Quality Payment
PROGRAM

Merit-based Incentive Payment System (MIPS)

Eligibility and Participation in the 2024 Performance Year

CMS

Table of Contents

How To Use This Guide 3

Overview 5

MIPS Eligibility and Participation Overview 9

How MIPS Eligibility is Determined 17

MIPS Participation Options 32

Reporting Factors 36

MIPS Payment Adjustments 42

Help and Version History 45

Appendices 48

Purpose: This detailed resource focuses on eligibility determinations and participation options for the 2024 MIPS performance year, including traditional MIPS, the Alternative Payment Model Pathway (APP), and MIPS Value Pathways (MVPs).

Already know what MIPS is? Skip ahead by clicking the links in the Table of Contents.

How to Use This Guide

Please Note: This guide was prepared for informational purposes only and isn't intended to grant rights or impose obligations. The information provided is only intended to be a general summary. It isn't intended to take the place of the written law, including the regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

Table of Contents

The Table of Contents is interactive. Click on a Chapter in the Table of Contents to read that section. You can also click on the icon on the bottom left to go back to the Table of Contents.

Hyperlinks

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

Overview

What is the Merit-based Incentive Payment System?

Quality Payment PROGRAM

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

If you're eligible for MIPS in 2024:

- You have to report measure and activity data for the quality (PDF, 271KB), improvement activities (PDF, 298KB), and Promoting Interoperability (PDF, 244KB) performance categories.
  - Exceptions to these reporting requirements include your MIPS reporting option, special status, clinician type, extreme and uncontrollable circumstances (EUC) or hardship exception. Detailed information will be available in the forthcoming 2024 Traditional MIPS Scoring Guide and 2024 APP Scoring Guide. These will be posted to the QPP Resource Library. The 2024 MIPS Value Pathways Implementation Guide (PDF, 1MB) is available now.
- We collect and calculate data for the cost (PDF, 348KB) performance category for you, if applicable.
  - Exceptions include your MIPS reporting option, participation option, EUC and whether or not you meet the case minimum for any cost measures. Detailed information is available in the 2024 MIPS Cost Quick Start Guide and 2024 MIPS Value Pathways (MVPs) Implementation Guide (PDF, 1MB) and forthcoming in the 2024 Traditional MIPS Scoring Guide. These will be posted to the QPP Resource Library.

Continued on next slide.

To learn more about MIPS eligibility and participation options:

- Visit the How MIPS Eligibility is Determined and Participation Options Overview webpages on the Quality Payment Program website.
- Check your current participation status using the QPP Participation Status Tool.

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

If you're eligible for MIPS in 2024 (Continued):

- Your performance across the MIPS performance categories, each with a specific weight, will result in a MIPS final score of 0 to 100 points.
- Your MIPS final score will determine whether you receive a negative, neutral, or positive MIPS payment adjustment.
  - Positive payment adjustment for clinicians with a 2024 final score above 75.
  - Neutral payment adjustment for clinicians with a 2024 final score equal to 75.
  - Negative payment adjustment for clinicians with a 2024 final score below 75.
- Your MIPS payment adjustment is based on your performance during the 2024 performance year and applied to payments for your Medicare Part B-covered professional services beginning on January 1, 2026.

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

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

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

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

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MIPS Eligibility and Participation Overview

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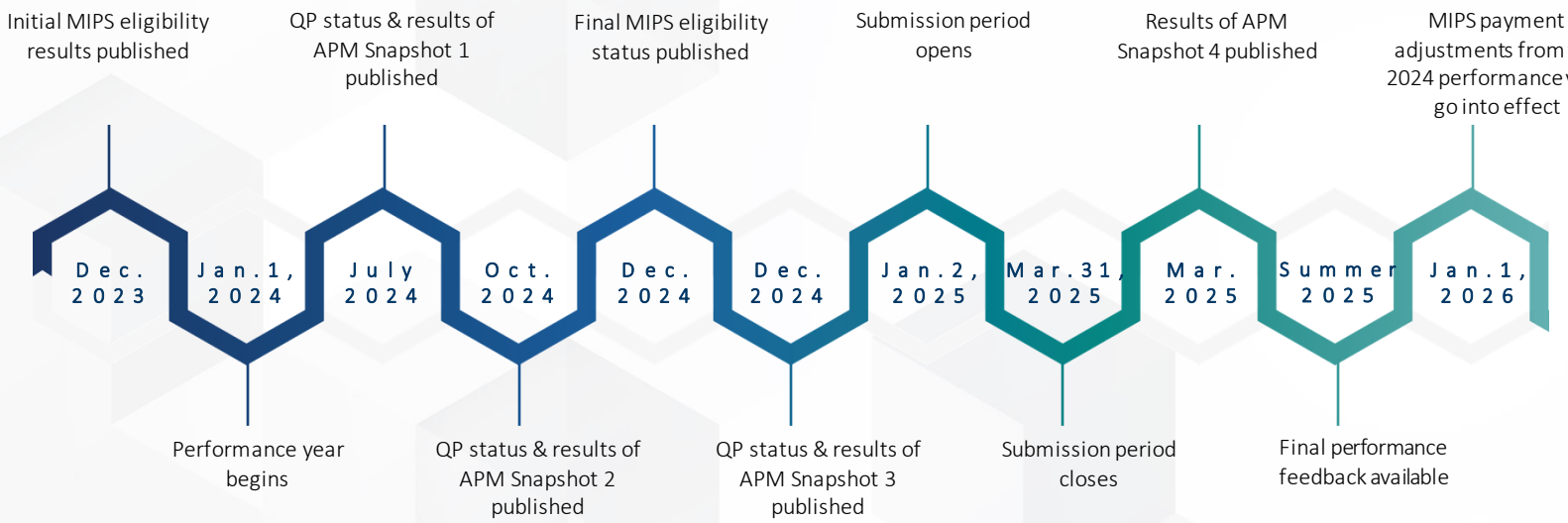
MIPS Eligibility and Participation Timeline

Key Dates for the 2024 Performance Year



MIPS Eligibility and Participation at a Glance

This user guide outlines details about MIPS eligibility and participation under MIPS, and will cover:

- What's New in 2024?
- How to Check Your Eligibility Status and Participation Options
- Eligibility Basics
- Participation Basics
- Reporting Factors
- MIPS Payment Adjustments

Eligibility requirements are the same for all 3 reporting options. However, the participation options vary between traditional MIPS, MVPs, and the APP.

