Quality Payment
PROGRAM

Merit-based Incentive Payment System (MIPS)

2025 Traditional MIPS Data Submission User Guide

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Need More Help?

- 2025 Data Submission Troubleshooting FAQs
- Contact the Quality Payment Program

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How to Use This Guide

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Hyperlinks

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

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.

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Getting Started

What to Expect During 2025 Submission

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

What should we expect during submission?

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

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

What to Expect During 2025 Submission (Continued)

What can change after the submission period?

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

What Can Change	How This Can Affect Your Score
Ex. Administrative claims quality measures are calculated	If you can be scored on any of these measures, this will increase the number of measures your quality score is based on.
Ex. CAHPS for MIPS measure is submitted	If your practice administered the CAHPS for MIPS Survey measure, this measure will be added to your score after the submission period.
Ex. Performance period benchmarks are calculated for quality measures without a historical benchmark	If a measure didn't have a historical benchmark and we can calculate a performance period benchmark, this will change the measure-level score. If you submitted more than 6 measures, performance period benchmarks can change which measures count towards your quality score.

When will our 2025 final score be available?

Final scores will be available in summer 2026, and your payment adjustment information will be available approximately 30 days later.

What to Expect During 2025 Submission

Reporting Update to CQM #510: First Year Standardized Waitlist Ratio (FYSWR)

CMS has received several inquiries about technical challenges with reporting Quality Measure 510: First Year Standardized Waitlist Ratio (FYSWR), which is available only as a MIPS clinical quality measure (CQM). After assessing the issue, CMS determined that it's not technologically feasible to calculate both the 1st and 2nd performance rates using the existing submission JavaScript Object Notation (JSON) structure. As a result, only the 2nd submission criteria will be accepted when submitting the measure for the 2025 performance period. For guidance on reporting Measure 510, please see Slide 51.

Electronic Case Reporting Measure Suppression

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

To avoid adverse consequences beyond the MIPS eligible clinicians' control, we're suppressing the Electronic Case Reporting measure 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 will meet the measure requirements by attesting either "Yes" or "No" to being in active engagement with a public health agency or claiming an applicable exclusion. MIPS eligible clinicians who report the suppressed Electronic Case Reporting measure will receive full credit for the measure.

Purpose

This guide reviews the data submission process and troubleshooting for **traditional MIPS.**

- For more information about data submission for a **MIPS Value Pathway (MVP)**, review the 2025 MVP Data Submission User Guide (PDF, 84KB).
- For more information about data submission for the **APM Performance Pathway (APP) and APM Performance Pathway Plus (APP Plus)**, review the 2025 APP Data Submission User Guide (PDF, 84KB).

Accessing the System

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

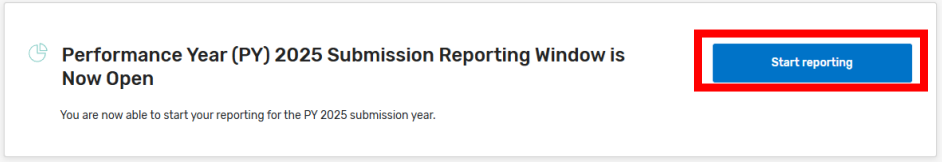
- An account (user ID and password)
- Access to an organization (a role)

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

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

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

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



DISCLAIMER:

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

Before You Begin

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

- Chrome
- Edge

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

Accessing the System

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

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

Learn how to connect to an organization as a practice.

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

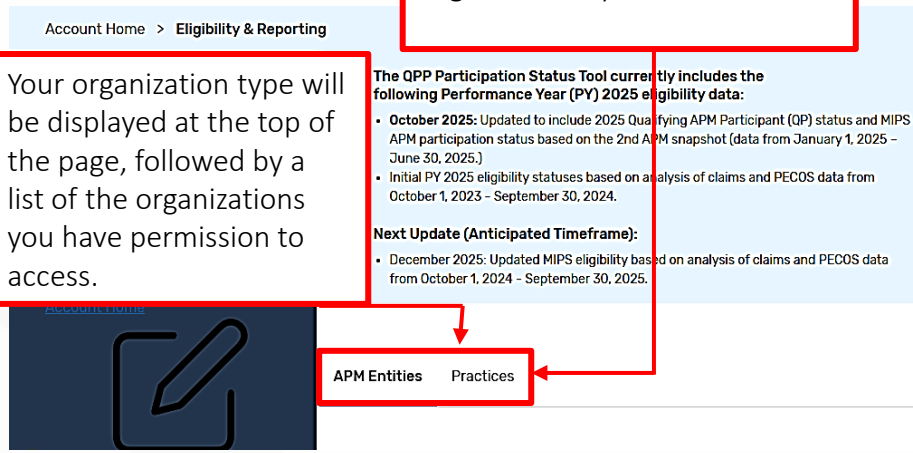
Learn how to connect to an organization as an APM Entity.

- Virtual Group (virtual group reporting, all performance categories)

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

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

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



Helpful Hint

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

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Preparing to Submit Your Data

Overview

This section reviews the information that can be accessed and viewed by users with the staff user or security official roles for different organization types – registries, practices, APM Entities, and virtual groups.

This section also reviews which performance data can be submitted for APM Entities versus the practices that include clinicians in the Entity.

Skip ahead to:

- Practice Representatives
- APM Entity Representatives
- Virtual Group Representatives

Preparing to Submit Your Data:
Registry Representatives

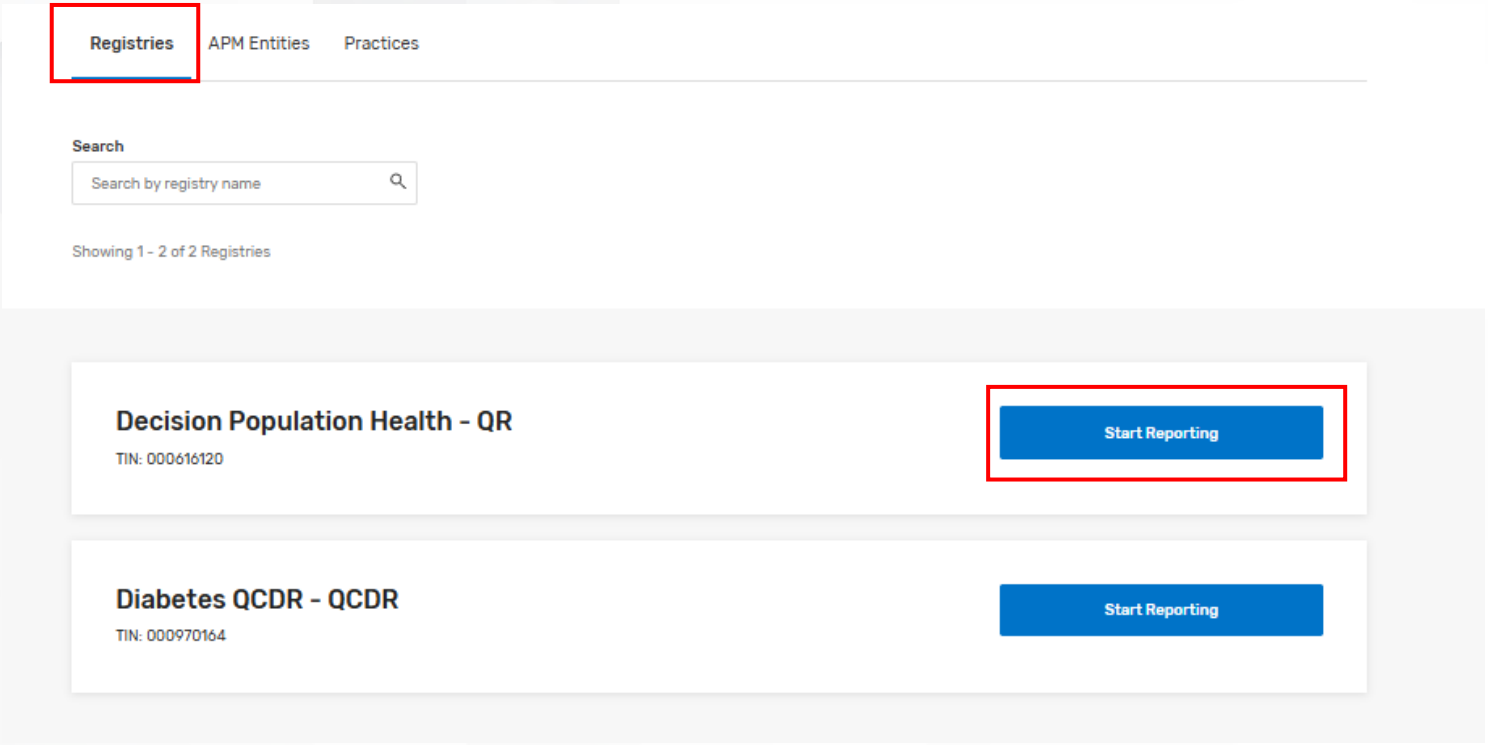
Registry Representatives

This section includes information for users with a Staff User or Security Official role for a **Registry organization** – Qualified Registry or QCDR – identified by Taxpayer Identification Number (TIN).

With this Access	You CAN do this during and after the submission period	You CAN'T do this during or after the submission period
Staff User or Security Official for a **Registry** (QCDR or Qualified Registry)	✓ Download your API token (security officials only) ✓ Upload a submission file on behalf of your clients (groups and/or individuals) ✓ Submit opt-in elections on behalf of your clients ✓ View measure and activity level scores for your clients based on the data your organization submitted for them	✗ View data submitted directly by your clients ✗ View data submitted by another third party on behalf of your clients ✗ View data collected and calculated by CMS on behalf of your clients • Cost and administrative claims quality measures (if applicable) ✗ View preliminary category level scores

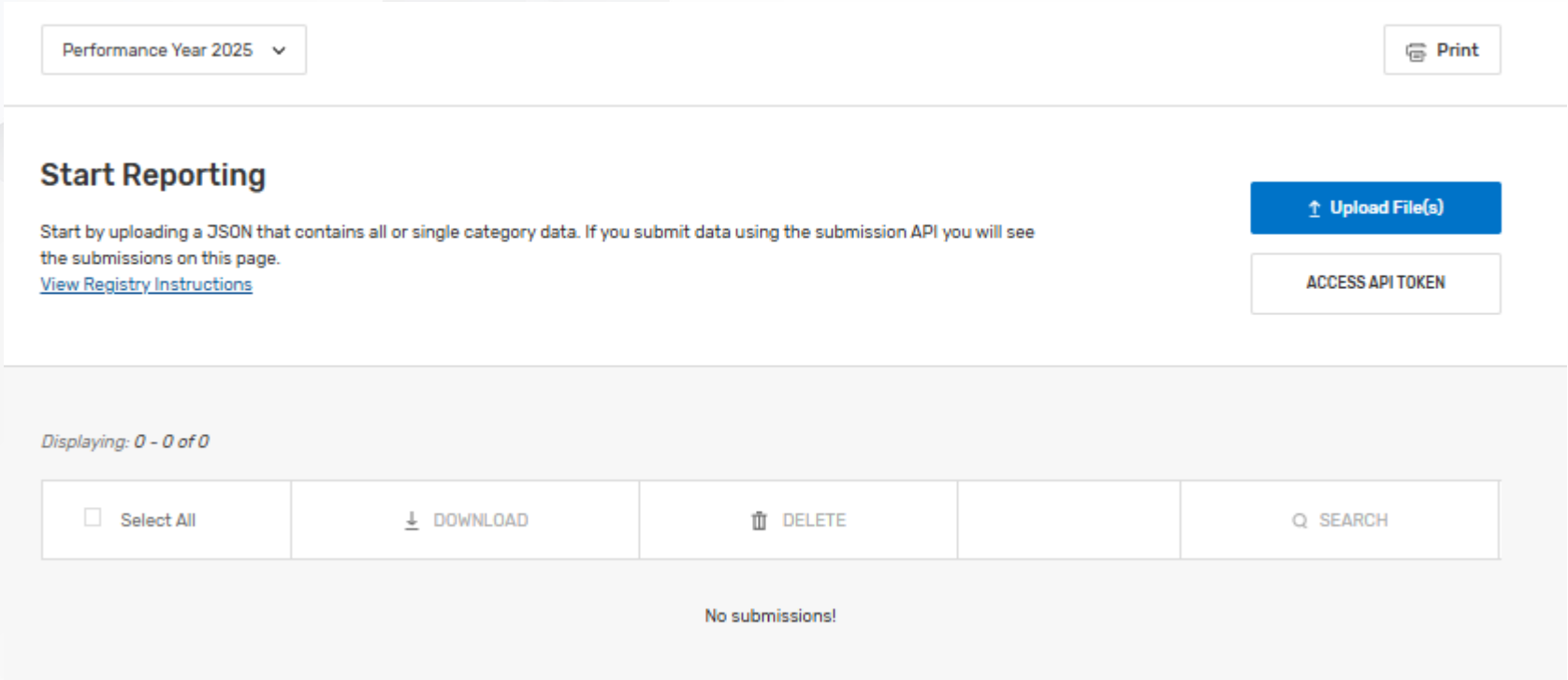
Registry Representatives (Continued)

From the Eligibility & Reporting page, make sure you click the Registries tab if you access to multiple organization types and select Start Reporting next to your registry's name to open your dashboard and start uploading files.



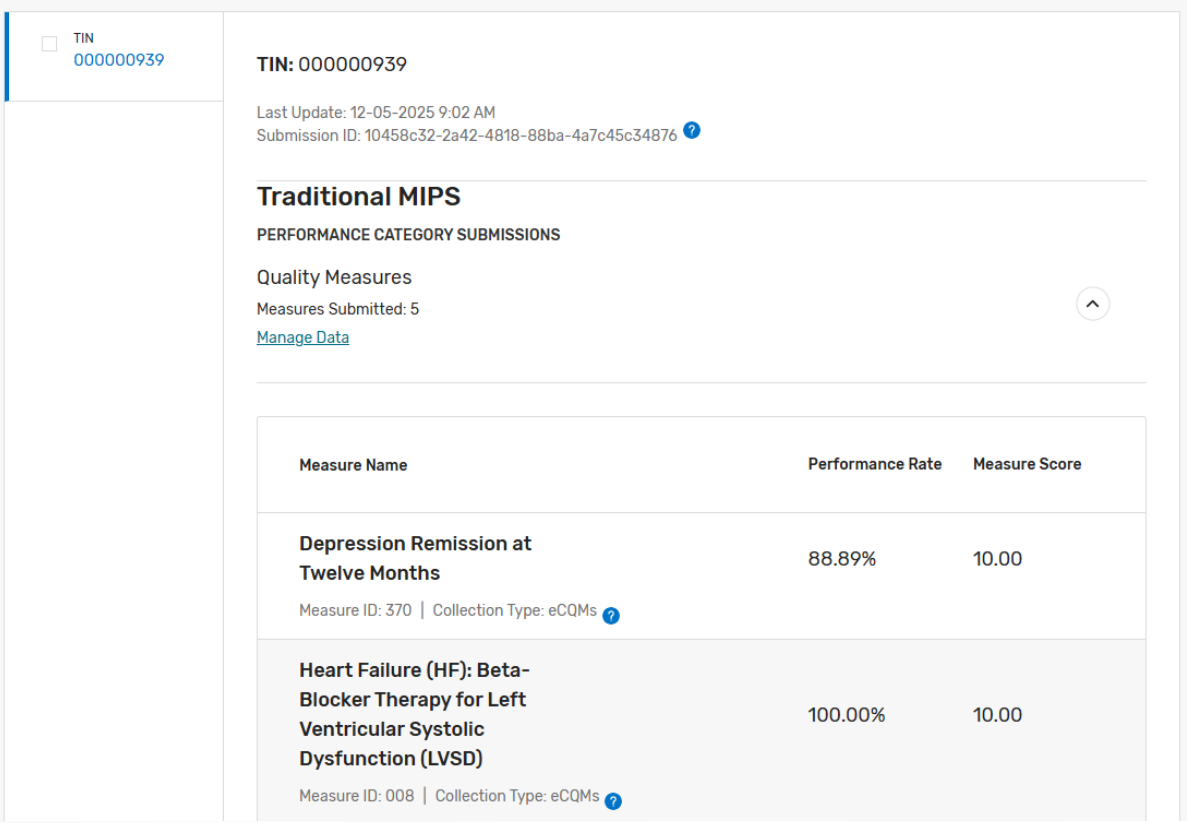
Registry Representatives (Continued)

You won't see any information until you've submitted data.



Registry Representatives (Continued)

Once you've started submitting data, you will see a list of Taxpayer Identification Numbers (TINs) – for group submissions – and TIN/National Provider Identifiers (TIN/NPIs) – for individual submissions.



Quality Payment
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Preparing to Submit Your Data:
Practice Representatives

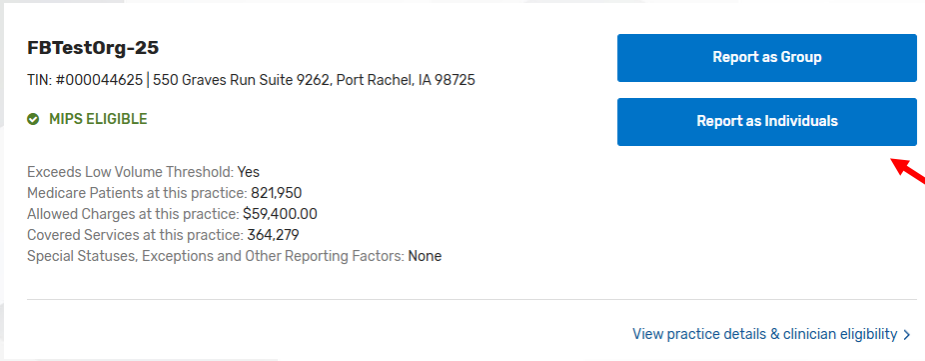
Practice Representatives

This section includes information for users with a Staff User or Security Official role for a **Practice organization**, identified by Taxpayer Identification Number (TIN).

With this Access	You CAN do this during and after the submission period	You CAN'T do this during or after the submission period
Staff User or Security Official for a **Practice** (includes solo practitioners)	✓ Access information about eligibility and special status at the individual clinician and group level ✓ View information about performance category reweighting (including from approved exception applications) ✓ Submit data on behalf of your practice (as a group and/or individuals) • Includes Promoting Interoperability data for MIPS APM participants ✓ Submit opt-in elections on behalf of your practice (as a group and/or individuals) ✓ View data submitted on behalf of your practice (group and/or individual) ✓ View measure-level scoring for Part B claims measures reported throughout the performance period • This data will be updated during the submission period to account for claims received by CMS until March 1, 2026 • **REMINDER**: We'll only score small practices as a group if they submit data at the group level for another performance category. ✓ View measure and activity-level scores and a sub-total of points for the group and individual clinicians	✗ View feedback or scores for administrative claims quality measures or the CAHPS for MIPS measure (if applicable) ✗ View cost measures feedback (if applicable) • Cost data won't be available during the submission period ✗ View facility-based scoring for quality / cost (if applicable) ✗ View data submitted by your APM Entity • **Example:** If you're a Participant TIN in a Shared Savings Program ACO, you won't be able to view the quality data reported by the ACO. ✗ View data submitted by your virtual group (if your TIN is part of a CMS-approved virtual group) ✗ Overall preliminary score or preliminary performance category scores

Practice Representatives

Group vs Individual Reporting



As a group. You're reporting aggregated data for each performance category that represents all the clinicians in your practice (as appropriate to the measures and activities you've selected).

As Individuals. You're reporting individual data for each performance category for each MIPS eligible clinician in the practice.

Practices that Registered to Report an MVP

If the group registered to report an MVP, they can still report traditional MIPS instead of the MVP they registered for or in addition to the MVP they registered for.

- Select **Start Reporting** on the Traditional MIPS card to report traditional MIPS.
- For more information about MVP data submission, review the 2025 MVP Data Submission User Guide (PDF, 84KB).

Practices with MIPS APM Participants

If your practice includes clinicians who participate in a MIPS APM, you'll see the option to report the APM Performance Pathway (APP), APM Performance Pathway Plus (APP Plus) and traditional MIPS.

- Select **Start Reporting** on the Traditional MIPS card to report traditional MIPS.
- For more information about APP and APP Plus data submission, review the 2025 APP Data Submission User Guide (PDF, 84KB).

Practice Representatives (Continued)

Did you know?

The level at which you participate in MIPS (individual or group) applies to all performance categories. We won't combine data submitted at the individual and group level into a single final score.

For example:

- If you submit any data as an individual, you will be evaluated for all performance categories as an individual.
- If your practice submits any data as a group, you will be evaluated for all performance categories as a group.
- If data is submitted both as an individual and a group, you will be evaluated as an individual and as a group for all performance categories, but your payment adjustment will be based on the higher score.

REMINDER: We'll **only** calculate a quality score at the group level for small practices reporting Medicare Part B claims measures for their MIPS eligible clinicians if the practice also submits data at the group level for another performance category.

