can meaningfully influence the volume and types of services provided to their patients. Please continue to provide your patients with the right care in the most appropriate settings.

### **Can a Clinician Be Scored on an Episode-based Cost Measure if That Clinician Isn't Individually Attributed Episodes for the Measure?**

Yes, when the clinician reports as part of a group. Due to the nature of MIPS group reporting, it's expected that some specialists may be scored on cost measures even if the clinician isn't individually attributed to episodes or beneficiaries for those measures. Clinicians may be participating in MIPS as part of a group that's attributed sufficient episodes under those measures to meet the established case minimum. If a clinician participates in MIPS as part of a large group that provides a variety of care, it's reasonable that they may be attributed a measure assessing types of care that they didn't provide but that someone else from their group did. This is like group reporting for quality measures, where a clinician may be scored for a quality measure that's outside the specific care they provide.

## Where Can I Go for Help?

Contact the Quality Payment Program Service Center by emailing [QPP@cms.hhs.gov](mailto:QPP@cms.hhs.gov), by creating a [QPP Service Center ticket](#), or by calling 1-866-288-8292 (Monday through Friday, 8 a.m. - 8 p.m. ET). To receive assistance more quickly, please consider calling during nonpeak hours—before 10 a.m. and after 2 p.m. ET.

- People who are deaf or hard of hearing can dial 711 to be connected to a TRS Communications Assistant.

Visit the [Quality Payment Program website](#) for additional information, to learn more about [MIPS](#), and to check out the resources available on the [Quality Payment Program Resource Library](#).

## Version History

| Date       | Change Description |
|------------|--------------------|
| 09/21/2026 | Original Posting   |

## Appendix A: Automatic Extreme and Uncontrollable Circumstances (EUC) Policy

**Table 1. Performance Category Weights and Payment Adjustment Based on Individual Data Submission (Clinicians in a Small Practice)**

The table below illustrates the 2025 performance category reweighting policies under the MIPS automatic EUC policy that apply to clinicians in a small practice participating as individuals. Learn more in [the 2025 MIPS Automatic Extreme and Uncontrollable Circumstances Policy Fact Sheet \(PDF\)](#).

| 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                        |
| <b>Submit Data for 1 Performance Category</b>                     |                         |                                            |                                        |                      |                                |
| Quality Only                                                      | 100%                    | 0%                                         | 0%                                     | 0%                   | Neutral                        |
| Promoting Interoperability Only                                   | 0%                      | 100%                                       | 0%                                     | 0%                   | Neutral                        |
| Improvement Activities Only                                       | 0%                      | 0%                                         | 100%                                   | 0%                   | Neutral                        |
| <b>Submit Data for 2 Performance Categories</b>                   |                         |                                            |                                        |                      |                                |
| Quality   Promoting Interoperability                              | 70%                     | 30%                                        | 0%                                     | 0%                   | Positive, Negative, or Neutral |
| Quality   Improvement Activities                                  | 50%                     | 0%                                         | 50%                                    | 0%                   | Positive, Negative, or Neutral |
| Improvement Activities   Promoting Interoperability               | 0%                      | 85%                                        | 15%                                    | 0%                   | Positive, Negative, or Neutral |
| <b>Submit Data for 3 Performance Categories</b>                   |                         |                                            |                                        |                      |                                |
| Quality and Improvement Activities and Promoting Interoperability | 55%                     | 30%                                        | 15%                                    | 0%                   | Positive, Negative, or Neutral |

## Appendix B: Performance Category Reweighting

**Table 1. Performance Category Weight Redistribution (Small Practices)**

Table 1 reviews the performance category redistribution policies that apply to small practices in the 2025 performance year. **NOTE:** If you have multiple performance categories reweighted to 0% so that a single performance category is weighted as 100% of your final score, you'll receive a score equal to the performance threshold regardless of any data submitted or not submitted.