Helpful Hint
Your initial eligibility status is available until December 2024, after which your final eligibility status will be available.

What's New in 2024?

There are no changes to MIPS eligibility requirements or participation options for the 2024 performance year.

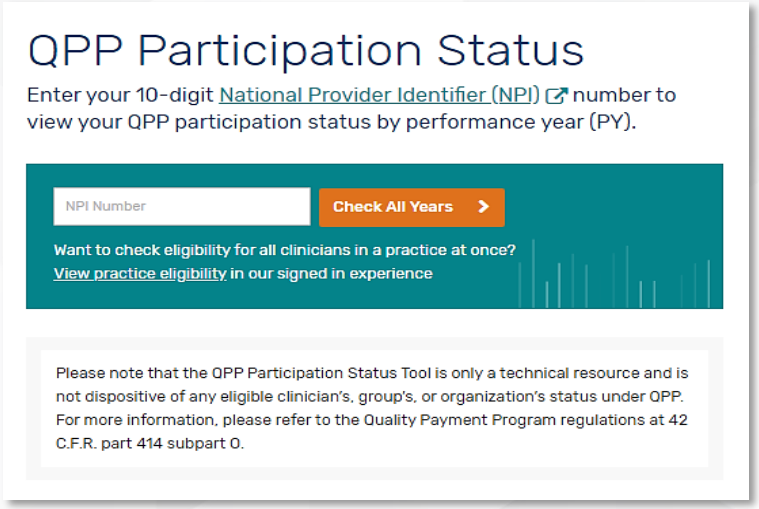
How to Check Your Eligibility and Participation

To quickly assess your eligibility status, you may:

- Check the QPP Participation Status Tool.
- Sign in to the Quality Payment Program website.

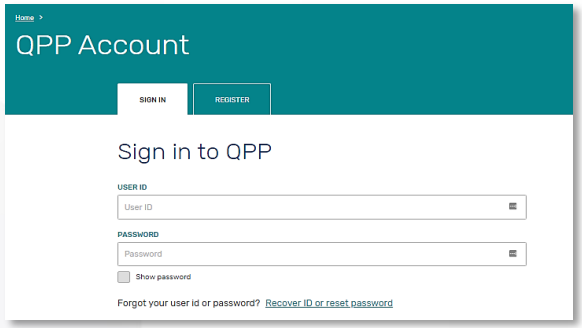
QPP Participation Status Tool

To use the status tool, enter your 10-digit National Provider Identifier (NPI) and make sure you're viewing your **PY 2024** Eligibility Status:



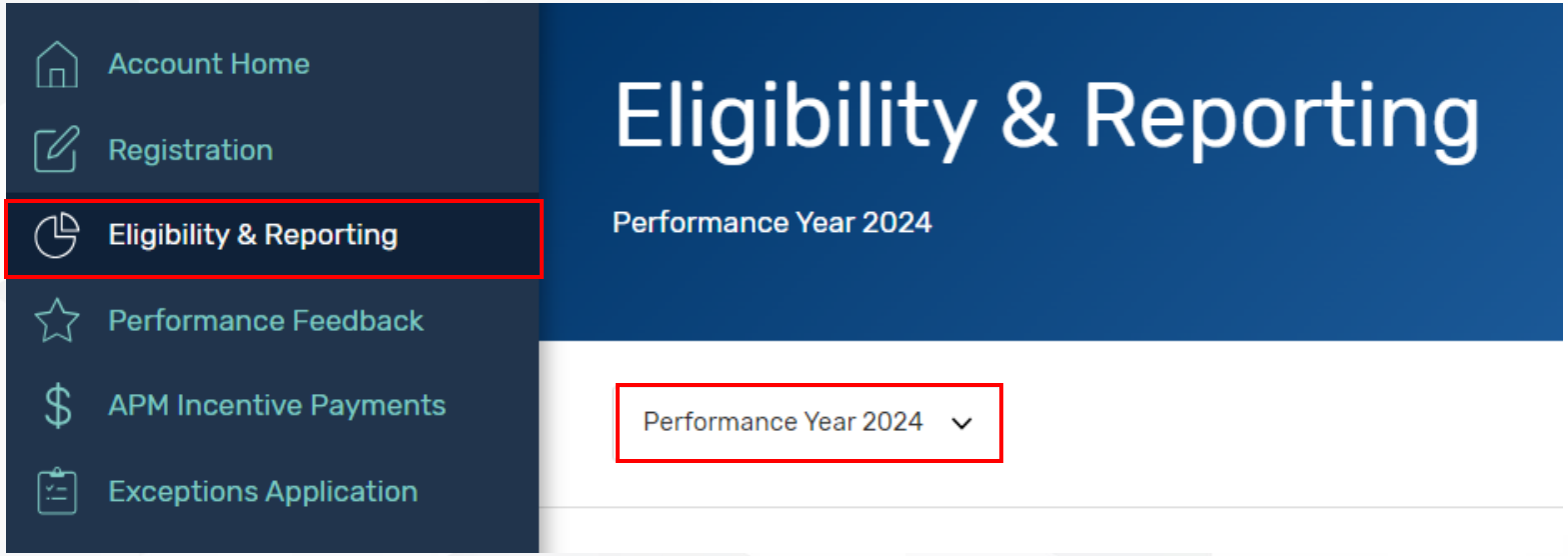
Sign in to the Quality Payment Program website