Practice Representatives (Continued)

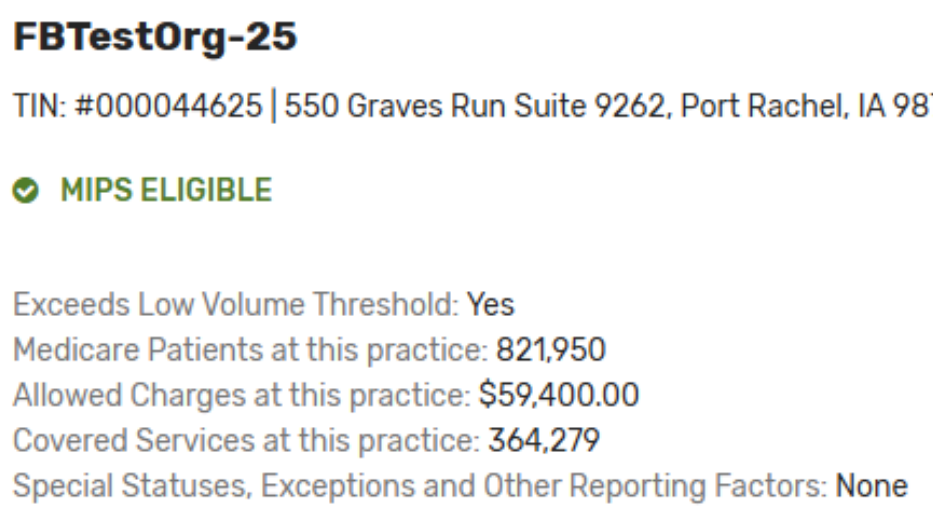
Reporting as a Group

When you report as a group, you're reporting aggregated data for each performance category that represents all the clinicians in your practice (as appropriate to the measures and activities you've selected).

From the Eligibility & Reporting page, you can view eligibility and special statuses at the practice level, which are applicable to group reporting.

Practice-level eligibility (applies to group reporting only)

Practice-level **special statuses** and **exception applications** (applies to group reporting only)

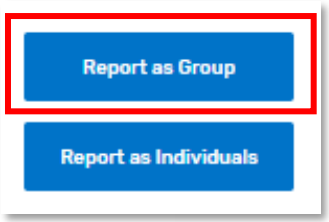


Practice Representatives (Continued)

Eligibility Refresher (Group Reporting)

You See	This Means
PRACTICE LEVEL (Applies to Group Reporting)	
✓ MIPS ELIGIBLE	If you choose to report as a group, all of your MIPS eligible clinicians (including those who are individually below the low-volume threshold) will receive a payment adjustment based on your group submission
⊘ MIPS EXEMPT	You can choose to voluntarily report as a group, but none of your clinicians will receive a payment adjustment You will also see this status when your group was "opt-in eligible" and a practice representative or third-party (such as a QCDR or Qualified Registry) has made an election for your group to voluntarily report.
Opt-in Option: Opt-in eligible as group	Your practice isn't eligible for MIPS and your clinicians will not receive a MIPS payment adjustment from group reporting **unless** you make an election to Opt-In as a group. **No action is needed if you don't want to submit data.** If you want to submit group-level data, you will be prompted to make an election before you can submit data. • **Opt-In to MIPS** and your clinicians will receive a MIPS payment adjustment (even if no data is submitted) • **Voluntarily Report** and your clinicians will NOT receive a MIPS payment adjustment based on any data submitted
✓ MIPS ELIGIBLE VIA OPT-IN	A practice representative or third-party (such as a QCDR or Qualified Registry) has made an election for your group to opt-in to MIPS. Your MIPS eligible clinicians will receive a payment adjustment.

If your practice is **"MIPS eligible"** or **"MIPS exempt"** as a group, clicking Report as a Group will take you the Reporting Overview page, where you can submit data or view data submitted on your behalf.



Practice Representatives (Continued)

Opt-in Eligible

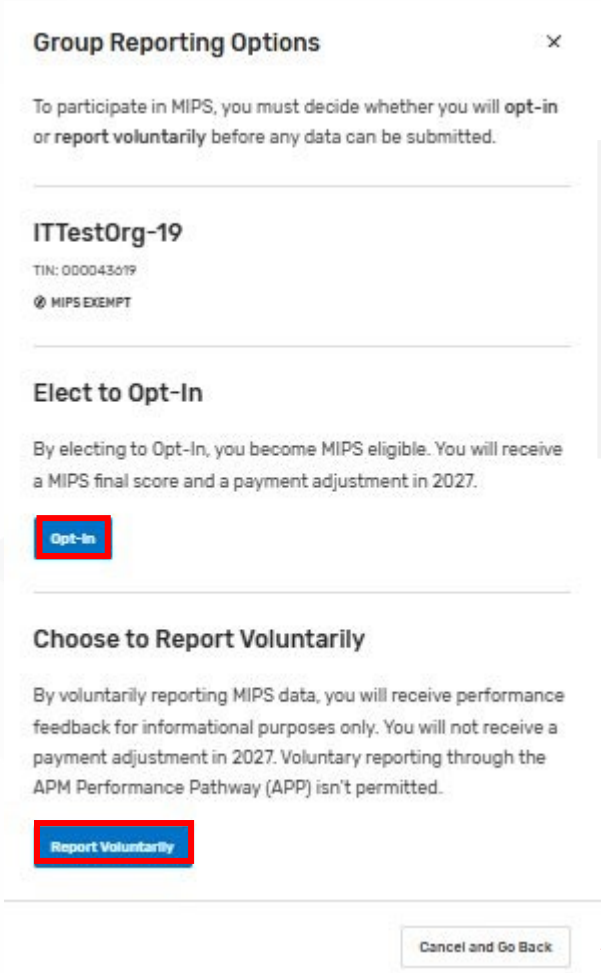
If your practice is opt-in eligible, you'll be prompted to make an election before you can submit data. Once made, this election can't be changed.

Select either **Opt-In** or **Report Voluntarily** to proceed with the election process.

- Select **Opt-In** if you're electing for the practice to receive a MIPS final score based on a group submission and for all MIPS eligible clinicians to receive a payment adjustment.
- Select **Report Voluntarily** if you're electing for the practice to receive a MIPS final score based on a group submission, but no payment adjustment for your clinicians.

Note: You can't voluntarily report an MVP or APM Performance Pathway.

Review the 2025 MIPS Opt-In and Voluntary Reporting Election Guide for more information.



Once an election to opt-in or voluntarily report is confirmed that election can't be undone or changed.

Change Your Mind?

If you change your mind, you also can **cancel and go back** to the main Eligibility & Reporting page

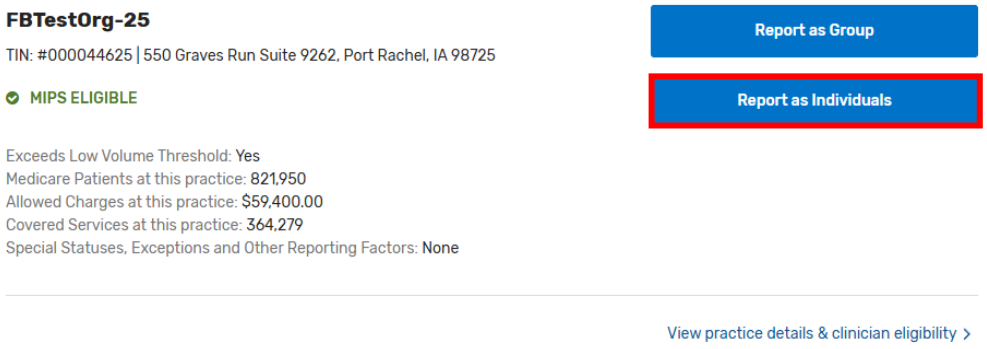
Practice Representatives (Continued)

Reporting as Individuals

When you're reporting as individuals, you're reporting individual data for each performance category for each MIPS eligible clinician in the practice.

Users with access to their practice can view eligibility and special statuses at the individual level, which are applicable to the specific clinician for individual reporting.

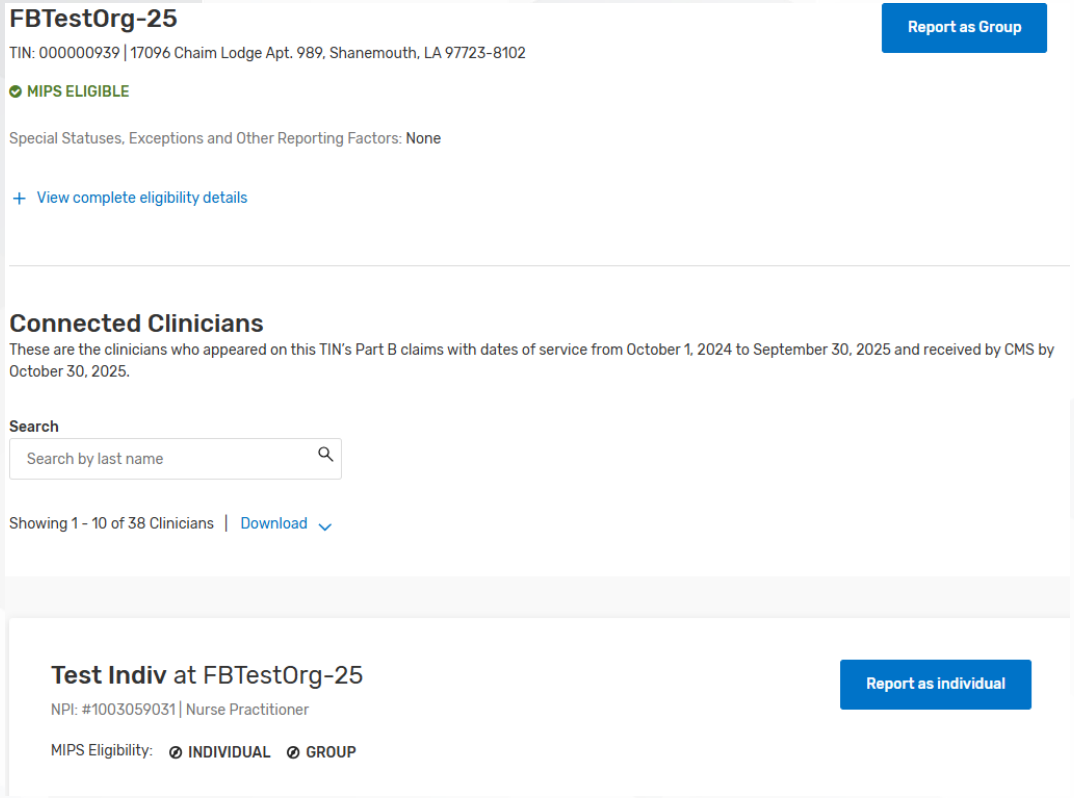
Click **Report as Individuals** or **View Clinician Eligibility** (under the option to Report as Individuals) to access Practice Details and Clinicians.



This page displays the clinicians who (identified by National Provider Identifier, or NPI) billed services under your practice's TIN **with dates of service between October 1, 2024, and September 30, 2025,** and received by CMS by October 30, 2025.

- This includes clinicians who left your practice and/or have terminated the reassignment of their billing rights to your practice's TIN in PECOS during this timeframe.

Practice Representatives (Continued)



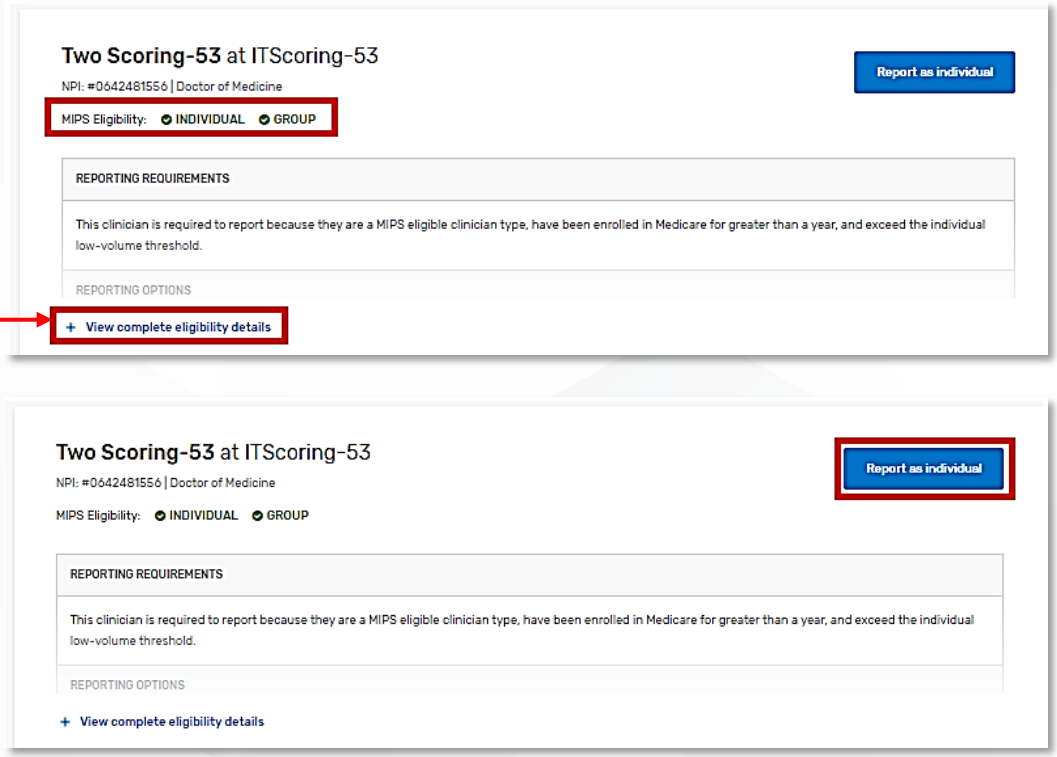
Did you know?

Clinicians who started billing for services under your Taxpayer Identification Number (TIN) between October 1 and December 31, 2025, **won't** appear on the QPP website during the submission period.

- These clinicians will be added to your practice's downloadable Payment Adjustment CSV when payment adjustments are released in summer 2026:
  - They'll receive a neutral MIPS payment adjustment if your practice reported as individuals; or
  - They'll receive a MIPS payment adjustment based on the group's final score (provided they are otherwise eligible for MIPS) if your practice reported as a group.

Practice Representatives (Continued)

Each clinician will have an eligibility indicator at the individual and group level. If your practice is reporting as individuals, click **View complete eligibility** details to better understand the clinician's reporting requirements, reporting options and payment adjustment information



If the clinician is "**MIPS eligible**" or "**MIPS exempt**" as an individual, clicking Report as Individuals will take you the Reporting Overview page, where you can submit data or view data submitted on your behalf.

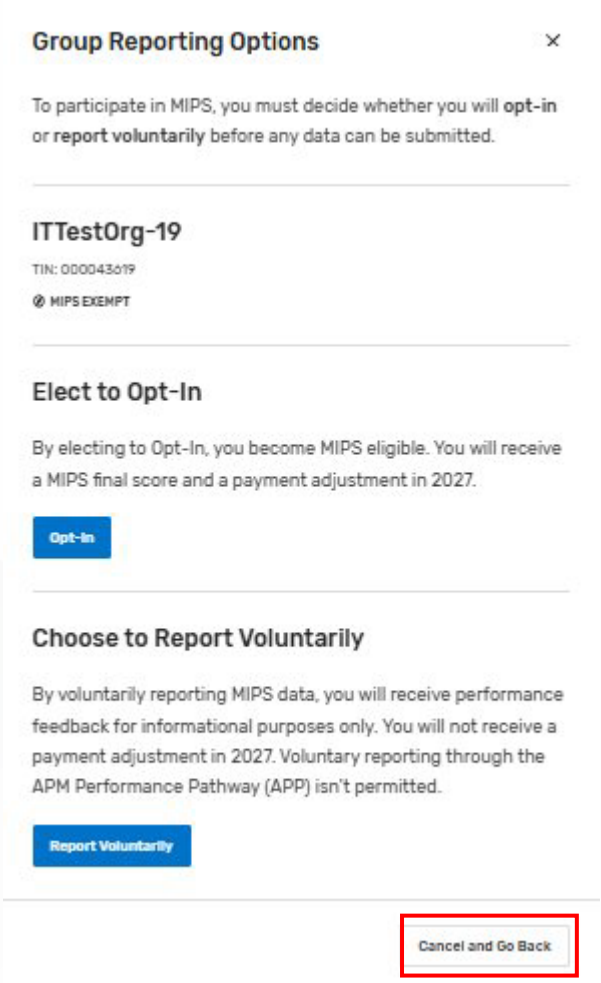
Practice Representatives (Continued)

Opt-in Eligible

If the clinician is opt-in eligible, you'll be prompted to make an election before you can submit data. Once made, this election **can't** be changed.

Select either **Opt-In** or **Report Voluntarily** to proceed with the election process.

- Select **Opt-In** if you're electing for the clinician to receive a MIPS payment adjustment.
- Select **Report Voluntarily** if you're electing for the clinician to receive a MIPS final score but no payment adjustment.
  - **Note:** You can't voluntarily report an MVP or the APM Performance Pathway.



Change Your Mind?

If you change your mind, you also can **cancel and go back** to the main Eligibility & Reporting page.

Review the 2025 MIPS Opt-In and Voluntary Reporting Election Guide for more information.

Preparing to Submit Your Data:
APM Entity Representatives

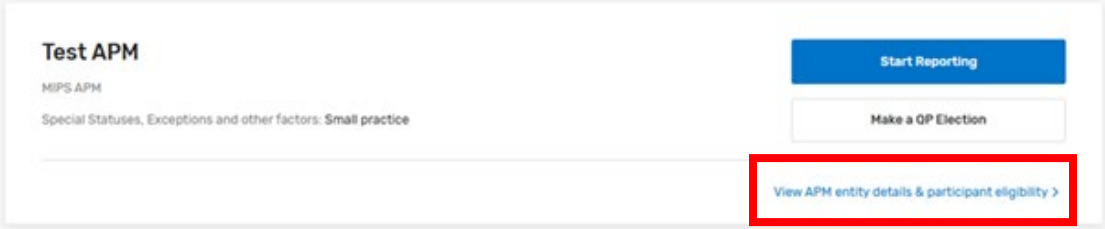
APM Entity Representatives

This section includes information for users with a Staff User or Security Official role for an **APM Entity organization**, identified by an APM Entity ID.

