

**Supporting Statement – Part B**  
**Quality Payment Program (QPP)/Merit-Based Incentive Payment System (MIPS)**  
**(CMS-10621, OMB control number: 0938-1314)**

**Background**

Authorized by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114-10, April 16, 2015), the Quality Payment Program is a value-based payment program, by which the Medicare program rewards clinicians who provide high-value, high-quality care to their patients in a cost-efficient manner. There are two ways for clinicians who provide services under the Medicare program to participate in the Quality Payment Program: Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (Advanced APMs). The statutory requirements for the Quality Payment Program are set forth in section 1848(q) and (r) of the Act for MIPS and section 1833(z) of the Act for Advanced APMs.

For the MIPS participation track, MIPS eligible clinicians (defined in § 414.1305) are subject to MIPS payment adjustments (positive, negative, or neutral) based on their performance in four performance categories: cost, quality, improvement activities, and Promoting Interoperability. We apply the MIPS payment adjustment factor to amounts otherwise paid under Part B with respect to covered professional services for the MIPS eligible clinician for the applicable MIPS payment year.

For the Advanced APM track, eligible clinicians that participate in an Advanced APM and achieve Qualifying APM Participant (QP) status are excluded from MIPS. Clinicians who achieve Partial QP status only need to participate in MIPS if they (or their APM Entity) submit an election to do so. Beginning with the CY 2025 performance year (payment year 2027), QPs receive a higher Physician Fee Schedule (PFS) payment rate (calculated using the differentially higher “qualifying QP conversion factor”) than non-QPs.

The primary purpose of this collection is to generate data on a MIPS eligible clinician, group, or subgroup so that we can assess MIPS eligible clinician performance in the four performance categories, calculate the final score, and apply performance-based payment adjustments. We will also use this information to provide required performance feedback to MIPS eligible clinicians and eligible entities. This information will also be made available to Medicare beneficiaries, as well as the general public, on the Care Compare tool to allow the general public to compare care provided by their providers. In addition, the data collected under this Paperwork Reduction Act (PRA) package will be used for MIPS program use only.

Specifically, we use the data to produce annual statistical reports that provide a comprehensive representation of the overall experience of MIPS eligible clinicians. Further, we have processes to monitor and assess measures to ensure their soundness and appropriateness for continued use in MIPS. As required by MACRA, the ongoing measure assessment and monitoring process will be used to refine, add, and drop measures as appropriate, as shown in the proposed changes to the measure sets discussed in the CY 2026 Physician Fee Schedule (PFS) proposed rule. Supporting Statement Part B characterizes the respondents of this collection, and any sampling used in data collection so that, when grouped/aggregated data are presented, the inferences that can be drawn from those data are clear.

There are 25 information collections included in this PRA package. Burden estimates updated to reflect policy proposals in the CY 2026 PFS proposed rule are detailed in the CY 2026 PFS proposed rule collection of information pages (90 FR 32352). Updates to information collection requests (ICRs) that reflect the availability of updated data and assumptions are detailed in Supporting Statement A of this PRA package. The discussion in this Supporting Statement Part B focuses on the seven information collections for which we plan to conduct statistical reporting and analyses: quality performance category data submitted via Medicare Part B claims, electronic clinical quality measure (eCQM), and MIPS clinical quality measure (CQM) and Qualified Clinical Data Registry (QCDR) collection types, the quality performance category submissions for MIPS Value Pathways (MVPs), the quality performance category submissions for the Alternative Payment Model (APM) Performance Pathway (APP) quality measure set, and data submitted for the Promoting Interoperability and improvement activities performance categories.

## **B1. Respondent Universe and Sampling Methods**

### ***Quality Performance Category Data Submission***

#### ***Potential respondent universe and response rates***

We anticipate that two groups of MIPS eligible clinicians would submit quality data under MIPS: those are required to submit and those who submit voluntarily. We estimate the potential respondent universe and response rates for MIPS eligible clinicians and clinicians excluded from MIPS using data from the CY 2023 performance period/2025 MIPS payment year and other CMS sources. To determine QPs that are excluded from MIPS, we used Advanced APM payment and patient percentages from the APM Participant List for the third snapshot date for the 2023 QP Performance Period and the QP thresholds applied to the regulatory impact analysis. Due to data limitations, we could not identify specific clinicians who may become QPs in the CY 2026 performance period/2028 MIPS payment year; hence, our model may underestimate or overestimate the percentage of clinicians and allowed charges for covered professional services that would remain subject to MIPS after the exclusions. Partial QPs who do not opt-in to participate in MIPS are excluded from MIPS.

There are three MIPS reporting options: traditional MIPS, MVPs, and the APP. In Supporting Statement A, we provide estimates per reporting option for the quality performance category, per relevant collection type: Medicare Part B claims measures (individual clinicians only), MIPS CQM and QCDR measures, and eCQM. Notably, we do not assess burden for the quality administrative claims collection type, as we automatically calculate scores for individual clinicians, groups, subgroups (as applicable for MVP reporting), or non-Shared Savings Program Accountable Care Organization (ACO) APM Entities that meet requirements to be scored. For each reporting option and for each collection type, we aggregate our estimates for individual clinicians, groups, virtual groups (as available for traditional MIPS reporting), subgroups (as applicable for MVP reporting), or non-Shared Savings Program ACO APM Entities.