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

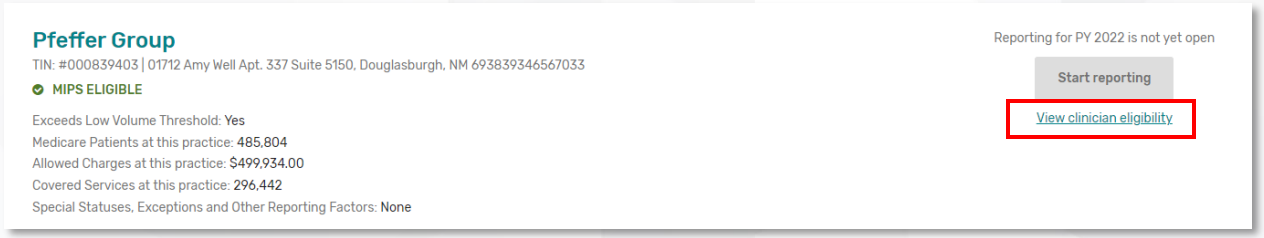


Sign in to the Quality Payment Program website (Continued)

Click Eligibility & Reporting and select “Performance Year 2024” from the drop down at the top of the page:



Click "View clinician eligibility”



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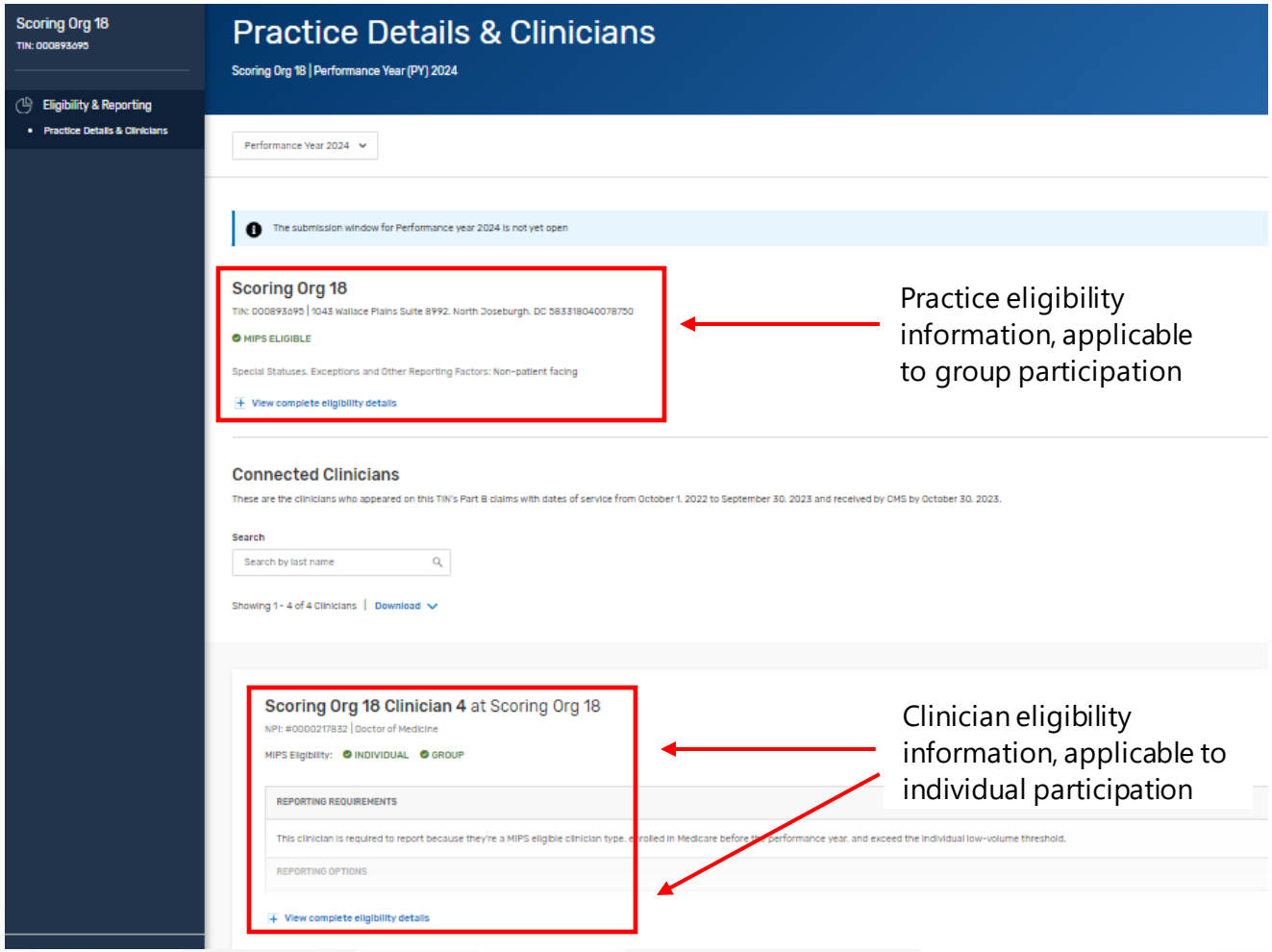
Sign in to the Quality Payment Program website (Continued)

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

Click View complete eligibility details to see detailed information about the low-volume threshold and any special statuses held by the practice (applicable to group participation) and individuals (applicable to individual participation).



Sign in to the Quality Payment Program website (Continued)

Did you know?