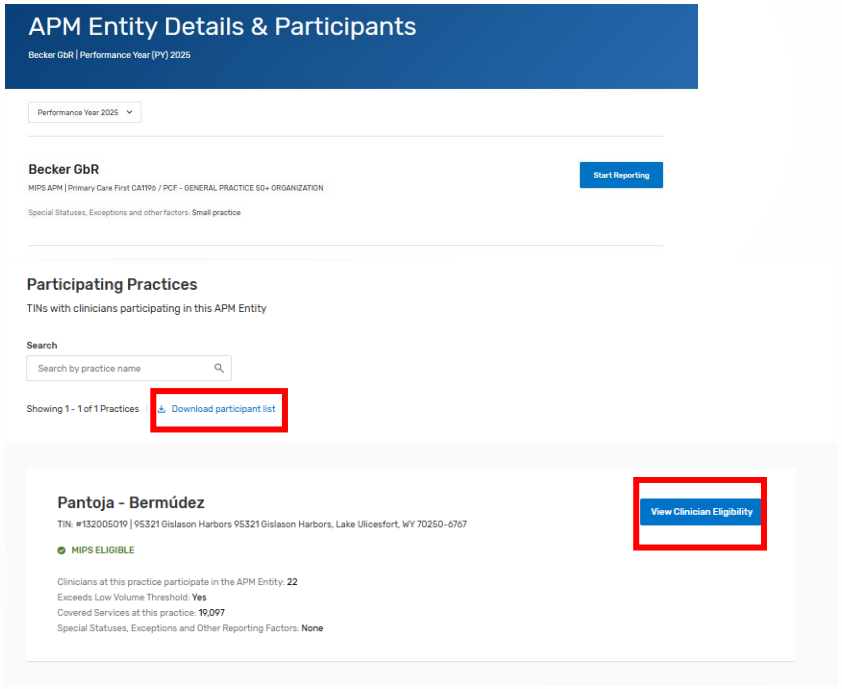
With this access	You CAN do this during the submission period	You CAN'T do this during the submission period
Staff User or Security Official for an **APM Entity**	✓ Access a list of the practices (TINs) and clinicians participating in the APM Entity ✓ **NEW:** Submit a Partial QP Election (**Security Officials Only**) ✓ View information about performance category reweighting (including from approved exception applications) ✓ Submit quality data through the CMS Web Interface (Shared Savings Program ACOs) ✓ Upload a QRDAIII file with your eCQM data to meet your model-specific requirements (Primary Care First practice sites) ✓ Upload a file of APM Entity-level quality and/or Promoting Interoperability measure data (all APM Entities in MIPS APMs) ✓ View measure and activity-level scores along with a sub-total of points on **quality** (and improvement activities if applicable) data submitted by or on behalf of the APM Entity	✗ View feedback or scores for administrative claims quality measures or the CAHPS for MIPS measure (if applicable) ✗ View the Promoting Interoperability data reported by clinicians and groups in your APM Entity ✗ View preliminary quality performance category score

APM Entity Representatives (Continued)

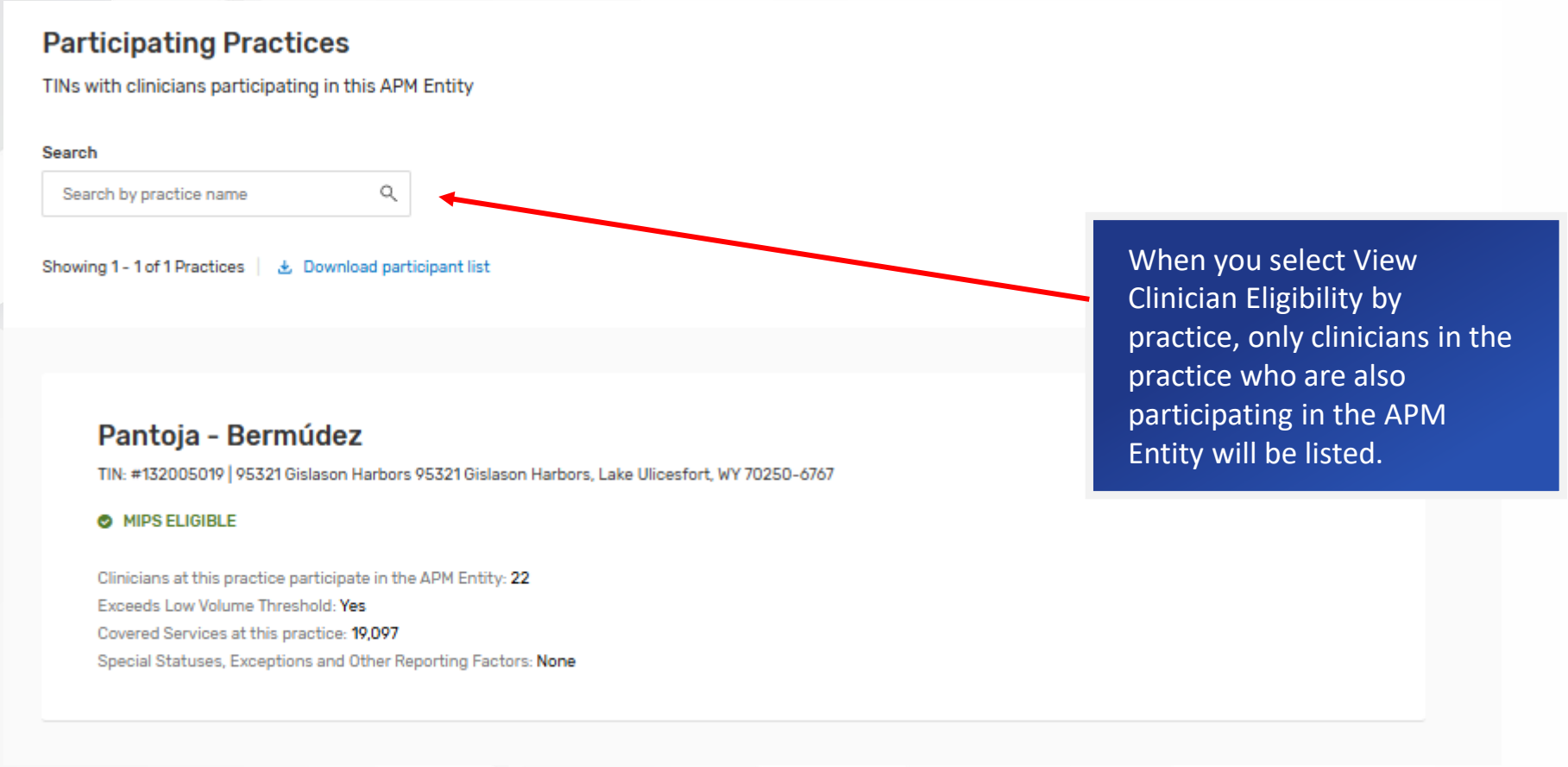
After signing in and clicking **Eligibility & Reporting** from the left-hand navigation, users with access to their APM Entity can access a list of the clinicians participating in the Entity by clicking **View Participant Eligibility** beneath Start Reporting.



From the **APM Entity Details & Participants** page, you will be able to **download** a list of all your participants or **view** participants by Practice. This is a list of the clinicians identified as participating in your APM Entity on the 1st, 2nd or 3rd APM Snapshot dates (March 31, June 30, and August 31, 2025).



APM Entity Representatives (Continued)



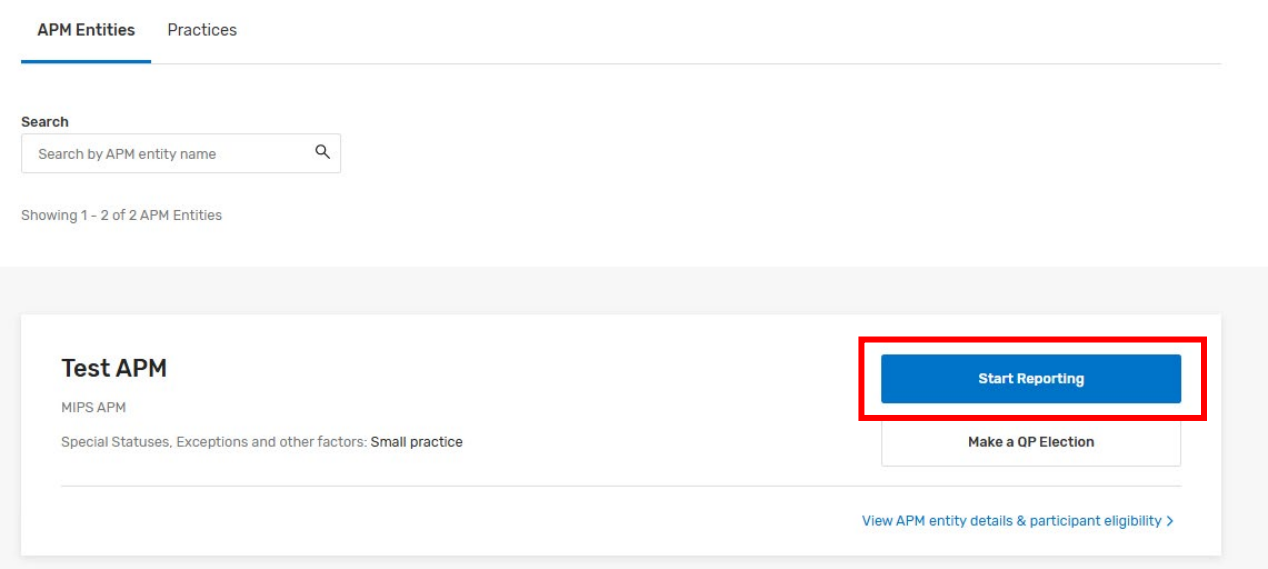
When you select View Clinician Eligibility by practice, only clinicians in the practice who are also participating in the APM Entity will be listed.

APM Entity Representatives (Continued)

Reporting Options

Once logged in, you will see the Account Dashboard, which will list all the APM Entities for which you can report data. This is based on the permissions/roles associated with your account.

From the Eligibility & Reporting page, select **Start Reporting** next to the APM Entity for which you'd like to report data.

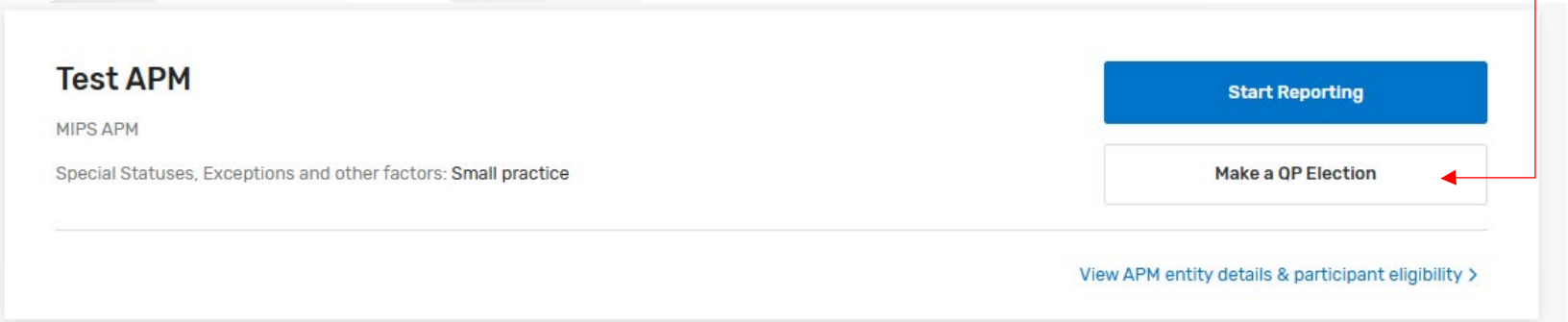


From here, you'll be directed to a new Reporting Options page which outlines any required or optional reporting.

APM Entity Representatives (Continued)

Partial QP Elections

APM Entities with Partial Qualifying APM Participation (QP) Status will see the option to **Make a QP Election** beneath **Start Reporting**.

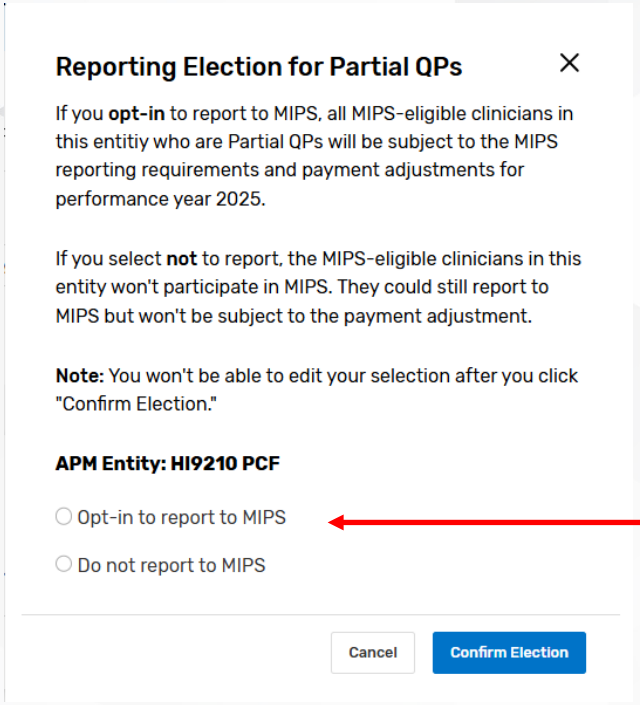


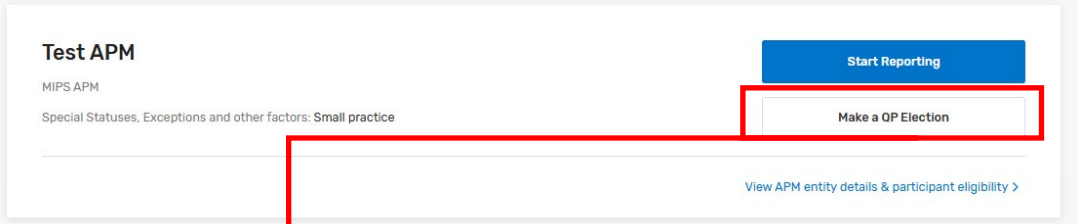
Partial QPs who want to report MIPS data and get a MIPS payment adjustment must complete their Partial QP election by March 31, 2026, at 8 p.m. ET.

APM Entity Representatives (Continued)

Partial QP Elections (Continued)

Click **Make a QP Election** to open a pop-up window which will allow you to make the Partial QP Election on behalf of your MIPS eligible clinicians.





APM Entity Representatives (Continued)

Partial QP Elections (Continued)

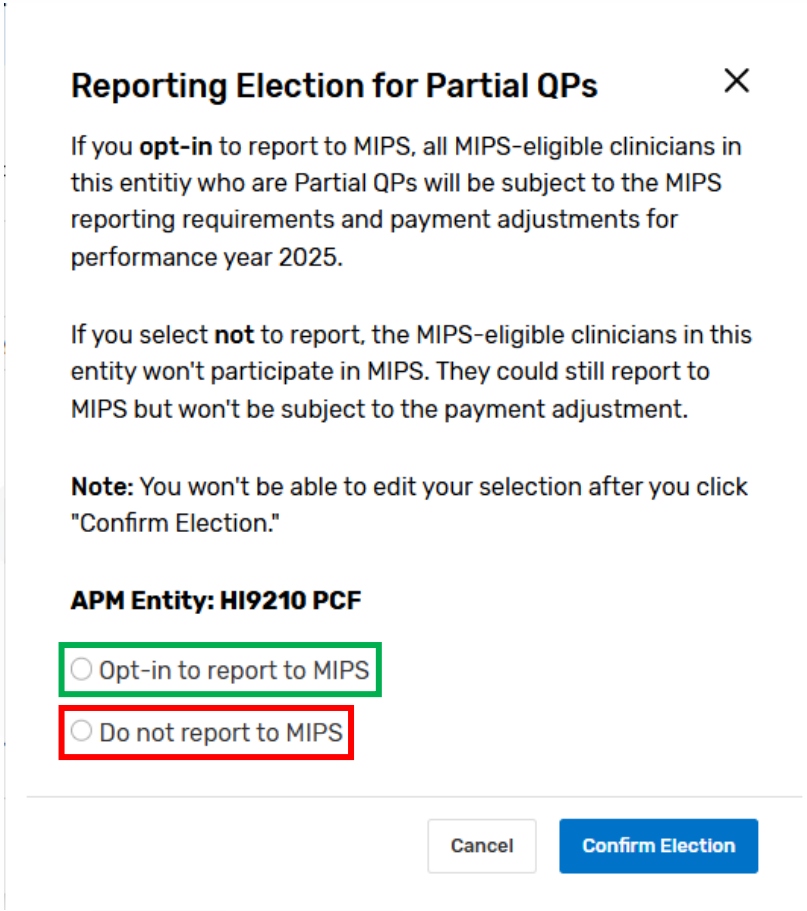
Opt-in to report to MIPS

- Select this if you want the MIPS eligible clinicians in your APM Entity to **receive a MIPS payment adjustment** for the 2025 performance period/2027 MIPS payment year.

Do not report to MIPS

- Select this if you don't want the MIPS eligible clinicians in your APM Entity to receive a MIPS payment adjustment for the 2025 performance period/2027 MIPS payment year.
- Any data reported will be considered voluntary.

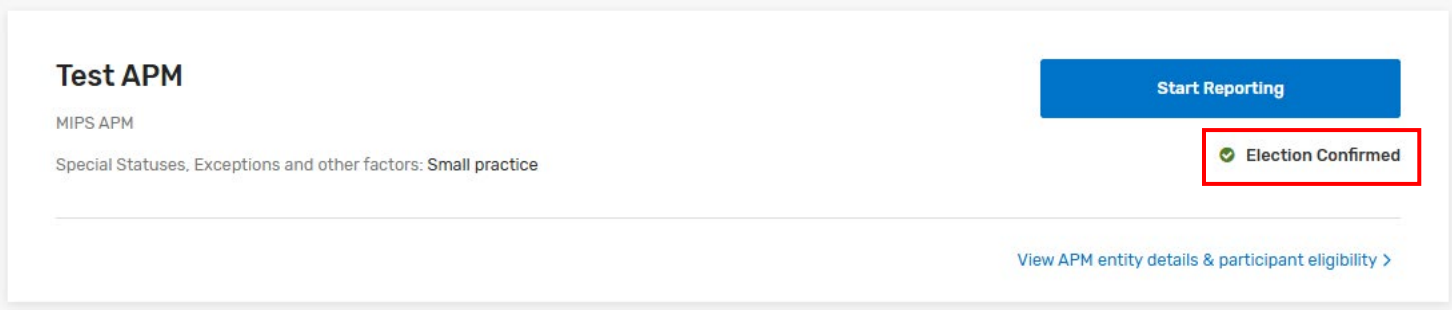
For more information about Partial QP status, review the 2025 Learning Resources for QP Status and APM Incentive Payments.



APM Entity Representatives (Continued)

Partial QP Elections (Continued)

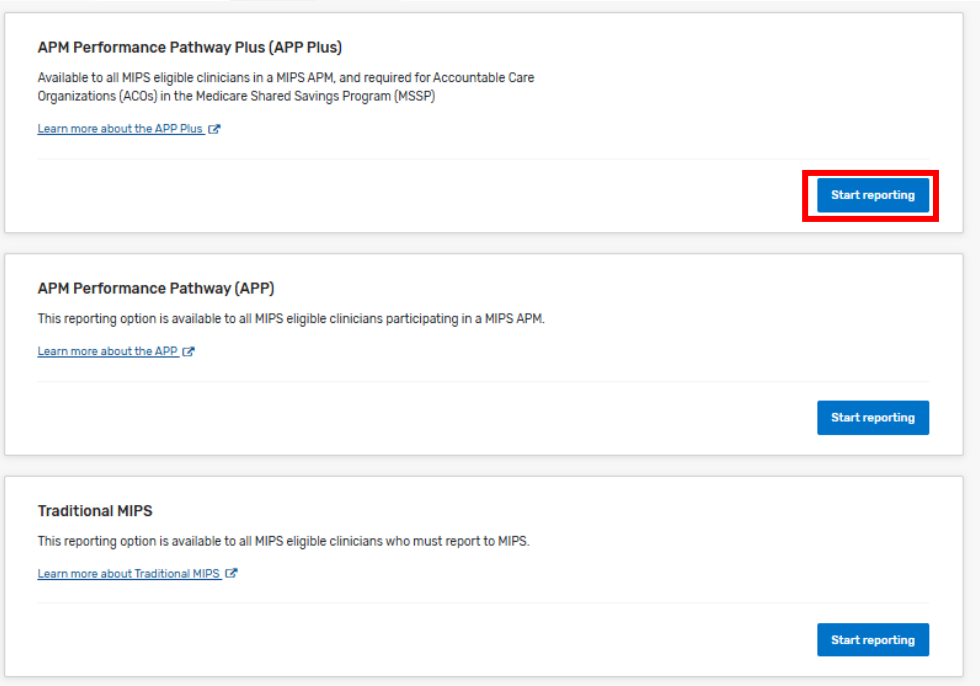
Once you've made and confirmed your election, you'll see an **Election Confirmed** indicator below Start Reporting.



APM Entity Representatives (Continued)

Shared Savings Program ACOs

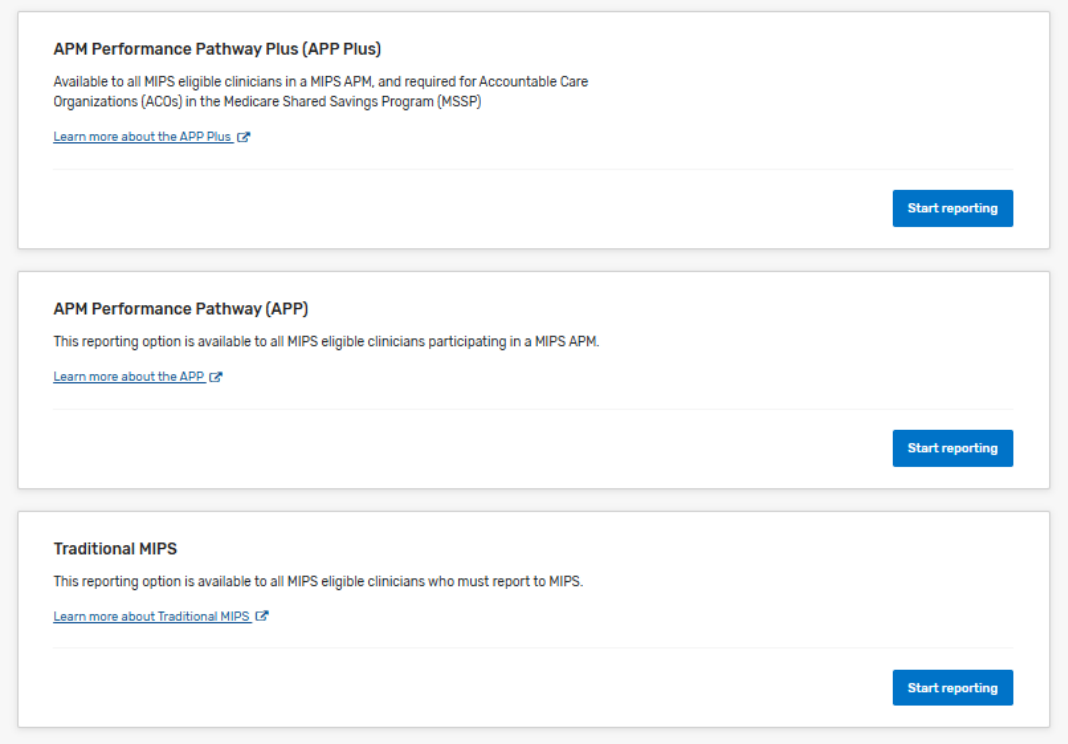
Shared Savings Program ACOs are required to report the APP Plus quality measure set as part of their participation in the Shared Savings Program. From the Reporting Options page, you'll select **Start Reporting** underneath the **APM Performance Pathway Plus (APP Plus)** option, and then you'll click **Report APP Plus** on the subsequent pop-up modal. Please refer to the 2025 APP Submission Guide (PDF, 84KB) for more information.