| Performance Category Redistribution for the 2025 Performance Year/2027 MIPS Payment Year for Small Practices |         |      |                             |                                 |
|--------------------------------------------------------------------------------------------------------------|---------|------|-----------------------------|---------------------------------|
| Reweighting Scenario                                                                                         | Quality | Cost | Improvement Activities (IA) | Promoting Interoperability (PI) |
| <b>No Reweighting Needed</b>                                                                                 |         |      |                             |                                 |
| General weighting for all 4 performance categories                                                           | 30%     | 30%  | 15%                         | 25%                             |
| <b>Reweighting 1 Performance Category</b>                                                                    |         |      |                             |                                 |
| <b>No Cost:</b> Cost → Quality and PI                                                                        | 55%     | 0%   | 15%                         | 30%                             |
| <b>No Promoting Interoperability:</b> PI → Quality and IA                                                    | 40%     | 30%  | 30%                         | 0%                              |
| <b>No Quality:</b> Quality → PI                                                                              | 0%      | 30%  | 15%                         | 55%                             |
| <b>No Improvement Activities:</b> IA → Quality                                                               | 45%     | 30%  | 0%                          | 25%                             |
| <b>Reweighting 2 Performance Categories</b>                                                                  |         |      |                             |                                 |
| <b>No Cost and No Promoting Interoperability</b><br>Cost and PI → Quality and IA                             | 50%     | 0%   | 50%                         | 0%                              |
| <b>No Cost and No Quality</b><br>Cost and Quality → PI                                                       | 0%      | 0%   | 15%                         | 85%                             |
| <b>No Cost and No Improvement Activities</b><br>Cost and IA → Quality and PI                                 | 70%     | 0%   | 0%                          | 30%                             |
| <b>No Promoting Interoperability and No Quality</b><br>PI and Quality → Cost and IA                          | 0%      | 50%  | 50%                         | 0%                              |
| <b>No Promoting Interoperability and No Improvement Activities</b><br>PI and IA → Cost and Quality           | 70%     | 30%  | 0%                          | 0%                              |
| <b>No Quality and No Improvement Activities</b><br>Quality and IA → PI                                       | 0%      | 30%  | 0%                          | 70%                             |

## Appendix C: Administrative Claims Measures

- **Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with Heart Failure under the Merit-based Incentive Payment System.**
  - This measure is automatically calculated for groups, virtual groups, and APM Entities that include at least 1 cardiologist and meet the case minimum (21 cases).
  - Review the [measure specification \(ZIP\)](#).
    - Included in traditional MIPS.
    - Available as 1 of the 4 required measures in MVP reporting.
    - Not included in APP reporting.
- **Risk-standardized Complication Rate (RSCR) following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) for Merit-based Incentive Payment System (MIPS).**
  - This measure is automatically calculated for individuals, groups, virtual groups, and APM Entities that meet the case minimum (25 cases).
  - This measure has a 3-year performance period (October 1, 2022 – September 30, 2025) with a 3-month numerator assessment period.
  - Review the [measure specification \(ZIP\)](#).
    - Included in traditional MIPS.
    - Available as 1 of the 4 required measures in MVP reporting.
    - Not included in APP reporting.

## Appendix D: Measures with Scoring Changes

The following measures reflect MIPS scoring updates resulting from substantive changes during the 2025 performance period.

| Measure ID/Name                                                                                                     | Impact on Scoring, Submission, and Feedback Expectations                                                                                                                              |
|---------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Measure 389/Cataract Surgery: Difference Between Planned and Final Refraction                                       | <p>This measure will be excluded from scoring and won't contribute to the MIPS quality performance category score.</p> <p>This measure won't be included in performance feedback.</p> |
| Measure 494/ Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults | <p>This measure will be excluded from scoring and won't contribute to the MIPS quality performance category score.</p> <p>This measure won't be included in performance feedback.</p> |
| COST_AKID_1/Acute Kidney Injury Requiring New Inpatient Dialysis                                                    | <p>This measure will be excluded from scoring and won't contribute to the MIPS cost performance category score.</p> <p>This measure won't be included in performance feedback.</p>    |
| COST_EDV_1/Emergency Medicine                                                                                       | <p>This measure will be excluded from scoring and won't contribute to the MIPS cost performance category score.</p> <p>This measure won't be included in performance feedback.</p>    |