When you sign in **before** eligibility statuses are updated in December 2024:

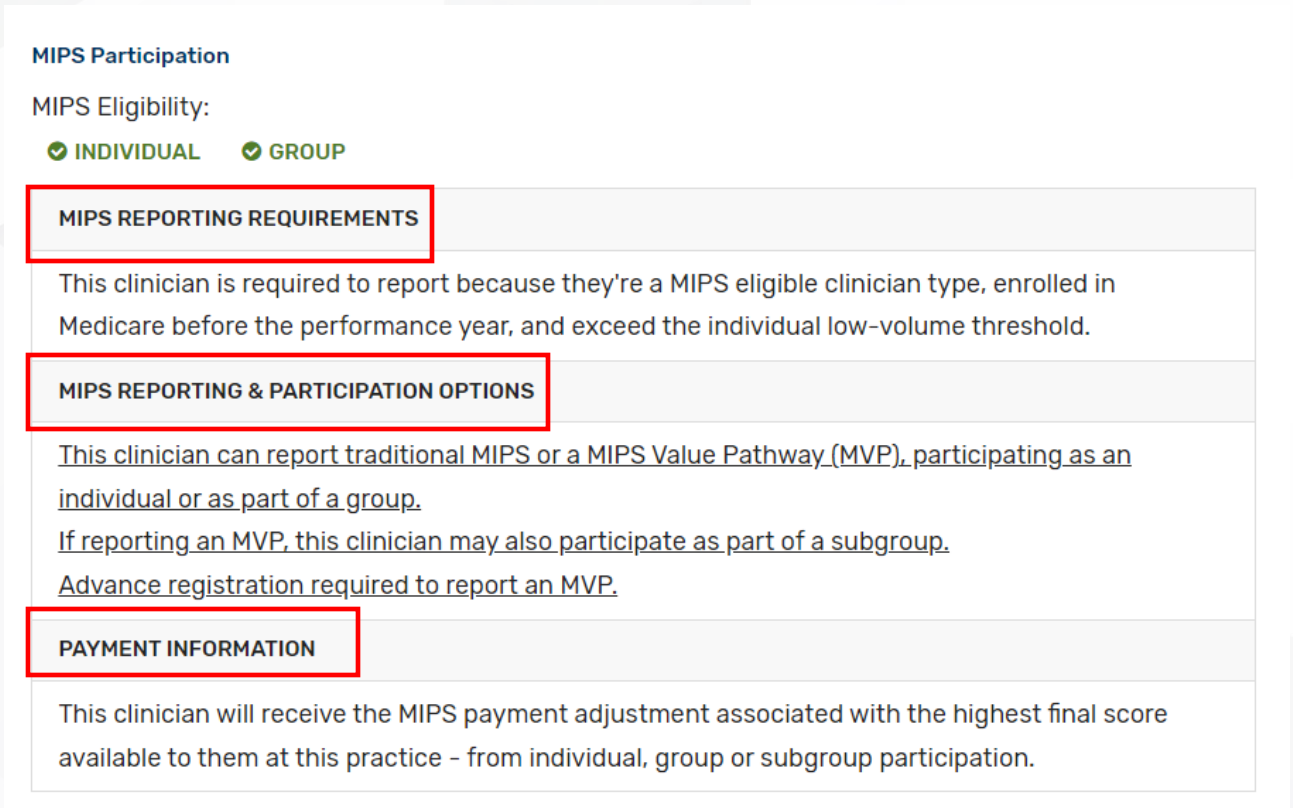
- The Practice Details & Clinicians page lists the clinicians who appeared in your TIN's Medicare Part B claims submitted with dates of service from Oct. 1, 2022, to Sept. 30, 2023, and received by CMS by October 30, 2023.

When you sign in **after** eligibility statuses are updated in December 2023:

- The Practice Details & Clinicians page lists the clinicians who appeared in your TIN's Medicare Part B claims submitted with dates of service from Oct. 1, 2023, to Sept. 30, 2024, and received by CMS by October 30, 2024.

Sign in to the Quality Payment Program website (Continued)

In addition to specifying clinician eligibility, the **Practice Details & Clinicians** page also provides information on which reporting options are available to the clinician as well as payment adjustment information.



How MIPS Eligibility is Determined

Eligibility Basics

Your eligibility is based on your:

- NPI and
- Associated TINs.

A TIN can belong to:

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

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

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

Your MIPS eligibility is determined by:

- Your clinician type
- The volume of care you provide to Medicare patients
- The date you enrolled as a Medicare provider
- The degree to which you participate in an Advanced APM (your Qualifying APM Participant (QP) status)

MIPS Determination Period

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

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

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

Segment 1:
October 1, 2022 – September 30, 2023

Segment 2:
October 1, 2023 – September 30, 2024

MIPS Eligible Clinician Types

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

[1] Includes doctors of medicine, osteopathy, dental surgery, dental medicine, podiatric medicine, and optometry.
[2] With respect to certain specified treatment, a Doctor of Chiropractic legally authorized to practice by a State in which he/she performs this function.

MIPS Low-volume Threshold

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

The 3 low-volume threshold criteria are:

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

AND

Patient count: see more than 200 Medicare Part B patients

AND

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

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

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

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

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

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

Applying the Low-volume Threshold (Individual Level)

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

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

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

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

***Subgroup participation and/or MVP reporting requires advance registration. We don't evaluate subgroups for the low-volume threshold, but in order to participate as a subgroup, the affiliated group must exceed the low-volume threshold at the TIN level and the subgroup must include at least one individually eligible clinician.

Applying the Low-volume Threshold (Group Level)

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

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

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

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

***Subgroup participation and/or MVP reporting requires advance registration. We don't evaluate subgroups for the low-volume threshold, but in order to participate as a subgroup, the affiliated group must exceed the low-volume threshold at the TIN level and the subgroup must include at least one individually eligible clinician.

Applying the Low-volume Threshold (Continued)

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

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You're a MIPS eligible clinician and will receive a MIPS payment adjustment if you meet the criteria below:

Are a MIPS eligible clinician type

AND

Exceed all 3 elements of the low-volume threshold as an individual

OR

Are participating as a group or subgroup and the TIN exceeds all 3 elements of the low-volume threshold

OR

Are participating as an APM Entity and your TIN exceeds all 3 elements of the low-volume threshold

OR

Are part of a CMS-approved virtual group

AND

Enrolled in Medicare before January 1, 2024

AND

Don't become a Qualifying APM Participant (QP) or Partial QP

Quality Payment PROGRAM

You're not a MIPS eligible clinician and won't receive a MIPS payment adjustment if you meet any of the criteria below:

Aren't a MIPS eligible clinician type

OR

Don't exceed all 3 elements of the low-volume threshold as an individual

AND

Aren't participating as a group, subgroup or APM Entity (regardless of whether your TIN exceeds the low-volume threshold)

AND

Aren't part of a CMS-approved virtual group

OR

Enrolled in Medicare on or after January 1, 2024

OR

Become a Qualifying APM Participant (QP) or Partial QP*

*Clinicians with Partial QP status may elect to participate in MIPS and receive a payment adjustment.