APM Entity Representatives (Continued)

APM Entities in All Other Models

If your organization qualifies as a MIPS APM, you'll see both traditional MIPS, APM Performance Pathway, and APM Performance Pathway Plus listed as optional.



Quality Payment
PROGRAM

Preparing to Submit Your Data:
Virtual Group Representatives

Virtual Group Representatives

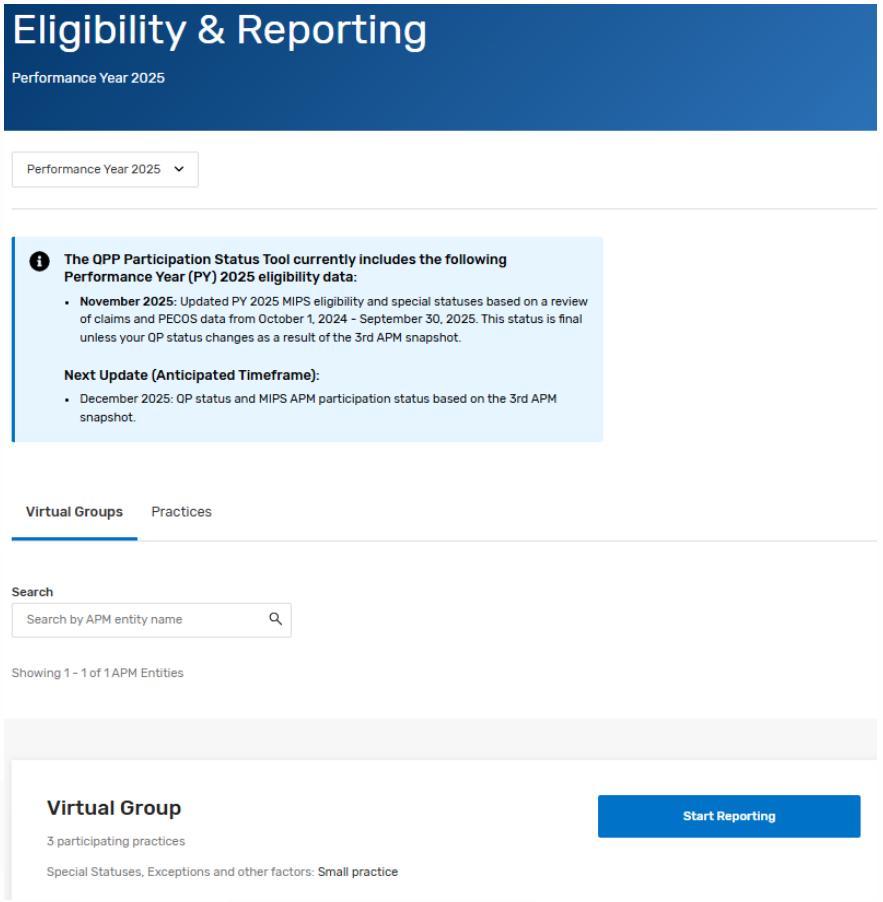
This section includes information for users with a Staff User or Security Official role for a **Virtual Group organization**, identified by Virtual Group ID.

With this access	You CAN do this during the submission period	You CAN'T do this during the submission period
Staff User or Security Official for a Virtual Group	✓ Access information about the practices (TINs) and clinicians participating in the virtual group ✓ View information about performance category reweighting (including from approved exception applications) ✓ Submit data on behalf of your virtual group ✓ View data submitted on behalf of your virtual group ✓ View measure-level scores for the virtual group	✗ View feedback or scores for administrative claims quality measures or the CAHPS for MIPS measure (if applicable) ✗ View your cost feedback (if applicable) • Cost data won't be available during the submission period ✗ View data submitted by individuals or practices in your virtual group (such data wouldn't count towards scoring and would only be considered a voluntary submission) ✗ View preliminary overall score or preliminary performance category scores

Virtual Group Representatives (Continued)

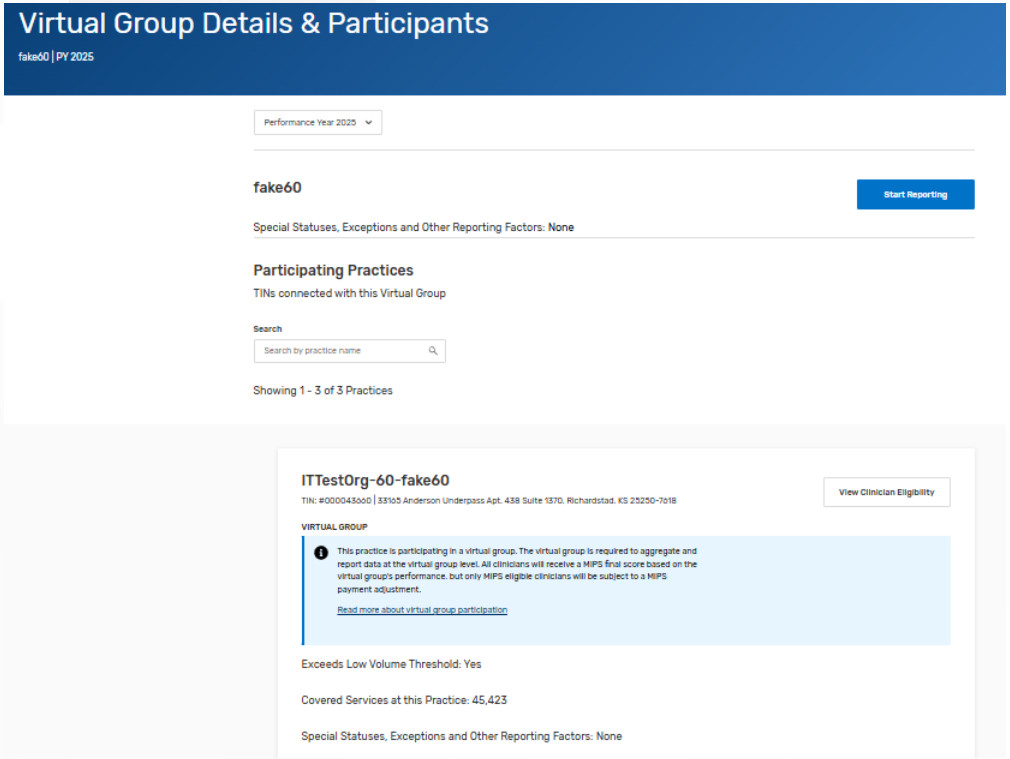
From the Eligibility & Reporting page, users with access to their virtual group can review any **special statuses and other reporting factors** attributed to the virtual group.

They can also access a list of the practices and clinicians participating in the virtual group by selecting **View participant eligibility**.



Virtual Group Representatives (Continued)

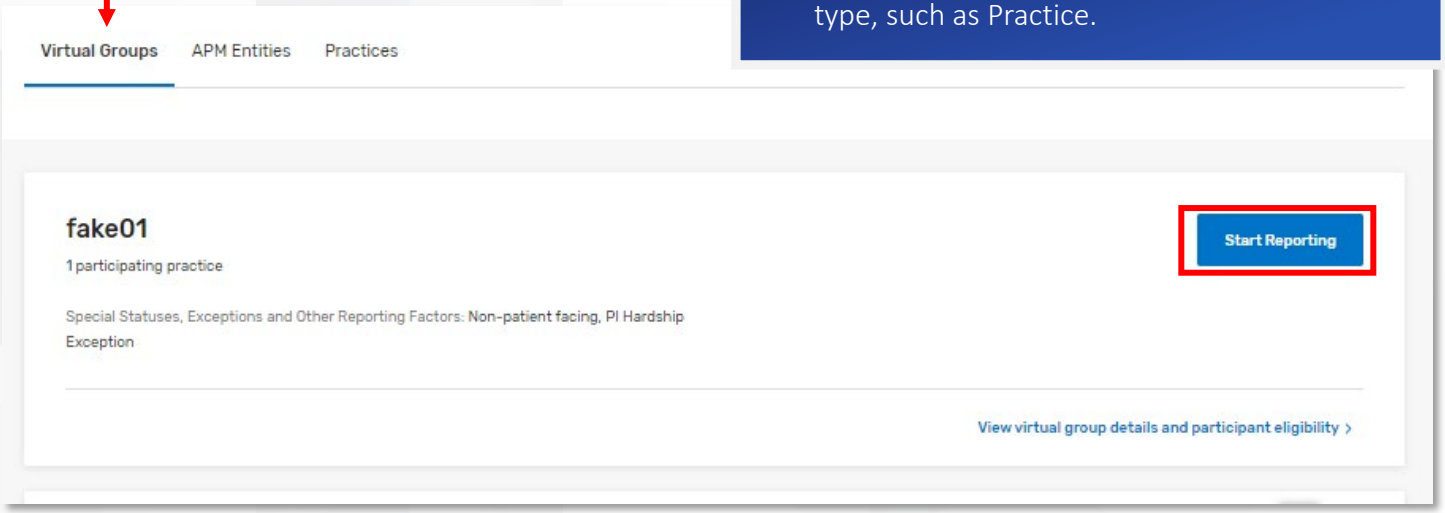
From the Participating Practices page, you can access a list of clinicians in each participating practice but can't download a list of all clinicians participating in the virtual group.



Virtual Group Representatives (Continued)

From the Eligibility & Reporting page, select **Start Reporting** next to the appropriate Virtual Group organization.

Make sure you see **Virtual Groups** as your organization type or click **Virtual Groups** if you have access to another organization type, such as Practice.



Did you know?

- Data submitted by Practices participating in the Virtual Group will be considered voluntary reporting (both individual and group submissions).
- Appendix B offers helpful information about Virtual Group access.

Quality Payment
PROGRAM

Submitting Data: Reporting Overview Page

Reporting Overview Page

From the Reporting Overview page, you'll be able to:

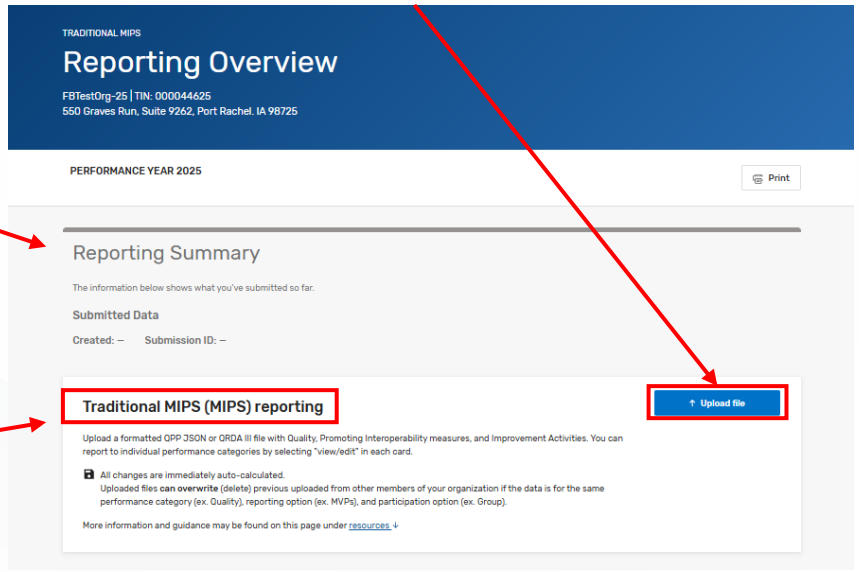
- Upload a file
- Access previously submitted data (by you or a third party)

Upload a File

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

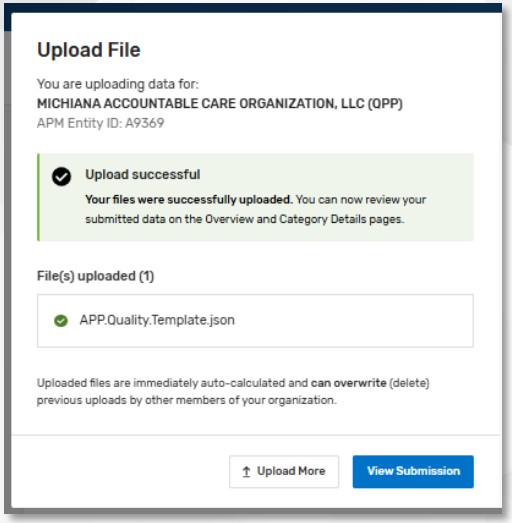
The Reporting Summary at the top of the page helps to easily determine if any data has been submitted. This section will be greyed out if no data have been submitted.

The reporting option header can be used to easily identify that your data is being/has been submitted for **traditional MIPS.**



Reporting Overview Page (Continued)

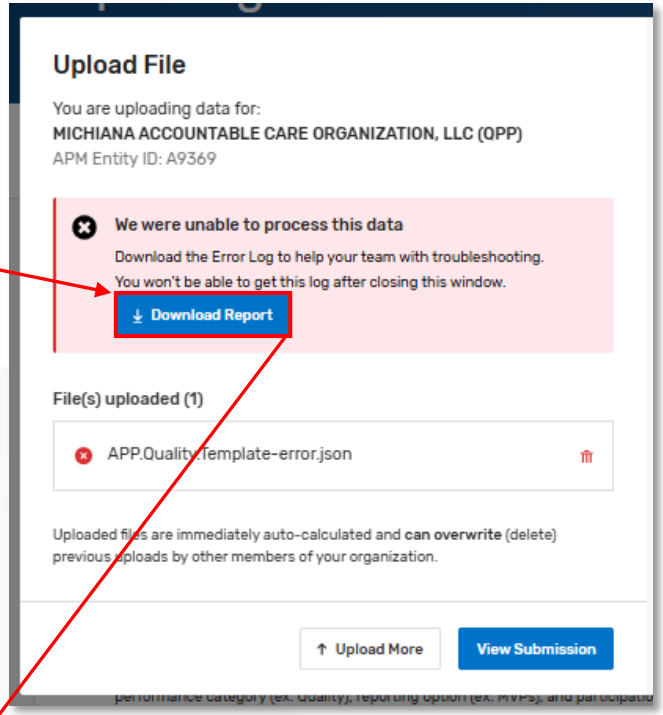
Once you've uploaded your file, you will see an indicator of success or error.

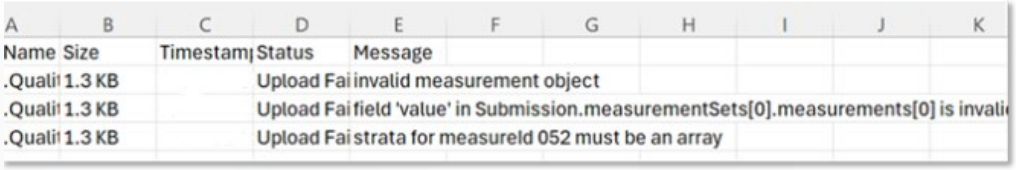


If there's an error with your file, you'll see a message indicating that the data couldn't be processed and have access to a detailed error report. Click **Download Report** for details of the submission issue.

Please work with your vendor to obtain an updated file, or you can contact the QPP Service Center with questions. Please have the error report available for faster assistance with your case.

- **By Email:** qpp@cms.hhs.gov
- **By Phone:** 1-866-288-8292 (711 for TRS)



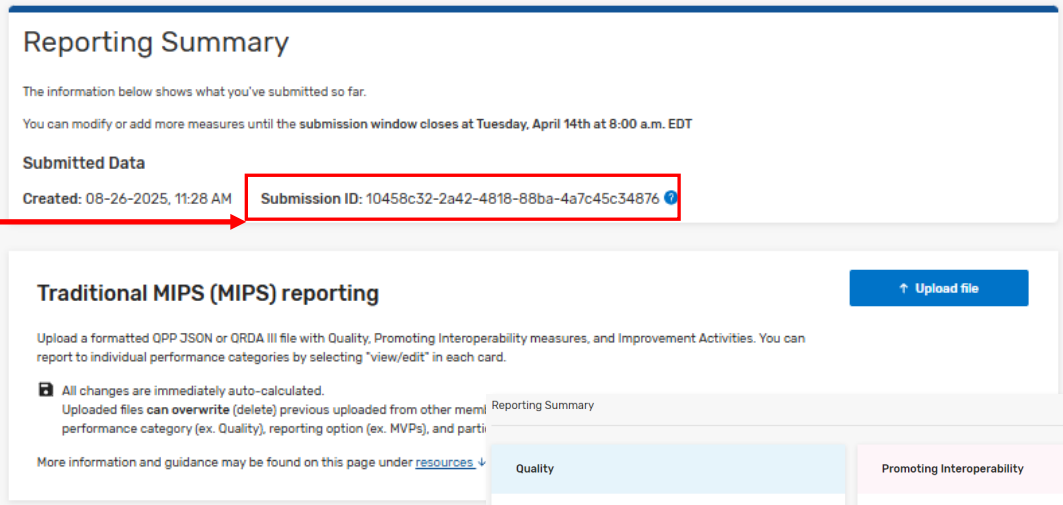


A	B	C	D	E	F	G	H	I	J	K
Name	Size	Timestam	Status	Message						
.Quali	1.3 KB		Upload Fai	invalid measurement object						
.Quali	1.3 KB		Upload Fai	field 'value' in Submission.measurementSets[0].measurements[0] is invali						
.Quali	1.3 KB		Upload Fai	strata for measureId 052 must be an array						

Reporting Overview Page (Continued)

Once data has been submitted, the Reporting Summary will reflect this. If you need to contact the Service Center about your submission, you'll need to provide your **Submission ID and Error Report**.

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



Note: If applicable, you'll also see performance category reweighting indicators (from auto EUC, exception applications, or special status) on the reporting overview page.

Submitting and Reviewing Quality Data

Reporting Update to CQM #510: First Year Standardized Waitlist Ratio (FYSWR)

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

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

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

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

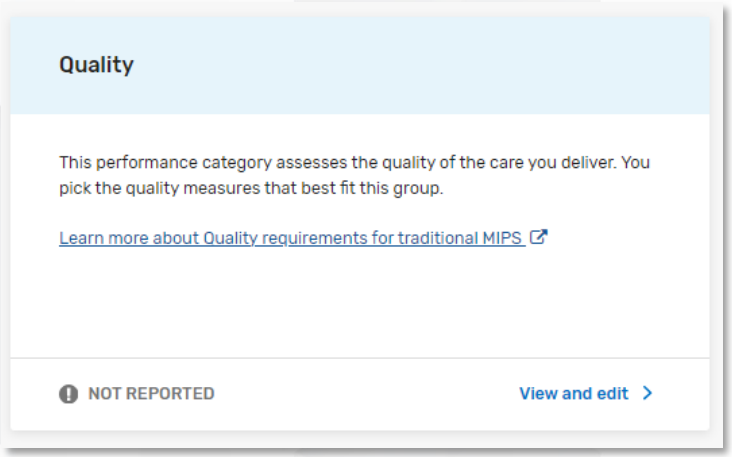
- DENOMINATOR (SUBMISSION CRITERIA 2): The denominator for the First Year Standardized Waitlist Ratio (FYSWR) is the total number of patients under the age of 75 in the practitioner group according to each patient's treatment history for patients within the first year following initiation of dialysis.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

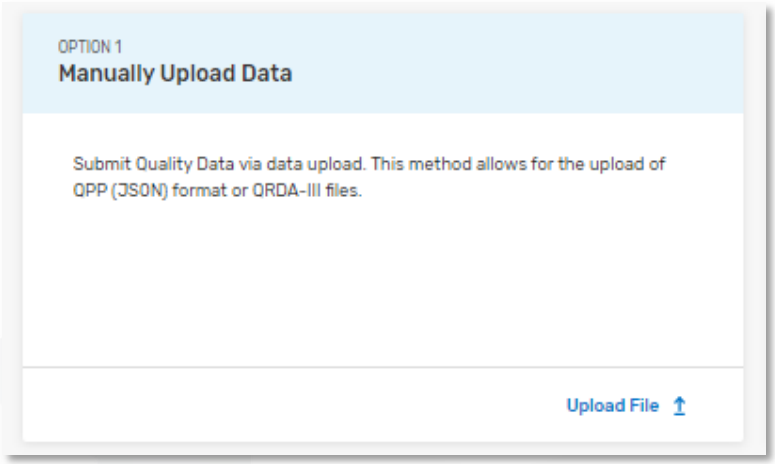
Your submission will be rejected for the 2025 submission period if:

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

Upload Your Quality Measures

You can upload files for any or all performance categories from the Reporting Overview page. Alternately, if no quality data has been reported, you can upload your own QRDA III or QPP JSON file with your eCQMs or MIPS CQMs by clicking **View & Edit** in the Quality section of the Reporting Overview and then **Upload File**:





Having trouble uploading your QRDAIII file?