How MIPS Eligibility Status Can Change

Your eligibility status can change between now and December 2024 for each practice (TIN) you're currently associated with:

Eligible	Opt-in Eligible	Exempt
If you're **currently eligible**, you could: • Remain eligible; • Become opt-in eligible; OR • Become ineligible.	If you're **currently opt-in eligible**, you could: • Remain opt-in eligible; OR • Become ineligible	If you're **currently ineligible**, you will remain ineligible, unless your QP status changes.

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

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

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

Reasons Eligibility Status Can Change

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

If you start billing Medicare Part B claims under a new TIN between October 1 and December 31, 2023, you'll:

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

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

Opt-In and Voluntary Reporting

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

Opt-In Eligible

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

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

- **Do nothing.** You don't exceed the low-volume threshold and aren't required to participate in MIPS.
- **Elect to opt-in (traditional MIPS and APP only. Opt-in eligible clinicians can't report an MVP.)** If you choose to opt-in, you'll submit data, receive performance feedback, and receive a MIPS payment adjustment in 2026.
- **Elect to voluntarily report (traditional MIPS only.)** If you don't want to receive a MIPS payment adjustment in 2026, but want to participate in MIPS, you can **voluntarily report** data and receive limited performance feedback on the data you report.

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

Voluntary Reporting

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

TIP: See Appendix 2 for examples of changing eligibility status

Virtual Groups: Opt-In and Voluntary Reporting

If you (as a solo practitioner or group) elected to be a part of a virtual group for the 2024 performance year and exceeded 1 or 2, but not all 3 of the low-volume threshold criteria, then the virtual group's election to participate in MIPS as a virtual group also serves as your election to opt-in to MIPS and be subject to the MIPS payment adjustment.

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

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

As a reminder, virtual groups can only report traditional MIPS in the 2024 performance year.

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

Implications for Clinicians Who Are MIPS Eligible vs. Those Who Opt-in or Voluntarily Report

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

MIPS Participation Options

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MIPS Participation Options (Continued)

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

Participation Options When Reporting Traditional MIPS

1. As an Individual

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

2. As a Group

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

3. As a Virtual Group

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

4. As an APM Entity

Made up of eligible clinicians participating in the MIPS APM Entity

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MIPS Participation Options (Continued)

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

Participation Options When Reporting an MVP

1. As an Individual

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

2. As a Group

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

3. As a Subgroup

A subset of clinicians (2 or more NPIs) in the group who have reassigned their billing rights to a single TIN

4. As an APM Entity

Made up of eligible clinicians participating in the MIPS APM Entity

Quality Payment PROGRAM

MIPS Participation Options (Continued)

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

Participation Options When Reporting the APP

1. As an Individual

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

2. As a Group

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

3. As an APM Entity

Made up of eligible clinicians participating in the MIPS APM Entity

Reporting Factors

Reporting Factors Overview

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

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

Special Status Designations

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

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

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

Special Status Designations (Continued)

Designation	Criteria by Participation Level	Impact to MIPS Reporting Requirement (Applicable to All Reporting Options Unless Otherwise Noted)
Ambulatory Surgical Center (ASC)-based	**Clinician (Individual Reporting)**: You furnish more than 75% of your covered professional services in sites of service identified by Place of Service (POS) code 24 during one or both 12-month segments of the MIPS Determination Period. **Practice (Group and Subgroup Reporting)**: All MIPS eligible clinicians associated with your practice are designated as ASC-based during one or both 12-month segments of the MIPS Determination Period. **Virtual Group**: All MIPS eligible clinicians associated with your virtual group are designated as ASC-based during one or both 12-month segments of the MIPS Determination Period.	You qualify for automatic reweighting of the Promoting Interoperability performance category to 0%. The category weight will be redistributed to another performance category (or categories) unless you choose to submit Promoting Interoperability data.
Hospital-based	**Clinician (Individual Reporting)**: You furnish 75% or more of your covered professional services in a hospital setting identified by POS codes 19, 21, 22, and 23 during one or both 12-month segments of the MIPS Determination Period. **Practice (Group and Subgroup Reporting)**: More than 75% of the clinicians associated with your practice are designated as hospital-based during one or both 12-month segments of the MIPS Determination Period. **Virtual Group**: More than 75% of the clinicians associated with your virtual group are designated as hospital-based during one or both 12-month segments of the MIPS Determination Period.	You qualify for automatic reweighting of the Promoting Interoperability performance category to 0%. The category weight will be redistributed to another performance category (or categories) unless you choose to submit Promoting Interoperability data.
Non-patient Facing	**Clinician (Individual Reporting)**: You have 100 or fewer Medicare Part B patient-facing encounters (including telehealth services) during one or both 12-month segments of the MIPS Determination Period **Practice (Group and Subgroup Reporting)**: More than 75% of the clinicians billing under your practice's TIN meet the individual definition of non-patient facing during one or both 12-month segments of the MIPS Determination Period. **Virtual Group**: More than 75% of the clinicians in your virtual group meet the individual definition of non-patient facing during one or both 12-month segments of the MIPS Determination Period.	You'll earn 2x the points for each improvement activity you submit. **(Traditional MIPS Only)** You also qualify for automatic reweighting of the Promoting Interoperability performance category to 0%. The category weight will be redistributed to another performance category or categories unless you choose to submit Promoting Interoperability data.