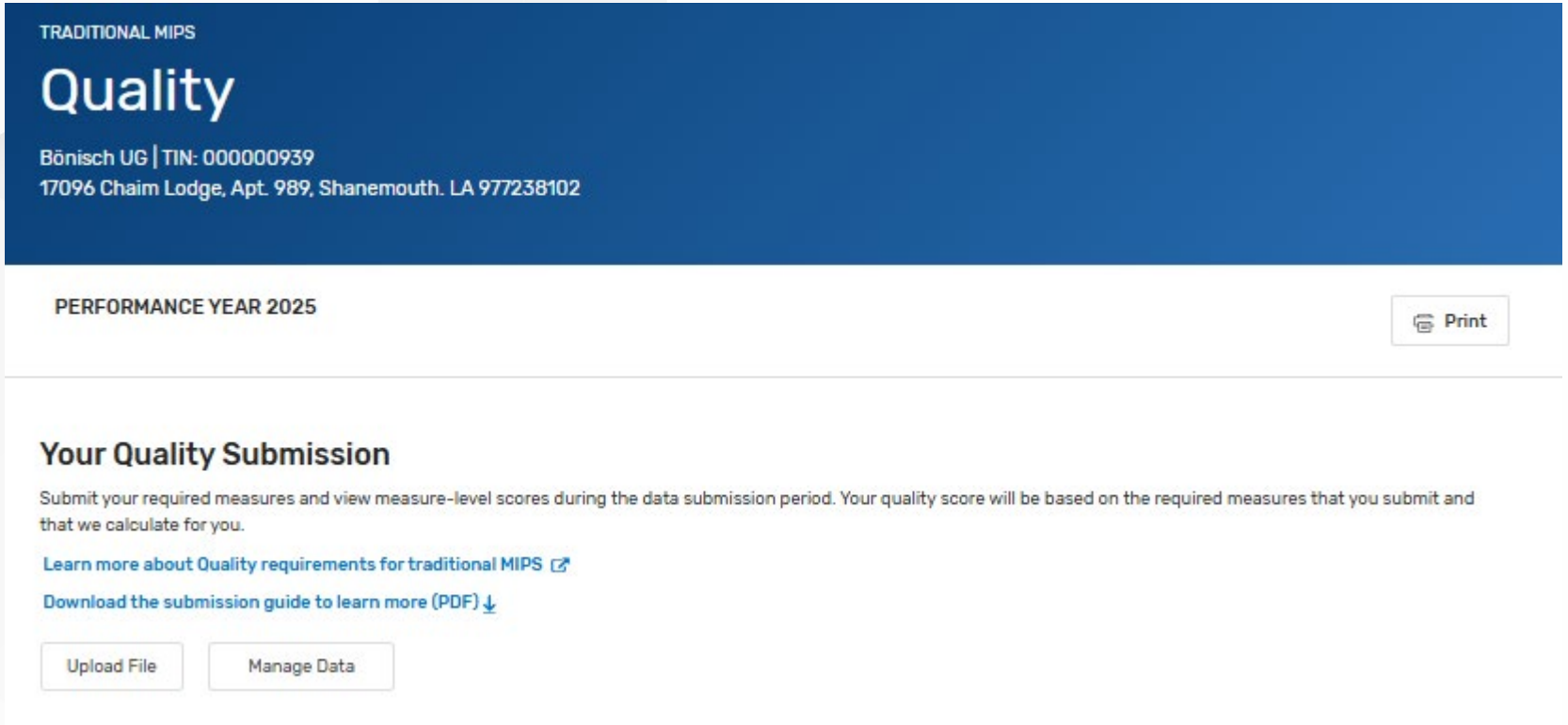
Please see the 2025 Data Submission Troubleshooting FAQs on the QPP Resource Library.

NEW for PY 2025: A CEHRT ID is now required when submitting eCQM data for the quality performance category. For **detailed instructions on how to generate a CMS EHR Certification ID**, review pages 23-25 of the CHPL Public User Guide (PDF, 1.21MB).

A **valid** CMS EHR Certification ID for the 2025 performance period will include **"15C"** (as it did in PY 2024) **or "2025C".**

Review Previously Submitted Data

From the Reporting Overview, click **View & Edit** in the Quality section to access the Quality details page.



Review Previously Submitted Data (Continued)

During the submission period, this page will reflect:

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

Medicare Part B Claims Measures

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

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

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

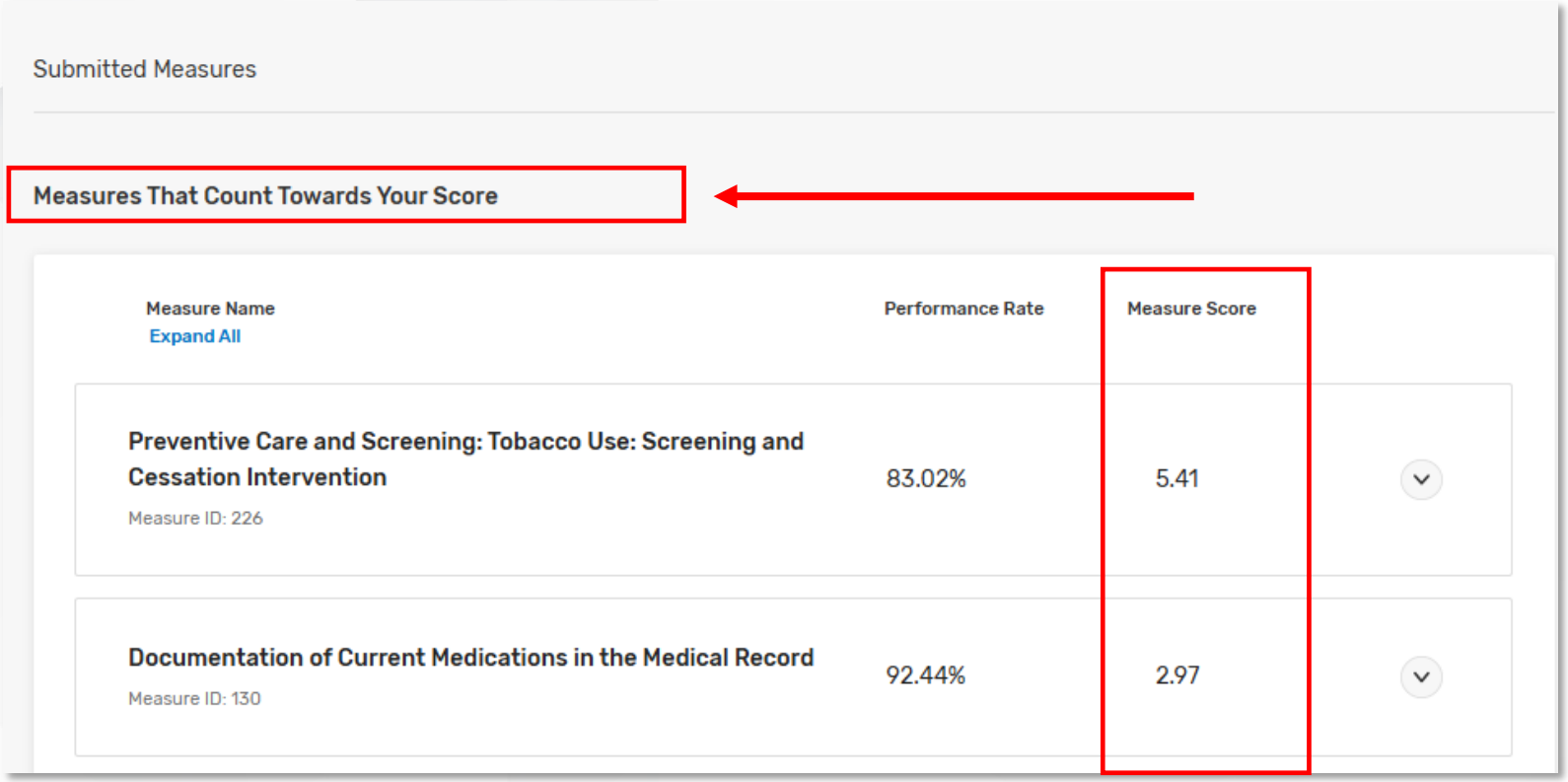
During the submission period, this page WON'T reflect:

- × Scoring for the CAHPS for MIPS measure.
- × Scoring on any administrative claims quality measures.
- × A preliminary score for the quality performance category.

Measure Information

Measures may be divided into 2 groups:

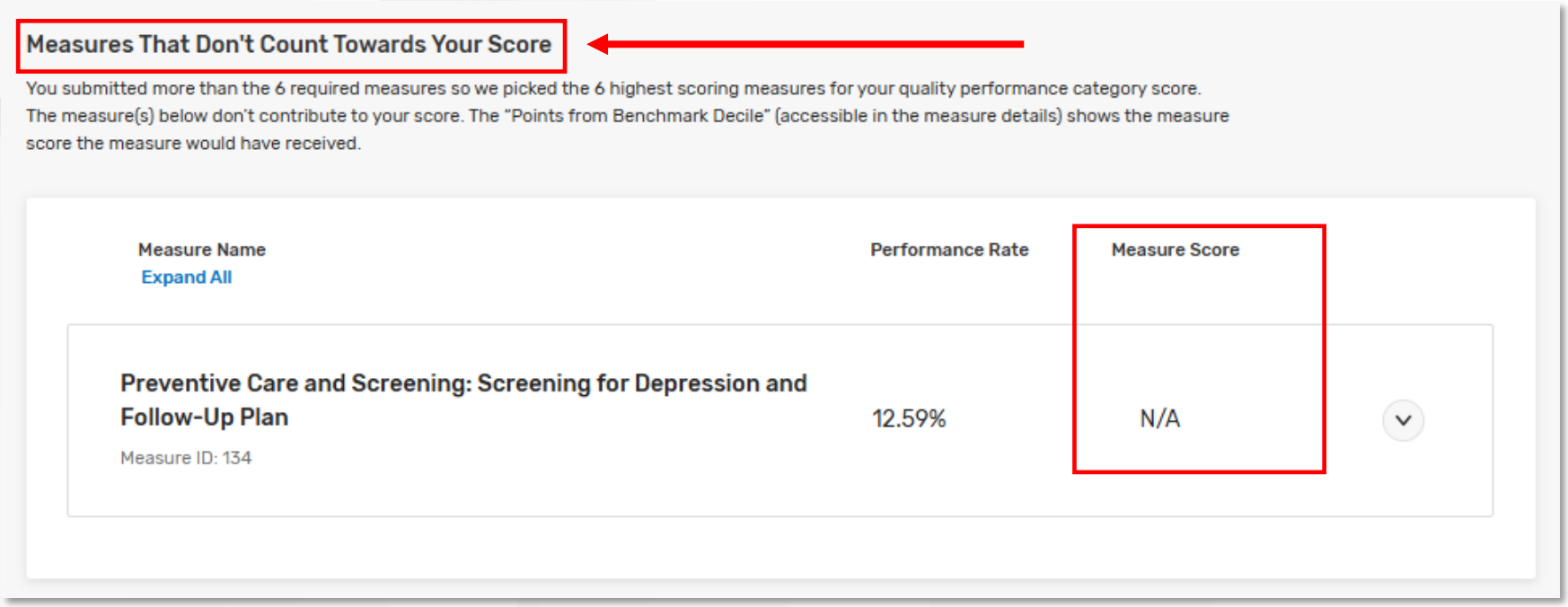
1. Measures whose performance points count toward your quality performance category score. The measure score will display your performance points (those achieved based on performance in comparison to the measure's benchmark).



Measure Information (Continued)

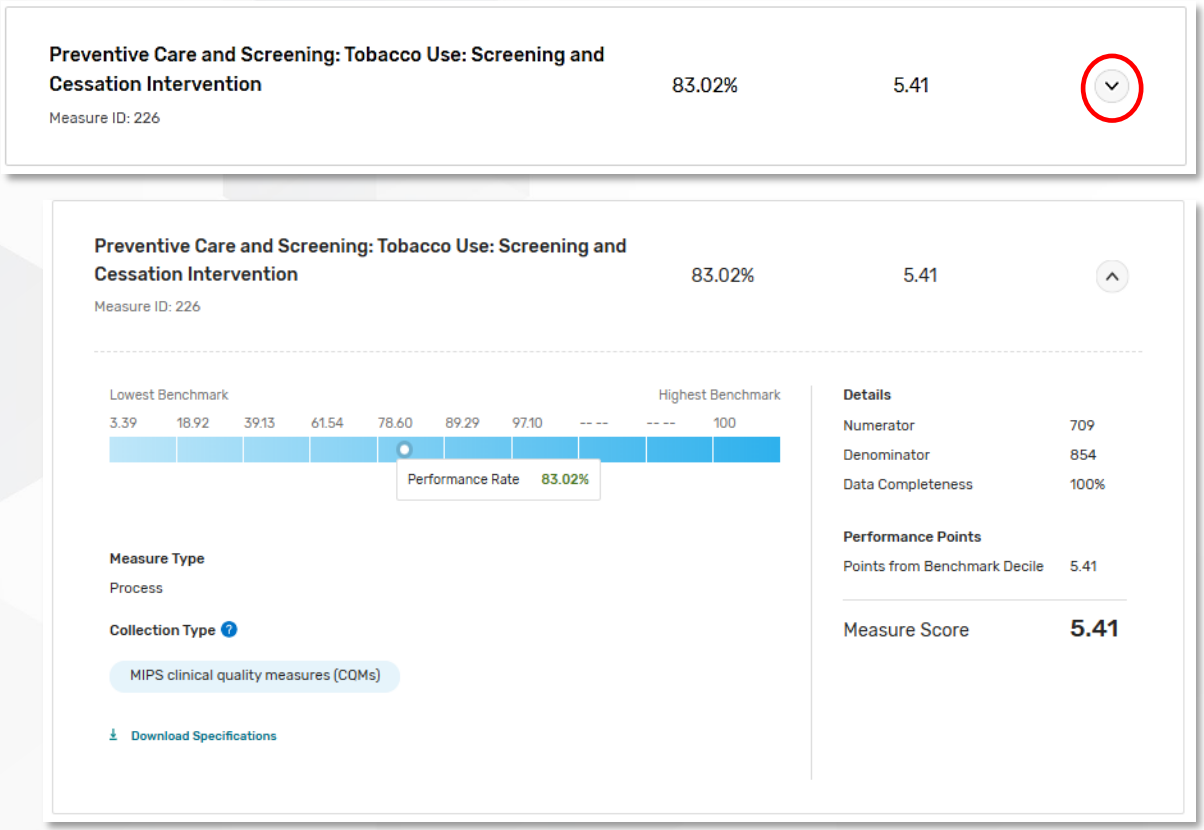
Measures may be divided into 2 groups (Continued):

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



Measure Information (Continued)

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



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

Measure Information (Continued)

In addition to the required outcome measure (or high priority measure if no outcome measure is available), we'll use your 5 highest scoring measures to determine your quality performance category score.

If you submit the same measure through multiple collection types*, we'll use the collection type that earned the most performance points.

***What's a collection type?**

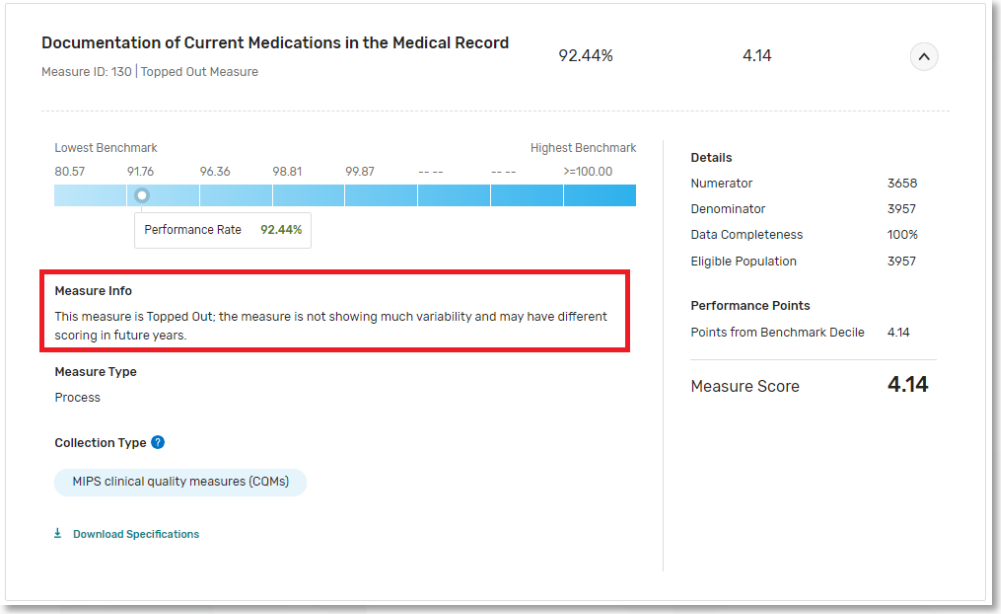
A collection type refers to a set of quality measures with comparable specifications and data completeness requirements. The same measure may be reported through multiple collection types, where each collection type has a distinct measure specification for collecting the data and calculating the measure.

For example, Measure 130 (Documentation of Current Medication in the Medical Record) may be reported as:

- A MIPS Clinical Quality Measure (MIPS CQM)
- An Electronic Clinical Quality Measure (eCQM)

Topped-Out Measures

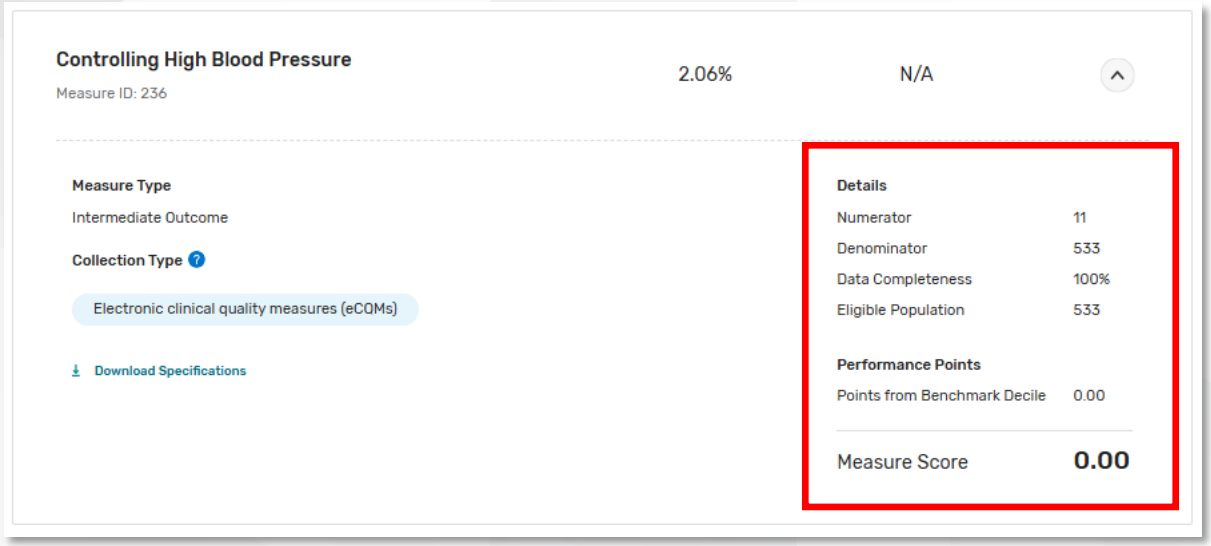
A topped-out measure is one where performance is high with little variation among those reporting the measure – a topped-out **process** measure is defined as a measure with a **median** performance rate of 95% or greater (or 5% or less, for inverse measures).



Did you know?

Not all topped-out measures are capped at 7 points. To be capped at 7 points, a measure must be in its 2nd (or 3rd or 4th) consecutive year of being topped-out through the same collection type. Refer to "Seven Point Cap" column (Column V) in the 2025 Quality Benchmarks file.

Measures Without a Historical Benchmark



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

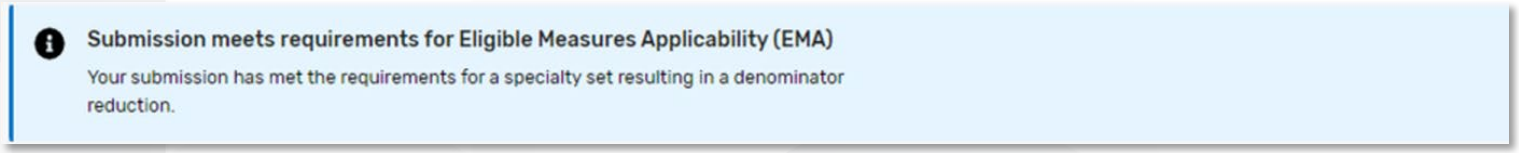
If we can calculate a performance period benchmark, we will update the measure's performance points in your final performance feedback (available summer 2026).

Submitting Fewer than 6 Measures

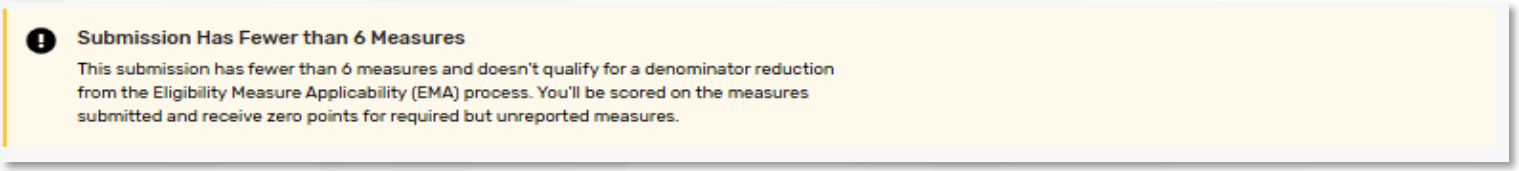
Clinicians who don't have 6 available quality measures and who report Medicare Part B claims measures or MIPS CQMs may qualify for the Eligible Measure Applicability, or EMA, process. We check for unreported, clinically related measures – or whether you reported all measures in a specialty measure set with fewer than 6 measures – which can result in a denominator reduction in the quality performance category.

If you submit fewer than 6 MIPS CQMs, the Quality Details page will display a message indicating whether the submission qualified for EMA.

Submission (MIPS CQMs) qualifies for denominator reduction



Submission (MIPS CQMs) doesn't qualify for denominator reduction



Did you know?

If you reported Medicare Part B Claims measures, the EMA process is generally applied **after the submission period** to account for the 60-day claims run out period (during which time, CMS may still receive Medicare Part B claims with dates of service in 2025).

For more information on EMA, review the 2025 EMA and Denominator Reduction Guide (PDF, 864KB) on the QPP Resource Library.

Multiple Quality Submissions from the Same Organization

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

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

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

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

Multiple Quality Submissions from the Same Organization (Continued)

Example 1.

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

John uploaded a file with 3 measures (047, 130, and 134) on Tuesday	Kathy uploaded a file with 3 measures (134, 155, and 181) on Thursday
✓ Quality performance category	✓ Quality performance category
✓ MIPS CQM collection type	✓ MIPS CQM collection type
✓ Group reporting	✓ Group reporting
✓ Traditional MIPS	✓ Traditional MIPS

The group will be scored on the 3 MIPS CQMs that Kathy submitted on Thursday.

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

Multiple Quality Submissions from the Same Organization (Continued)

Example 2.

Dr. Andrews is a solo practitioner reporting traditional MIPS.

- She reported 3 quality measures through Medicare Part B claims throughout the performance period.
- She uploaded a file with eCQMs (a report she extracted from her EHR) for 3 different quality measures during the submission period.

Dr. Andrews reported 3 measures during the performance period:	Dr. Andrews submitted 3 measures during the submission period:
✓ Quality performance category	✓ Quality performance category
× Medicare Part B claims	× eCQM collection type
✓ Individual reporting	✓ Individual reporting
✓ Traditional MIPS	✓ Traditional MIPS

Dr. Andrews will be scored on all 6 measures.

Why? The 3 measures submitted by file upload won't overwrite the 3 measures submitted through Medicare Part B claims because they were 6 different measures submitted through different methods and for different collection types.

Multiple Quality Submissions from the Same Organization (Continued)

Example 3.

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

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

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

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

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

Submitting and Reviewing Promoting Interoperability Data

Electronic Case Reporting Measure Suppression

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

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

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

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

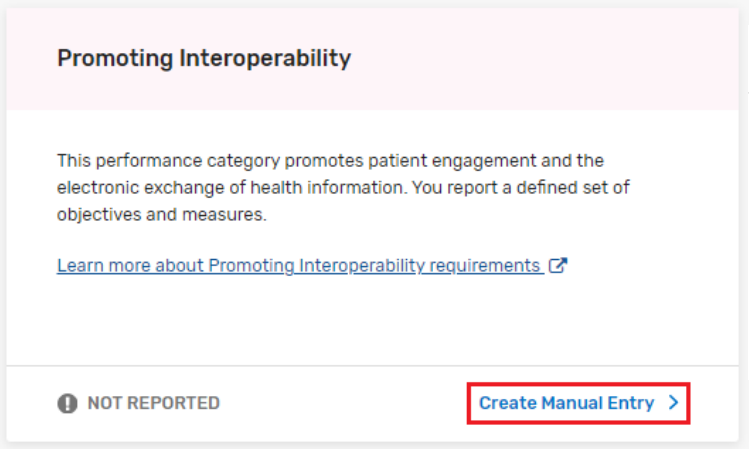
File Upload

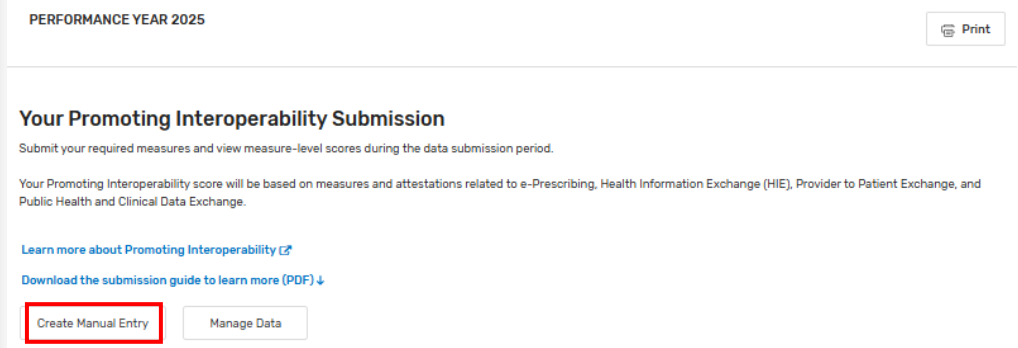
You can upload a QRDA III or QPP JSON file with your Promoting Interoperability data on the Reporting Overview page.

Manual Entry (Attestation)

You can also attest to your Promoting Interoperability data by manually entering numerators, denominators, and yes/no values as appropriate to the measure.

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

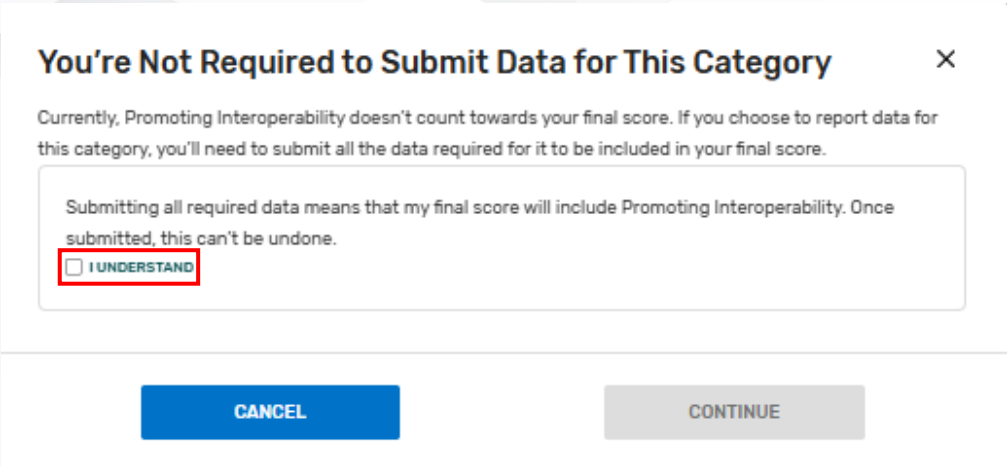




Manual Entry (Attestation) (Continued)

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

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



Did you know?

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

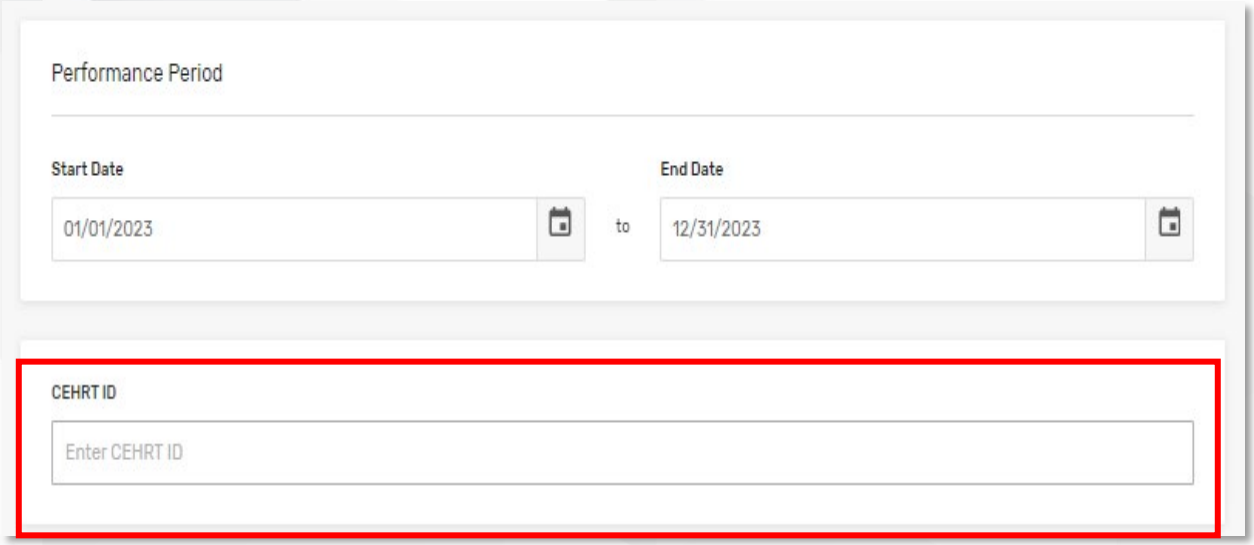
- **Quality:** 40%
- **Improvement Activities:** 30%
- **Cost:** 30%

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

Manual Entry (Attestation) (Continued)

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

Reminder: The Promoting Interoperability performance period increased to 180 days.



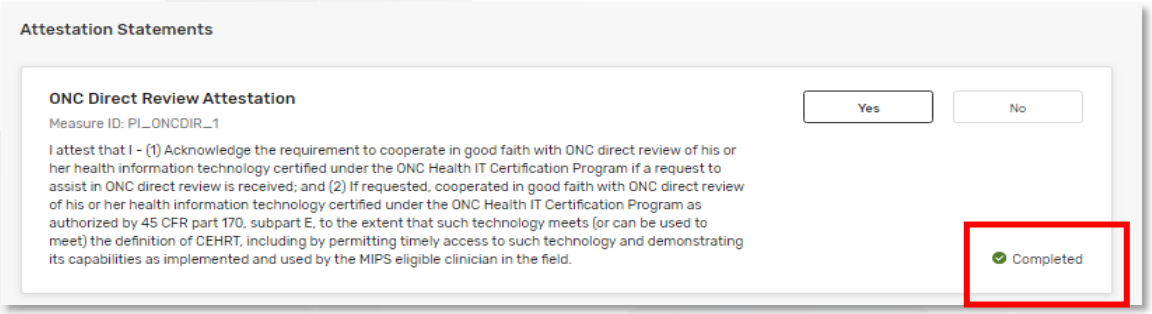
For **detailed instructions on how to generate a CMS EHR Certification ID**, review pages 23-25 of the CHPL Public User Guide (PDF, 1.21MB).

A **valid** CMS EHR Certification ID for the 2025 performance period will include **"15C"** (as it did in PY 2024) **or "2025C".**

Manual Entry (Attestation) (Continued)

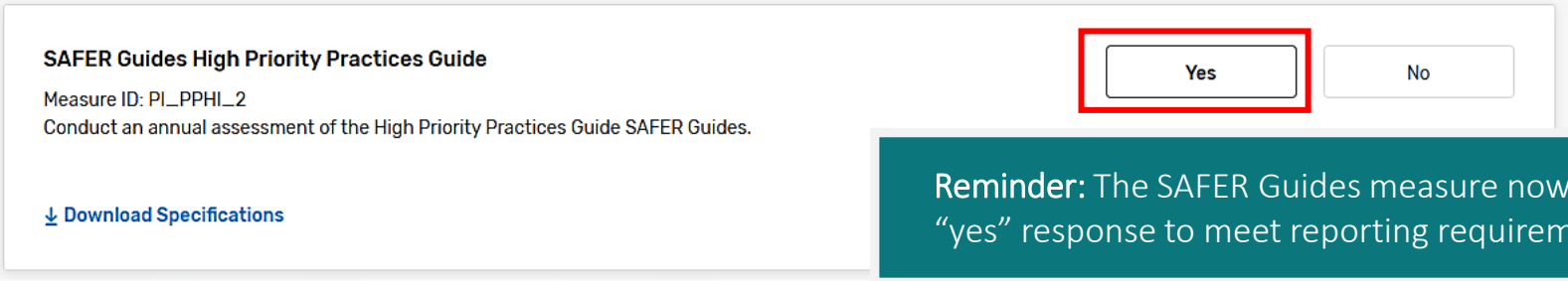
Complete Required Attestation Statements and Measures

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



To manually report a measure, you will need to either select **Yes** or enter the **numerator/denominator** value, according to the measure. You can also claim an exclusion if you qualify.

Example.



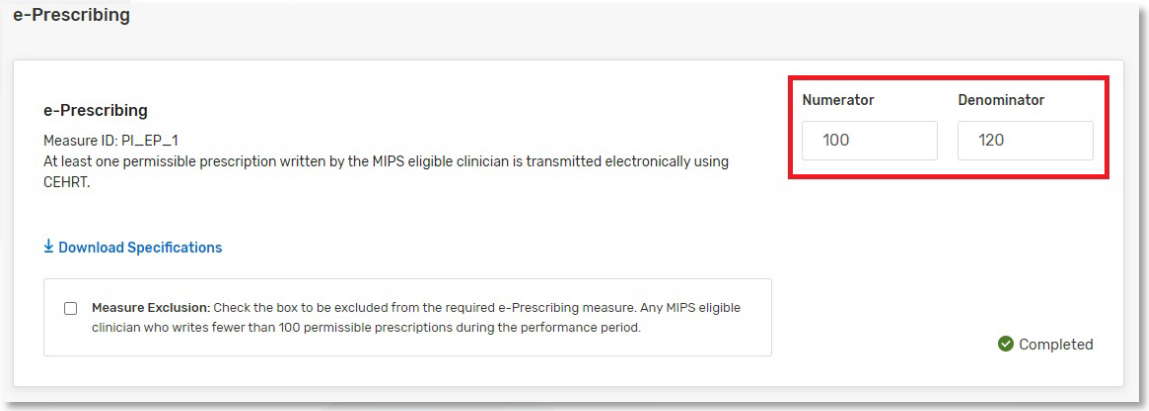
Reminder: The SAFER Guides measure now requires a "yes" response to meet reporting requirements.

Manual Entry (Attestation) (Continued)

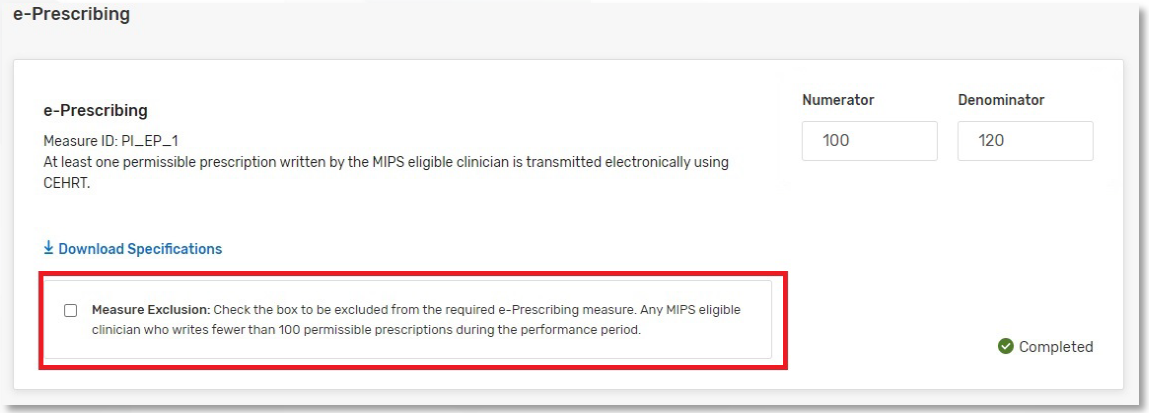
Complete Required Attestation Statements and Measures (Continued)

Numerator/Denominator Example

You must **report at least one patient in the numerator** for all required numerator/denominator measures, **or you'll earn zero points for the MIPS Promoting Interoperability performance category.**



Exclusion Example



Manual Entry (Attestation) (Continued)

Health Information Exchange Objective

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

Option 1:

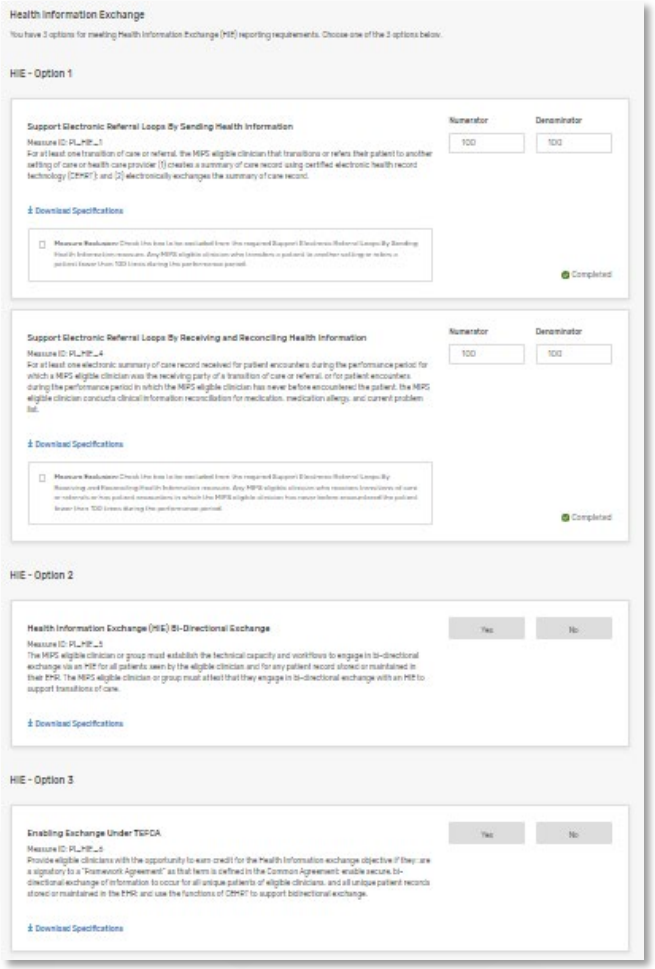
- Support Electronic Referral Loops by Sending Health Information
- Support Electronic Referral Loops by Receiving and Reconciling Health Information

Option 2:

- Health Information Exchange: Bi-Directional Exchange

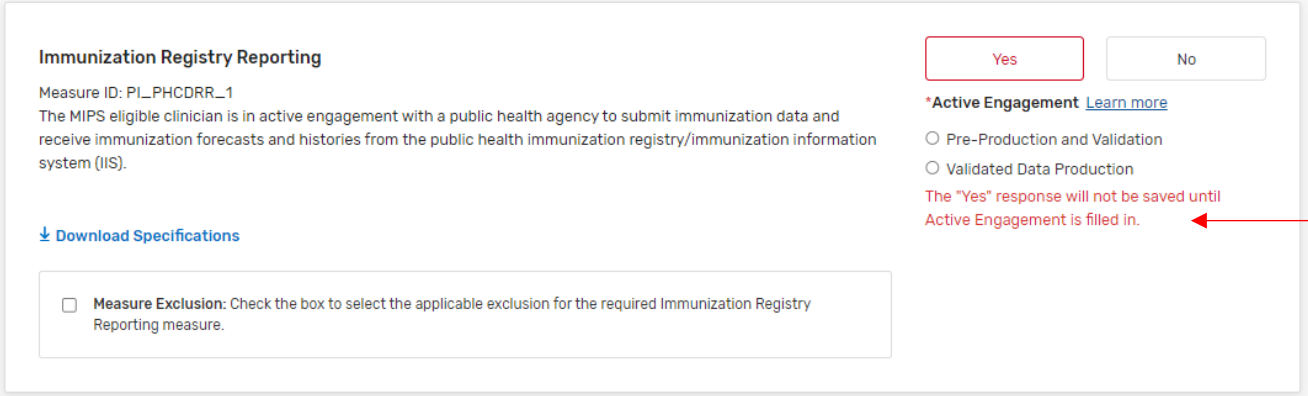
Option 3:

- Enabling Exchange Under TEFCA

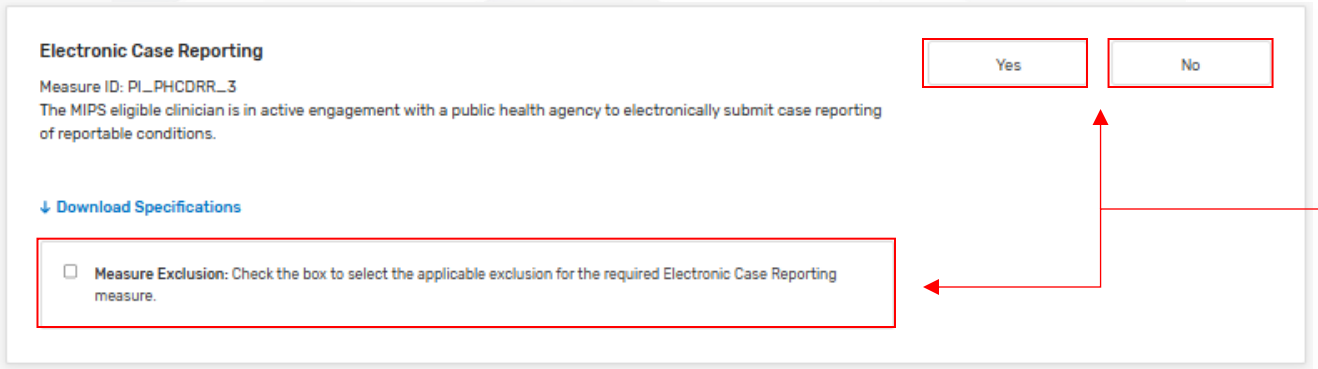


Manual Entry (Attestation) (Continued)

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



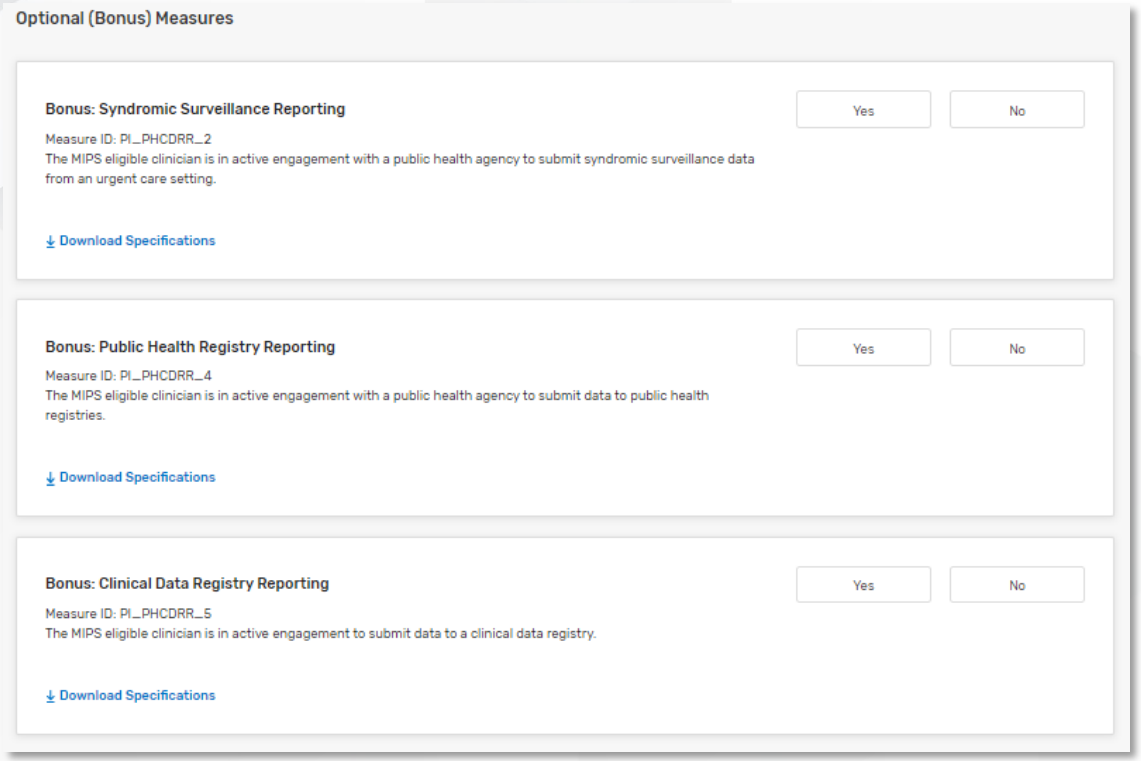
Choose one of the options for Active Engagement. A "Yes" response won't be saved until you make a selection.



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

Manual Entry (Attestation) (Continued)

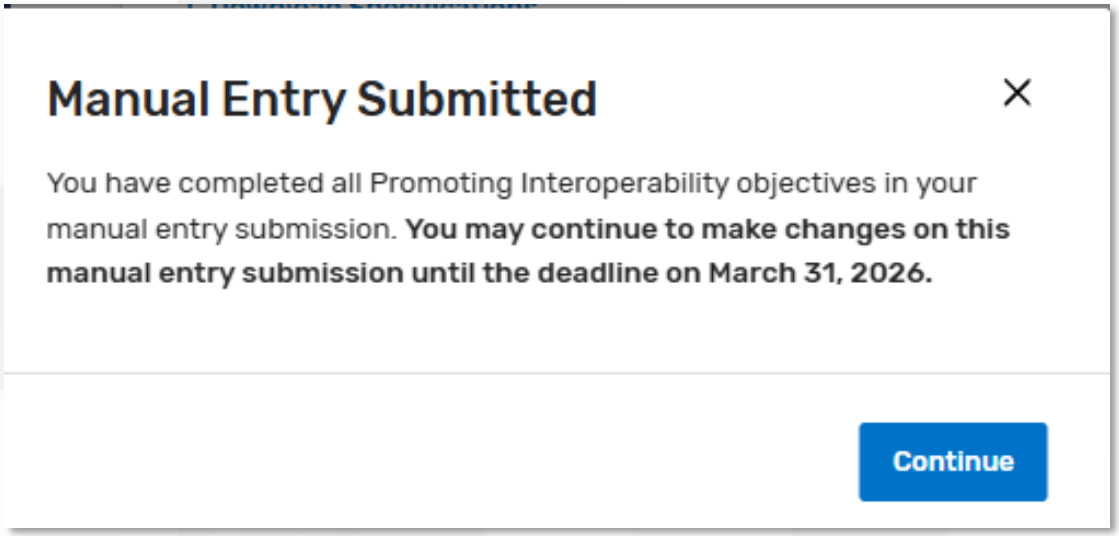
Optional/Bonus Measures – Public Health and Clinical Data Exchange



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

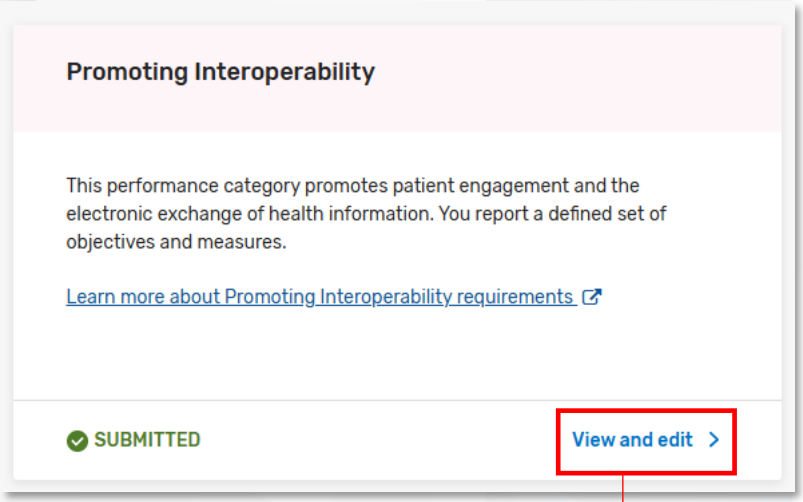
Manual Entry (Attestation) (Continued)

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



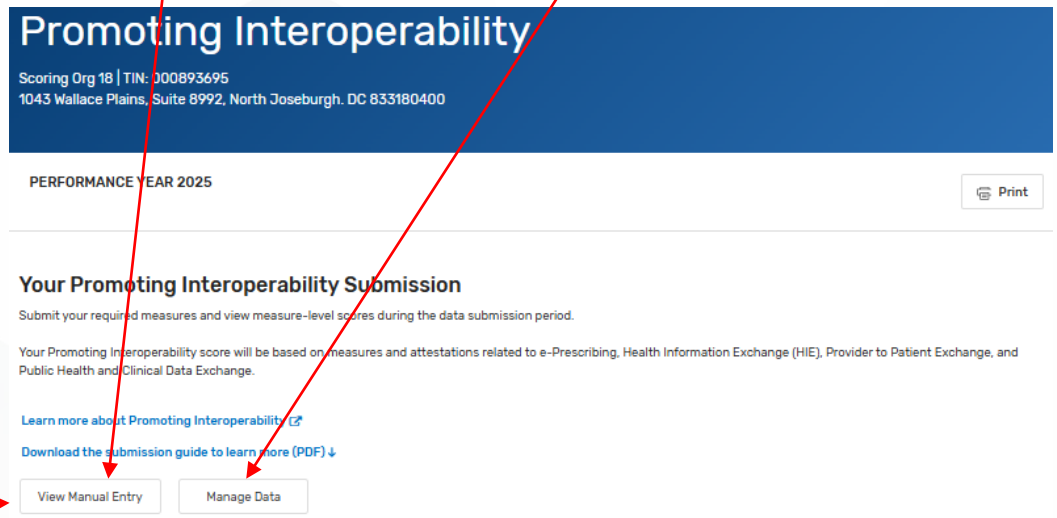
Review Previously Submitted Data

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



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

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



Multiple Submissions

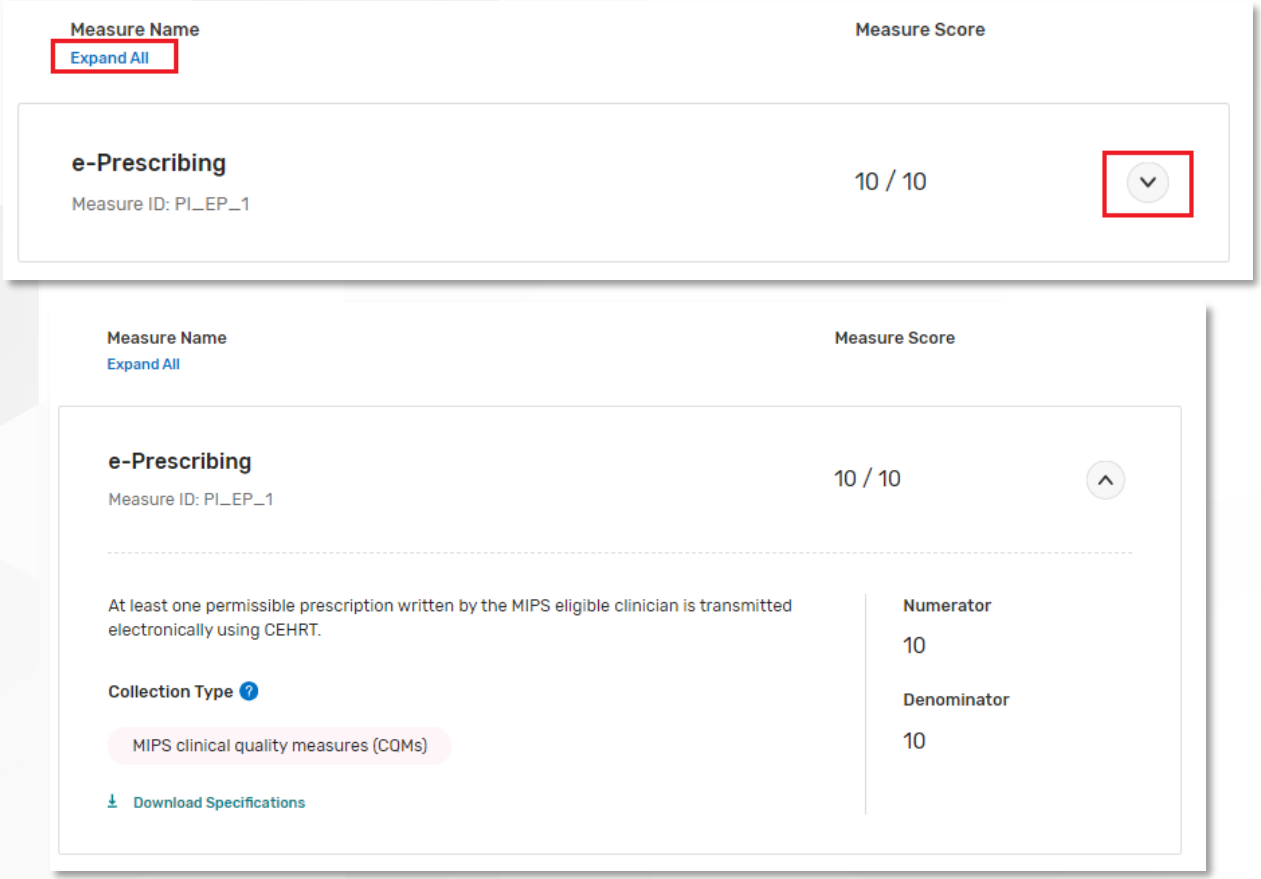
When there are multiple Promoting Interoperability submissions for an individual clinician, group, virtual group, or APM Entity, we'll score all submissions and assign the highest score to the clinician, group, virtual group, or APM Entity.

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

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

Access Previously Submitted Data

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



Submitting and Reviewing Improvement Activities Data

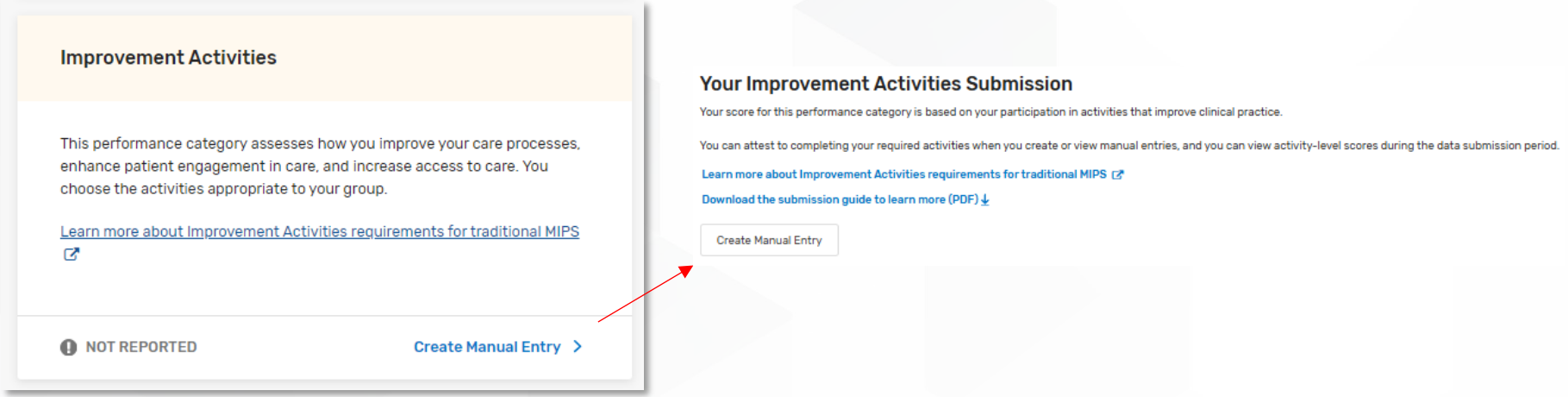
File Upload

You can upload a QRDA III or QPP JSON file with your Improvement Activities data on the Reporting Overview page.

Manual Entry (Attestation)

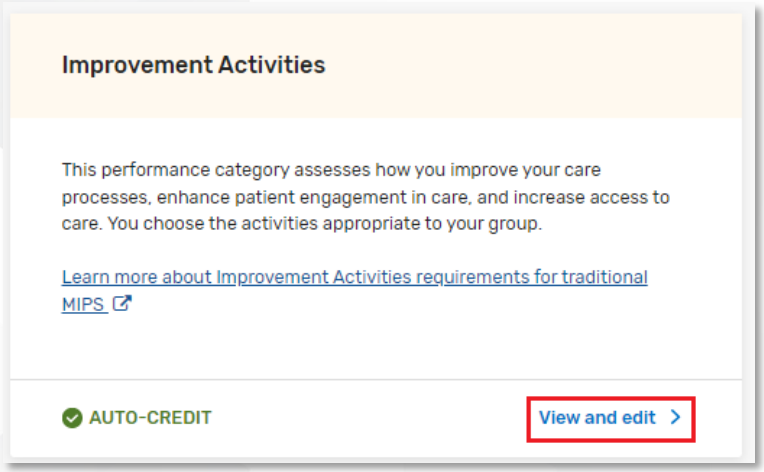
You can also attest to your Improvement Activities data by manually entering yes values to indicate you've completed the activity.

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

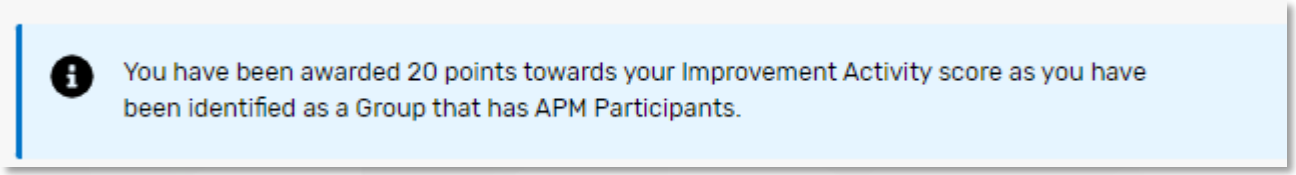


Manual Entry (Attestation) (Continued)

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

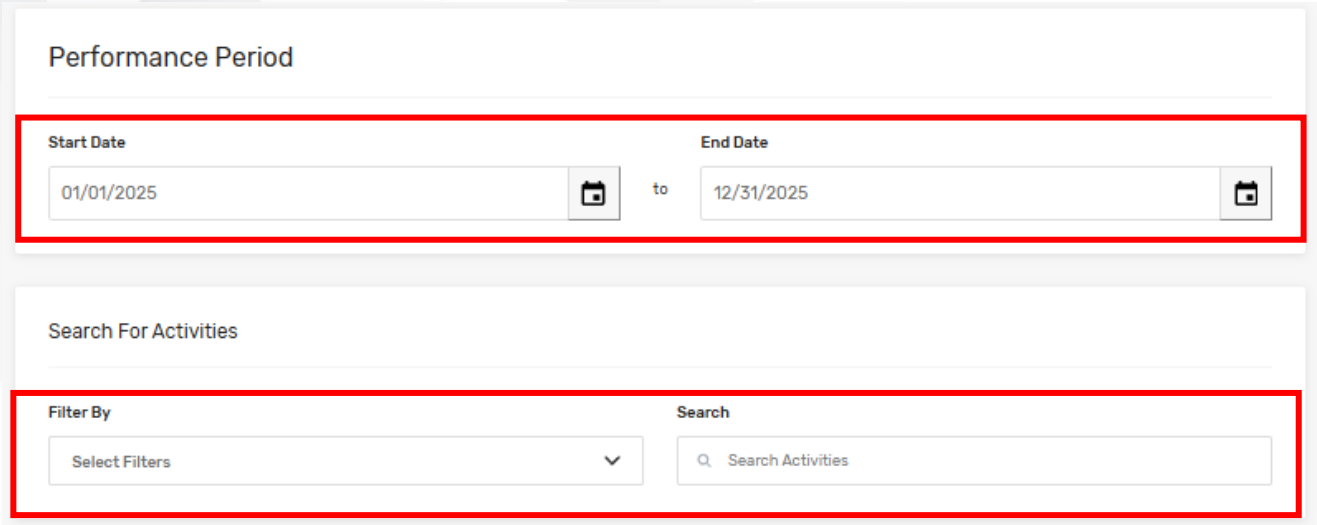


Once you select Create Manual Entry, you will see a message that 20 (out of 40 possible) points have been awarded based on your APM participation (or for Group reporting, based on having at least one clinician who participates in an APM).