Special Status Designations (Continued)

Designation	Criteria by Participation Level	Impact to MIPS Reporting Requirement
Small Practice	**Clinician (Individual Reporting)**: You're a MIPS eligible clinician who is one of 15 or fewer clinicians billing under the practice's TIN during one or both 12-month segments of the MIPS Determination Period.	You'll earn 2x the points for each improvement activity you submit. **(Traditional MIPS Only)** If you submit at least one quality measure, you'll also receive 6 bonus points in the quality performance category. You qualify for automatic reweighting of the Promoting Interoperability performance category to 0%. The category weight will be redistributed to another performance category (or categories) unless you choose to submit Promoting Interoperability data. You qualify for a different reweighting distribution when Promoting Interoperability is reweighted.
	Practice (Group and Subgroup Reporting): There are 15 or fewer clinicians billing under your practice's TIN during one or both 12-month segments of the MIPS Determination Period.	
	Virtual Group: There are 15 or fewer clinicians billing across all the TINs participating in the virtual group during one or both 12-month segments of the MIPS Determination Period.	
	APM Entity: There are 15 or fewer clinicians associated with the APM Entity.	
Health Professional Shortage Area (HPSA)	**Clinician (Individual Reporting)**: You're a MIPS eligible clinician who practices in an area designated as an HPSA under section 332(a)(1)(A) of the Public Health Service Act.	You'll earn 2x the points for each improvement activity you submit. **(Traditional MIPS Only)**
	Practice (Group Reporting): More than 75% of clinicians billing under the group's TIN are in an area designated as an HPSA.	
	Virtual group: More than 75% of the clinicians in your virtual group are in an area designated as an HPSA.	
Rural	**(Individual Reporting)**: You're a MIPS eligible clinician associated with a practice (TIN) billing claims within a ZIP code designated as rural by the Federal Office of Rural Health Policy (FORHP) using the most recent FORHP Eligible ZIP code file available.	You'll earn 2x the points for each improvement activity you submit. **(Traditional MIPS Only)**
	Practice (Group Reporting): More than 75% of the clinicians billing under the practices TIN are in a ZIP code designated as rural using the most recent FORHP ZIP code file.	
	Virtual Group: More than 75% of the clinicians in the virtual group are in a ZIP code designated as rural using the most recent FORHP ZIP code file.	

Special Status Designations (Continued)

Designation	Criteria by Participation Level	Impact to MIPS Reporting Requirement
Facility-based	**Clinician (Individual Reporting)**: During the first 12-month segment of the MIPS Determination Period, you: • Furnished 75% or more of your covered professional services in a hospital setting identified by POS codes 21, 22, and 23; AND • Billed at least one service in an inpatient hospital or emergency room; AND • Can be assigned to a facility with a FY 2024 Hospital VBP Program score.	Facility-based scoring offers clinicians and groups the opportunity to receive scores in the MIPS quality and cost performance categories based on the appropriate Fiscal Year score for the Hospital Value-Based Purchasing (VBP) Program earned by their assigned facility. *To receive facility-based scoring as a group or virtual group, your group or virtual group must submit group/virtual group level data for the improvement activities and/or Promoting Interoperability performance category(ies) to signal your practice's intent to participate as a group. **REMINDER:** Your facility-based status still will be removed if assigned facility doesn't receive a Fiscal Year (FY) 2024 Hospital VBP Program score. The facility-based status currently displayed is predictive until the end of 2024 when the FY 2025 scores are available.
	Practice (Group and Subgroup Reporting): 75% or more of the clinicians in the TIN are facility-based as individuals. Groups are assigned to the facility at which the plurality of clinicians in the TIN were assigned as individuals.	
	Virtual Group: 75% or more of the clinicians in the virtual group are facility-based as individuals. Virtual groups are assigned to the facility at which the plurality of clinicians in the virtual group were assigned as individuals.	

Reporting Factors Example

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

Clinician Level

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

Practice Level

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

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

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

MIPS Payment Adjustments

Who's Eligible for a MIPS Payment Adjustment?

The following will receive a MIPS payment adjustment even if data aren't submitted:	The following will receive a MIPS payment adjustment only if data are submitted:	The following won't receive a MIPS payment adjustment even if data are submitted:
MIPS eligible clinicians who exceed the low-volume threshold as an individual or elect to opt-in	MIPS eligible clinicians below the low-volume threshold as individuals in a practice that is eligible (or opted-in) and reports as a group or APM Entity	Eligible clinicians who don't exceed the low-volume threshold and don't elect to opt-in or otherwise participate at any level
MIPS eligible clinicians in a CMS-approved virtual group	MIPS eligible clinicians below the low-volume threshold as individuals in a practice that is eligible **and** reports an MVP as a subgroup	Ineligible clinician types
		Newly enrolled Medicare providers (on or after January 1, 2024)
Partial QPs that elect to participate in MIPS	MIPS eligible clinicians in a MIPS APM who report via the APP as an individual, group, or APM Entity group	QPs
		Partial QPs that don't elect to participate in MIPS

Hierarchy for assigning the 2024 MIPS final score when more than one final score is associated with a TIN/NPI combination for a MIPS eligible clinician

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

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

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

Refer to Appendix 3 for additional payment adjustment scenarios.

Help and Version History

Where Can You Go for Help?

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

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

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

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

Version History

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

DATE	DESCRIPTION
06/17/2024	Original Posting.

Appendices

Appendix 1: Examples of Eligibility Status Changing

Example 1. If you join a new practice (establish a new TIN/NPI combination in Medicare Part B claims) in the second 12-month segment of the MIPS Determination Period (October 1, 2023 - September 30, 2024), your eligibility at that practice is based solely on this segment.

Ann, a nurse practitioner and MIPS eligible clinician, joined Integrated Care Associates (TIN) on November 15, 2023. Ann wasn't included in our evaluation of the first 12-month segment of the MIPS Determination Period at Integrated Care Associates. Neither Ann nor Integrated Care Associates are identified as MIPS APM participants.

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

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

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

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

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

Appendix 1: Examples of Eligibility Status Changing

Example 2. If you start billing Medicare Part B claims under a new TIN between October 1 and December 31, 2024, you'll:

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

Dr. Ahmed is an optometrist who joined a practice called the Vision Center on October 1, 2024. The Vision Center is MIPS eligible as a group (TIN) and will be reporting to MIPS as a group.

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

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

Outcome: Dr. Ahmed is **ineligible for MIPS** as an **individual** at the Vision Center because he started billing under the practice's TIN beginning on October 1, 2024, after the conclusion of the MIPS Determination Period. The Vision Center is **MIPS eligible as a group** and will be reporting as a group.

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

Appendix 2A: Participation Scenarios for Individuals

The table below identifies the different low-volume threshold results across the two segments of the MIPS determination period and final eligibility determinations for an individual MIPS eligible clinician (identified by a unique TIN/NPI combination).

NOTE: Opt-in Eligible individuals who are also MIPS APM participants can elect to opt-in to report traditional MIPS or the APP, voluntarily report to traditional MIPS, or do nothing. You can't voluntarily-report the APP or an MVP; you can't opt-in and report an MVP.

1st Segment (10/1/2022-9/30/2023)	Initial MIPS Eligibility Status	2nd Segment (10/1/2023-9/30/2024)	FINAL MIPS Eligibility Status After Reconciling 1st And 2nd 12-month Segments		
	Text Displayed in QPP Participation Status Tool (Available NOW)		Text Displayed in QPP Participation Status Tool (Available December 2024)	Can Elect to Opt-in as an Individual?	Can Choose to Voluntarily Report as an Individual?[3]
No Medicare Part B claims billed under TIN/NPI combination	**N/A -** Not found in participation status tool	**No Medicare Part B claims billed** under TIN/NPI combination	**N/A -** Not found in participation status tool	No	No[4]
		Exceeded 0 low-volume threshold criteria as an individual	**Ineligible** as an individual	No	**Yes**
		Exceeded 1 or 2 low-volume threshold criteria as an individual	**Opt-in Eligible** as an individual (NOT required to report)	**Yes**	**Yes**

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

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

Appendix 2A: Participation Scenarios for Individuals (Continued)

1st Segment (10/1/2022-9/30/2023)	Initial MIPS Eligibility Status	2nd Segment (10/1/2023-9/30/2024)	FINAL MIPS Eligibility Status After Reconciling 1st And 2nd 12-month Segments		
	Text Displayed in QPP Participation Status Tool (Available NOW)		Text Displayed in QPP Participation Status Tool (Available December 2024)	Can Elect to Opt-in as an Individual?	Can Choose to Voluntarily Report as an Individual?[3]
No Medicare Part B claims billed under TIN/NPI combination	**N/A -** Not found in participation status tool	**Exceeded all 3** low-volume threshold criteria as an individual	**Eligible** as an individual (**Required** to report)	No	No
Exceeded 0 low-volume threshold criteria as an individual	**Ineligible** as an individual	**No Medicare Part B claims billed** under TIN/NPI combination	**N/A -** Not found in participation status tool	No	No[4]
		Exceeded 0 low-volume threshold criteria as an individual	**Ineligible** as an individual	No	**Yes**
		Exceeded 1 or 2 low-volume threshold criteria as an individual	**Ineligible** as an individual	No	No
		Exceeded all 3 low-volume threshold criteria	**Ineligible** as an individual	No	**Yes**

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

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

Appendix 2A: Participation Scenarios for Individuals (Continued)

1st Segment (10/1/2022-9/30/2023)	Initial MIPS Eligibility Status	2nd Segment (10/1/2023-9/30/2024)	FINAL MIPS Eligibility Status After Reconciling 1st And 2nd 12-month Segments		
	Text Displayed in QPP Participation Status Tool (Available NOW)		Text Displayed in QPP Participation Status Tool (Available December 2024)	Can Elect to Opt-in as an Individual?	Can Choose to Voluntarily Report as an Individual?[3]
Exceeded 1 or 2 low-volume threshold criteria as an individual	**Opt-in Eligible** as individual	**No Medicare Part B claims billed** under TIN/NPI combination	**N/A** -Not found in participation status tool	No	No[4]
		Exceeded 0 low-volume threshold criteria as an individual	**Ineligible** as an individual	No	**Yes**
		Exceeded 1 or 2 low-volume threshold criteria as an individual	**Opt-in Eligible** as an individual (NOT required to report)	**Yes**	**Yes**
		Exceeded all 3 low-volume threshold criteria	**Opt-in Eligible** as an individual (NOT required to report)	**Yes**	**Yes**

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

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

Appendix 2A: Participation Scenarios for Individuals (Continued)

1st Segment (10/1/2022-9/30/2023)	Initial MIPS Eligibility Status	2nd Segment (10/1/2023-9/30/2024)	FINAL MIPS Eligibility Status After Reconciling 1st And 2nd 12-month Segments		
	Text Displayed in QPP Participation Status Tool (Available NOW)		Text Displayed in QPP Participation Status Tool (Available December 2024)	Can Elect to Opt-in as an Individual?	Can Choose to Voluntarily Report as an Individual?[3]
Exceeded all 3 low-volume threshold criteria as an individual	**Eligible** as an individual	**No Medicare Part B claims billed** under TIN/NPI combination	**N/A -** Not found in participation status tool	No	No[4]
		Exceeded 0 low-volume threshold criteria as an individual	**Ineligible** as an individual	No	**Yes**
		Exceeded 1 or 2 low-volume threshold criteria as an individual	**Opt-in Eligible** as an individual	**Yes**	**Yes**
		Exceeded all 3 low-volume threshold criteria as an individual	**Eligible** as an individual (**Required** to report)	No	No

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

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

Appendix 2B: Participation Scenarios for Groups

The table below identifies the different low-volume threshold results across the two segments of the MIPS determination period and final eligibility determinations for a group (identified by TIN).

NOTE: Opt-in eligible groups with clinicians who are also MIPS APM participants can elect to opt-in to traditional MIPS or the APP, voluntarily report to traditional MIPS, or do nothing. You can't voluntarily-report the APP or an MVP; you can't opt-in and report an MVP.