Manual Entry (Attestation) (Continued)

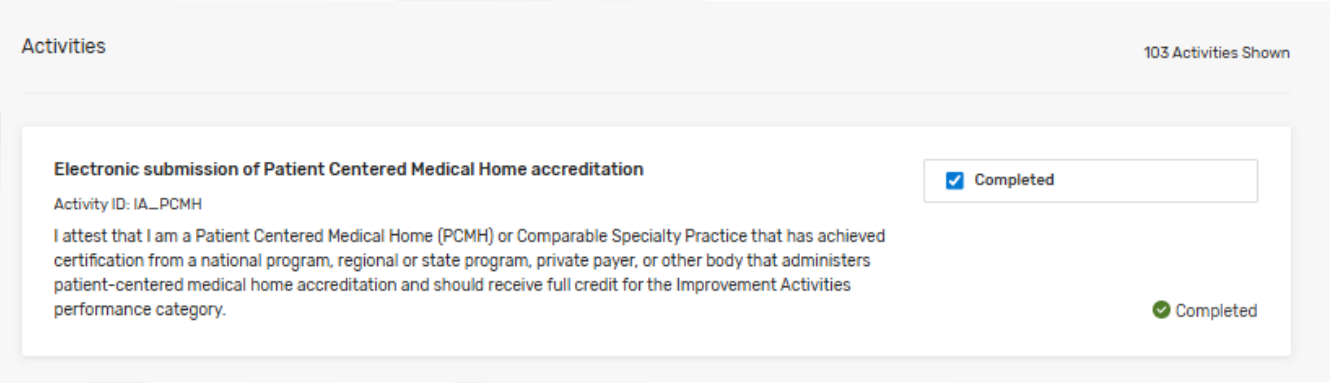
Once you enter your performance period, you can **search** for your activities by key term or **filter** by weight or subcategory. Check the box next to **Completed** to attest that the activity was performed.



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

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

Manual Entry (Attestation) (Continued)

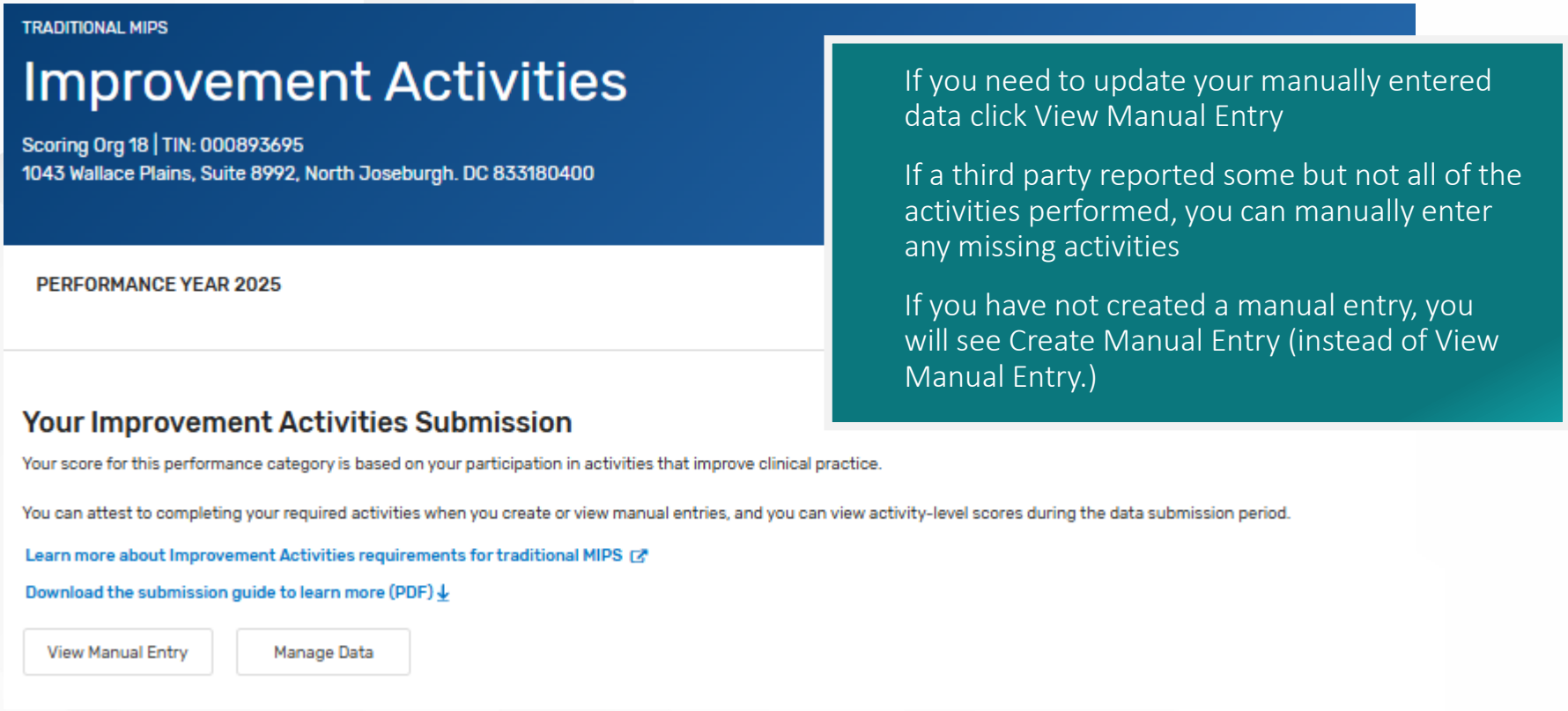


Helpful Hint:

The Patient Centered Medical Home attestation is the first activity listed.

Review Previously Submitted Data

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



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

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

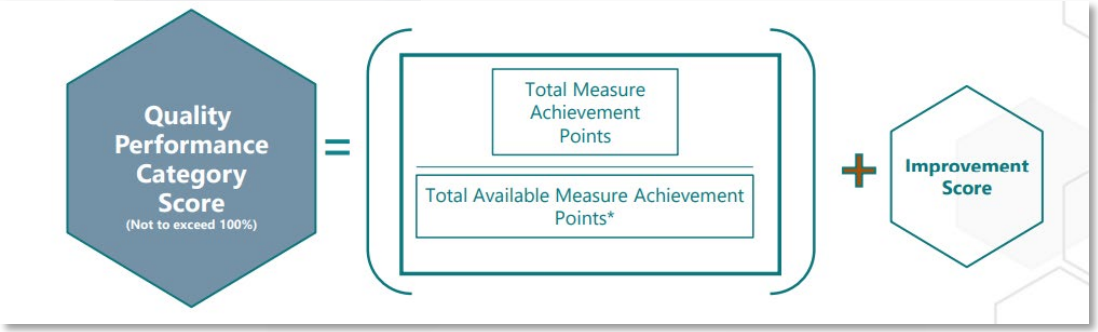
If you have not created a manual entry, you will see Create Manual Entry (instead of View Manual Entry.)

Quality Payment
PROGRAM

Scoring Calculation

Quality Score Calculation: How We'll Get There

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



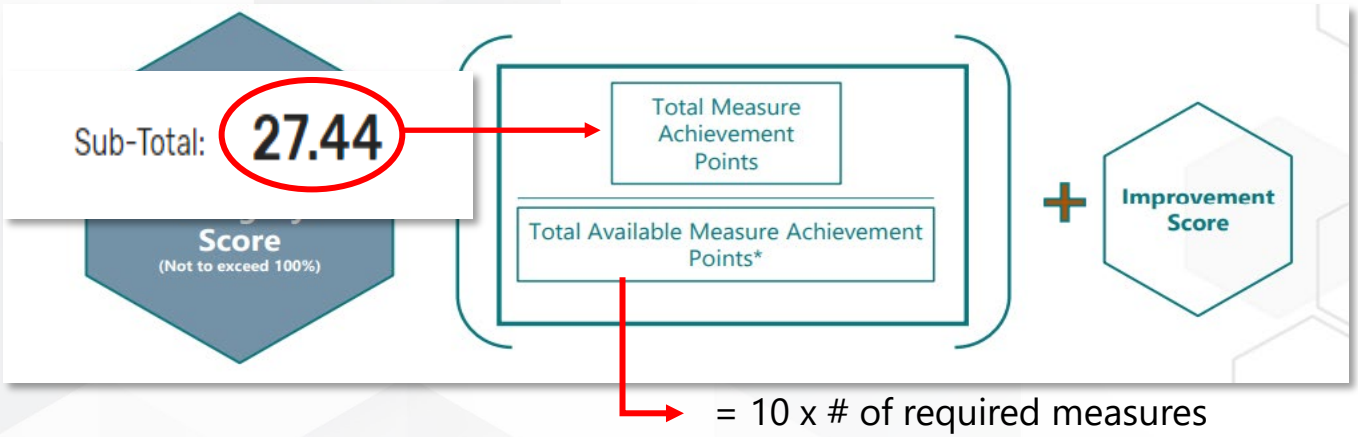
We don't display preliminary performance category scores.

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

For more information about quality score calculations, refer to the 2025 Traditional MIPS Scoring Guide (PDF, 3MB).

Quality Score Calculation

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



In traditional MIPS, you're generally required to submit **6 measures**, which would mean **60 total points** available. This number can be lower if you meet the requirements for a denominator reduction, such as through the Eligible Measure Applicability process or by reporting a specialty set with fewer than 6 measures. Learn more about dominator reductions, view the 2025 EMA and Denominator Reduction Guide (PDF, 864KB).

This number can change after the data submission period.

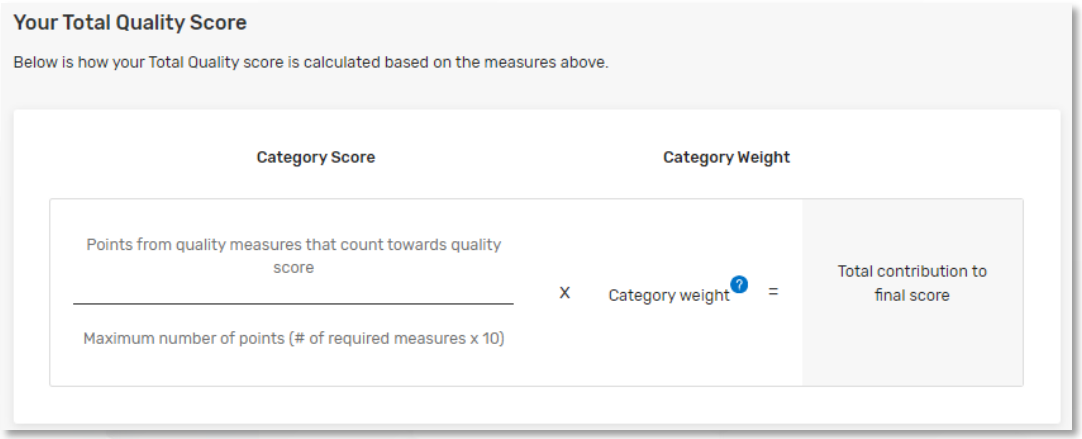
- For example, we'd increase this number by 10 points for each administrative claims measures you can be scored on.

Quality Score Calculation

Performance Category Weight.

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

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



Example.

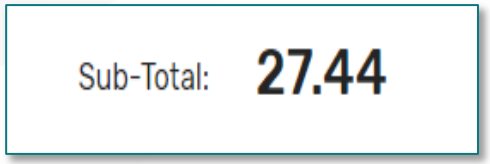
When quality is **weighted at 30%** of your final score, quality can contribute **up to 30 points to your final score**.

Quality Score Calculation

Scoring Calculation Example.

You're required to report 6 measures, for a possible total of 60 points for the measures you submit.

During the submission period, your group sees a Sub-Total of 27.44 points for the measures you submitted.



After the submission period, we calculate administrative claims measures and determine whether your group can be scored on 2 of these measures.

- This raises your group's total possible points from 60 points to 80 points.
- Your group earns 7.23 points on one administrative claims measure and 5.27 points on the other, for a total of 13 achievement points for these 2 administrative claims measures.
- Your group doesn't qualify for quality improvement scoring.

Quality Score Calculation

Your group's quality performance category is calculated:

Achievement points:

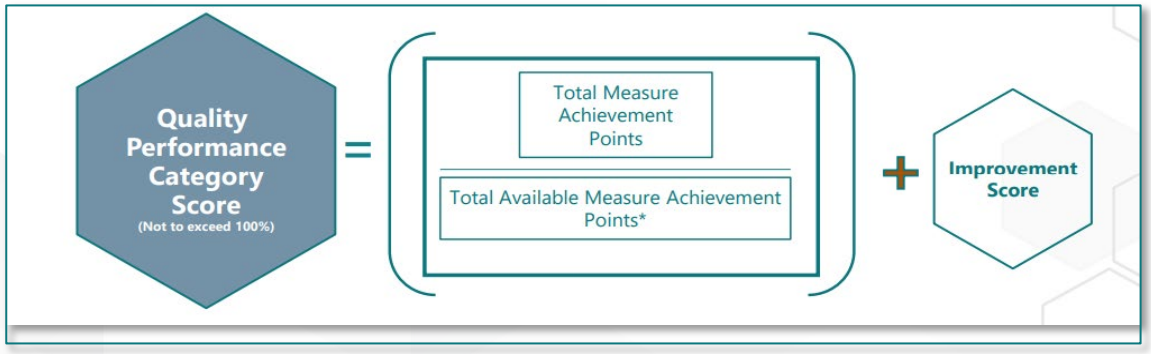
27.44 (measures submitted) + 13.00 (administrative claims measures)= 40.44

Available achievement points:

60 (required measures for submission) + 20 (2 administrative claims measures) = 80

Quality Performance Category Score:

[40.44 / 80] + 0 improvement = 50.55%



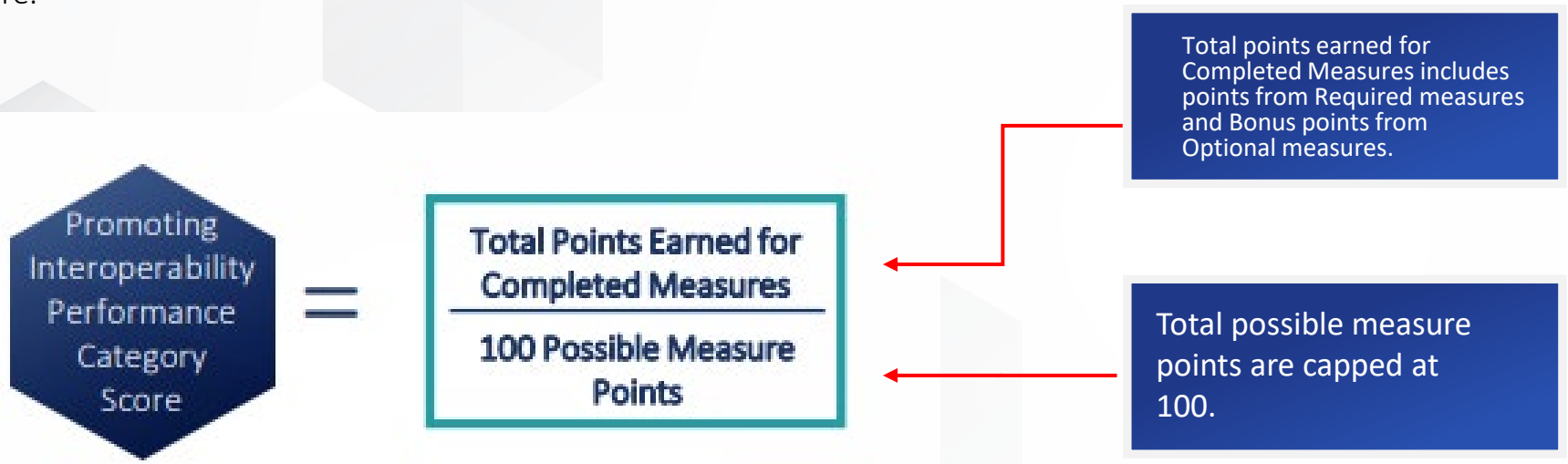
This category score (50.55%) is multiplied by the category weight (30%)

→ 15.17 quality points contributing to the group's final score.

For more information about quality score calculations, refer to the 2025 Traditional MIPS Scoring Guide (PDF, 3MB).

Promoting Interoperability Score Calculation

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



For more information about Promoting Interoperability score calculations, refer to the 2025 Traditional MIPS Scoring Guide (PDF, 3MB).

Improvement Activities Score Calculation

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

Reminder: We no longer display preliminary performance category scores.

For more information about improvement activities score calculations, refer to the 2025 Traditional MIPS Scoring Guide (PDF, 3MB).

Cost Score Calculation

Cost measures and cost performance category scores are calculated after the data submission period. You'll receive a cost score if you can be scored on at least one cost measure.

Then we'll multiply your score by the performance category weight to determine how many points the cost performance category will contribute to your final score.

It's generally weighted at 30% of your final score.

For more information about cost score calculations, refer to the 2025 Traditional MIPS Scoring Guide (PDF, 3MB).

Quality Payment
PROGRAM

Help and Version History

Where Can You Go for Help?

Contact the Quality Payment Program (QPP) Service Center by emailing QPP@cms.hhs.gov, creating a QPP Service Center ticket, or calling 1-866-288-8292 (Monday through Friday, 8 a.m. - 8 p.m. ET). Please consider calling during non-peak hours, before 10 a.m. and after 2 p.m. ET.

People who are hearing impaired can dial 711 to be connected to a TRS Communications Assistant.

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
3/10/2026	Updated Appendix C to identify the suppressed and truncated measures for the 2025 performance period (p. 104).
12/19/2025	Original Version.

Quality Payment
PROGRAM

Appendices

Data Submission and the Automatic EUC Policy

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

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

- Designated counties* in California for Wildfires
- Designated counties* in Texas for Severe Storms, Straight-line Winds, and Flooding

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

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

Data Submission and the Automatic EUC Policy (Continued)

Table 1: Reweighting for Clinicians Not in a Small Practice

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

[1] APM participants are eligible to receive automatic credit in the improvement activities performance category; for these MIPS eligible clinicians, submitting data for the quality and/or Promoting Interoperability performance categories will initiate a score in the improvement activities performance category (20 out of 40 possible points), and they'll receive a final score based on the data submitted and available for scoring.

Data Submission and the Automatic EUC Policy (Continued)

Table 2: Reweighting for Clinicians in a Small Practice

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

[2] APM participants are eligible to receive automatic credit in the improvement activities performance category; for these MIPS eligible clinicians, submitting data for the quality and/or Promoting Interoperability performance categories will initiate a score in the improvement activities performance category (20 out of 40 possible points), and they'll receive a final score based on the data submitted and available for scoring.

Submission Period: QPP Access and Permissions by Organization Type

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

With this access	You CAN	You CAN'T
Staff User or Security Official for a **Practice** (includes solo practitioners)	✓ Access information about eligibility and special status at the individual clinician and group level ✓ View information about performance category reweighting (including from approved exception applications) ✓ Submit data on behalf of your practice (as a group and/or individuals) • Includes Promoting Interoperability data for MIPS APM participants ✓ Submit opt-in elections on behalf of your practice (as a group and/or individuals) ✓ View data submitted on behalf of your practice (group and/or individual) ✓ View measure-level scoring for Part B claims measures reported throughout the performance period • This data will be updated during the submission period to account for claims received by CMS until March 1, 2026 ✓ View measure and activity-level scores and a sub-total of points for the group and individual clinicians	✗ View feedback or scores for administrative claims quality measures or the CAHPS for MIPS measure (if applicable) ✗ View your cost feedback (if applicable) • Cost data won't be available during the submission period ✗ View facility-based scoring for quality / cost (if applicable) ✗ View data submitted by your APM Entity **Example.** If you're a Participant TIN in a Shared Savings Program ACO, you will not be able to view the quality data reported by the ACO. ✗ View data submitted by your virtual group (if your TIN is part of a CMS-approved virtual group) ✗ View the overall preliminary score or preliminary performance category score

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

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

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

Quality Measures with MIPS Scoring or Submission Changes

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

Quality Measure Number/Title	Impact Collection Type(s)	Reason for Measure Change	Result	Impact to Scoring Submission and Feedback Expectations
Measure 389: Cataract Surgery: Difference between Planned and Final Refraction	MIPS CQM	Quality Measure implementation resulting in misleading results	Suppressed	This measure will be excluded from scoring if it's submitted, and your quality denominator will be reduced by 10 points.
Measure 491: Mismatch Repair (MMR) or Microsatellite Instability (MSI) Biomarker Testing Status	MIPS CQM	Measure significantly impacted by ICD-10 coding changes	Truncated	Truncated performance period for those reporting this measure should only include denominator eligible reports for the first 9 months of the performance period (January 1–September 30, 2025) in their submission.
Measure 494: Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults	eCQM	Quality measure implementation resulting in misleading results	Suppressed	This measure will be excluded from scoring if it's submitted, and your quality denominator will be reduced by 10 points.