1st Segment (10/1/2022-9/30/2023)	Initial MIPS Eligibility Status	2nd Segment (10/1/2023-9/30/2024)	FINAL MIPS Eligibility Status After Reconciling 1st And 2nd 12-month Segments		
	Text Displayed in QPP Participation Status Tool (Available NOW)		Text Displayed in QPP Participation Status Tool (Available December 2024)	Can Elect to Opt-in as a Group?	Can Choose to Voluntarily Report as a Group?
No Medicare Part B claims billed under TIN/NPI combinations associated with TIN	**N/A -** Not found in participation status tool	**No Medicare Part B claims billed** under TIN/NPI combinations associated with TIN	**N/A -** Not found in participation status tool	No	No[5]
		Exceeded 0 low-volume threshold criteria as a group	**Ineligible** as a group	No	**Yes**
		Exceeded 1 or 2 low-volume threshold criteria as a group	**Opt-in Eligible** as a group	**Yes**	**Yes**
		Exceeded all 3 low-volume threshold criteria as a group	**Eligible** as a group (Can **choose** to participate as a group)	No	No

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

Appendix 2B: Participation Scenarios for Groups (Continued)

1st Segment (10/1/2022-9/30/2023)	Initial MIPS Eligibility Status	2nd Segment (10/1/2023-9/30/2024)	FINAL MIPS Eligibility Status After Reconciling 1st And 2nd 12-month Segments		
	Text Displayed in QPP Participation Status Tool (Available NOW)		Text Displayed in QPP Participation Status Tool (Available December 2024)	Can Elect to Opt-in as a Group	Can Choose to Voluntarily Report as a Group?
Exceeded 0 low-volume threshold criteria as a group	**Ineligible** as a group	**No Medicare Part B claims billed** under TIN/NPI combinations associated with TIN	**N/A -** Not found in participation status tool	No	No[5]
		Exceeded 0 low-volume threshold criteria as a group	**Ineligible** as a group	No	**Yes**
		Exceeded 1 or 2 low-volume threshold criteria as a group	**Ineligible** as a group	No	**Yes**
		Exceeded all 3 low-volume threshold criteria as a group	**Ineligible** as a group	No	**Yes**

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

Appendix 2B: Participation Scenarios for Groups (Continued)

1st Segment (10/1/2022-9/30/2023)	Initial MIPS Eligibility Status	2nd Segment (10/1/2023-9/30/2024)	FINAL MIPS Eligibility Status After Reconciling 1st And 2nd 12-month Segments		
	Text Displayed in QPP Participation Status Tool (Available NOW)		Text Displayed in QPP Participation Status Tool (Available December 2024)	Can Elect to Opt-in as a Group?	Can Choose to Voluntarily Report as a Group?
Exceeded 1 or 2 low-volume threshold criteria as a group	**Opt-in Eligible** as a group	**No Medicare Part B claims billed** under TIN/NPI combinations associated with TIN	**N/A -** Not found in participation status tool	No	No[5]
		Exceeded 0 low-volume threshold criteria as a group	**Ineligible** as a group	No	**Yes**
		Exceeded 1 or 2 low-volume threshold criteria as a group	**Opt-in Eligible** as a group	**Yes**	**Yes**
		Exceeded all 3 low-volume threshold criteria as a group	**Opt-in Eligible** as a group	Yes	**Yes**

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

Appendix 2B: Participation Scenarios for Groups (Continued)

1st Segment (10/1/2022-9/30/2023)	Initial MIPS Eligibility Status	2nd Segment (10/1/2023-9/30/2024)	FINAL MIPS Eligibility Status After Reconciling 1st And 2nd 12-month Segments		
	Text Displayed in QPP Participation Status Tool (Available NOW)		Text Displayed in QPP Participation Status Tool (Available December 2024)	Can Elect to Opt-in as a Group?	Can Choose to Voluntarily Report as a Group?
Exceeded all 3 low-volume threshold criteria as a group	**Eligible** as a group	**No Medicare Part B claims billed** under TIN/NPI combinations associated with TIN	**N/A -** Not found in participation status tool	No	No[5]
		Exceeded 0 low-volume threshold criteria as a group	**Ineligible** as a group	No	**Yes**
		Exceeded 1 or 2 low-volume threshold criteria as a group	**Opt-in Eligible** as a group	**Yes**	**Yes**
		Exceeded all 3 low-volume threshold criteria as a group	**Eligible** as a group	No	**Yes**

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

Appendix 3: Which MIPS Payment Adjustment is Applied in the 2026 Payment Year?

2024 Final Score Scenario	2026 MIPS Payment Adjustment
Clinician has a 2024 final score under TIN A. Clinician continues to bill under TIN A in the 2026 payment year.	Clinician will receive a payment adjustment for covered professional services under their TIN A/NPI combination based on 2024 final score attributed to that TIN A/NPI combination.
Clinician has a single 2024 final score, received at TIN A and didn't practice at any other TIN in 2024. Clinician leaves TIN A and joins TIN B in 2026 payment year and begins to bill under TIN B.	Clinician will receive a payment adjustment for covered professional services under their TIN B/NPI combination based on 2024 final score attributed to their TIN A/NPI combination.
Clinician has a single 2024 final score, received at TIN A. The clinician then joined another TIN, TIN B in 2026. The clinician begins to bill under TIN B in 2026, in addition to TIN A.	Clinician will receive a payment adjustment under both TIN/NPI combinations based on their TIN A score.
Clinician has two 2024 final scores under two TINs (TIN A and TIN B). The clinician joins TIN C in the 2026 payment year and begins to bill under TIN C. (Doesn't bill under TIN A or TIN B.)	Clinician will receive a payment adjustment for covered professional services under their TIN C/NPI combination based on their higher 2024 final score – either attributed to their TIN A/NPI combination or TIN B/NPI combination.
Clinician has two 2024 final scores under two TINs (TIN A and TIN B). • Clinician has a 2024 final score under TIN A. • Clinician has a 2024 final score under TIN B. Clinician bills under TIN A and TIN B in the 2026 payment year.	Clinician will receive a payment adjustment for covered professional services under their TIN A/NPI combination based on 2024 final score attributed to that TIN A/NPI combination. Clinician will receive a payment adjustment for covered professional services under their TIN B/NPI combination based on 2024 final score attributed to that TIN B/NPI combination.