In Supporting Statement A, we are adding a new ICR to reflect submissions for the APP quality measure set, due to the availability of updated data. The APP is an optional MIPS reporting and scoring pathway for MIPS eligible clinicians who are also participants in MIPS APMs, as defined under 42 CFR § 414.1367. ACOs participating in the Shared Savings Program are required to report the APP for purposes of assessing their quality performance for that program.

MIPS eligible clinicians participating in Shared Savings Program ACOs also have the option of reporting for MIPS outside of the APP, or within it as an individual or group level like with other MIPS APM participants. Our burden estimates for the APP quality measure set focus on submissions by individuals, groups, or non-Shared Savings Program ACO APMs for the APP quality measure set. We are not estimating burden for Shared Savings Program ACOs under the APP quality measure set. Section 1899(e) of the Act provides that chapter 35 of title 44 U.S.C., which includes such provisions as the PRA, shall not apply to the Shared Savings Program. Additionally, we are not establishing an ICR for the APP Plus quality measure set. In the CY 2025 PFS final rule (89 FR 98355 through 98371), we established the APP Plus as a new quality measure set designed for APP participants that expands the existing APP quality measure set and is mandatory for Shared Savings Program ACOs starting in the CY 2025 performance period/2027 MIPS payment year. We continue our assumption from the CY 2025 PFS final rule (89 FR 98549 and 98550) that MIPS eligible clinicians, groups, and APM Entities (excluding Shared Savings Program ACOs) would not elect to submit the APP Plus quality measure set due to the increased reporting burden relative to the APP beginning in the CY 2025 performance period/2027 MIPS payment year. We assume that non-Shared Savings Program ACO APM Entity submissions represent single Taxpayer Identification Number (TIN) APMs.

As described in Supporting Statement A and the CY 2026 PFS proposed rule (90 FR 32789), we are updating our assessment of estimated MVP quality performance category submissions and registrations, assessing measure-level submission trends from the CY 2023 performance period/2025 MIPS payment year (87 FR 70650 through 70701) alongside the MVP inventory finalized in the CY 2025 PFS final rule Appendix 3 (89 FR 98972 through 99057), and the six new MVPs proposed in section IV.A.4.a.(1) of the 2026 PFS proposed rule. The CY 2023 performance year/2025 MIPS payment year submission data includes MVP submissions and registration for the 12 MVPs available at that time for MIPS reporting. Due to the expanded MVP inventory (16 MVPs available for the CY 2024 performance year/2026 MIPS payment year (88 FR 79978 through 80047), 21 MVPs available for the CY 2025 performance year/2027 MIPS payment year (89 FR 98972 through 99057)), and 6 newly proposed MVPs for a total of 27 MVPs for the CY 2026 performance period/2028 MIPS payment year, we anticipate increased MVP adoption for the CY 2026 performance period/2028 MIPS payment year and beyond. Accordingly, we continue to estimate MVP quality performance category submissions and MVP registrations as percent of historic quality performance category submissions. For this proposed rule, we estimate MVP submissions as a percentage of the total traditional MIPS and MVP submissions based on the data available from the CY 2023 performance period/2025 MIPS payment year.

Burden estimates for quality measure submissions under the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS collection type are provided under OMB control number: 0938-1222 (CMS-10450).

As discussed in Supporting Statement A, we assume 607,419 MIPS eligible clinicians would be subject to MIPS performance requirements. Included in this number, we estimate that 4,813 clinicians who exceeded at least one but not all low-volume threshold criteria and elected to opt-in and submitted data in the CY 2023 performance period/2025 MIPS payment year would elect to opt-in to MIPS in the CY 2026 performance period/2028 MIPS payment year. Also included in this number are an estimated 38,784 clinicians who are MIPS eligible as an individual because

they exceeded all the low-volume threshold in all three criteria, but we predict would not report in the CY 2026 performance period/2028 payment year. While this is the estimated number of MIPS eligible clinicians, the number of respondents that actually submit data varies significantly due to differences in individual, group, virtual group, subgroup, and non-Shared Savings Program ACO APM Entity reporting and by the requirements and policies for each performance category.

CMS' annual statistical reports about MIPS will be able to provide estimates of the numbers and percentages of MIPS eligible clinicians submitting quality performance category data that can be generalized to the entire population of MIPS eligible clinicians, and to relevant subpopulations (such as eligible clinicians participating in MIPS APMs).

*Sampling for quality data submission*

In the CY 2024 PFS final rule, we maintained the data completeness criteria threshold of at least 75 percent for the CY 2026 performance period/2028 MIPS payment year (88 FR 79334 through 79337). In the CY 2025 PFS final rule (89 FR 98383 through 98387), we finalized maintaining the data completeness criteria threshold of at least 75 percent for the CY 2027 and CY 2028 performance periods/2029 and 2030 MIPS payment years. Tables 1 and 2 summarize the previously established data completeness criteria and submission requirements for the CY 2026 performance period/2028 MIPS payment year and CY2027 performance period/2029 MIPS payment year.

**Table 1: Summary of Data Completeness Requirements and Performance Period by Collection Type for the CY 2026 Performance Period/2028 MIPS Payment Year and CY 2027 Performance Period/2029 MIPS Payment Year**

Collection Type	Performance Period	Data Completeness
Medicare Part B claims measures	Jan 1- Dec 31	At least 75 percent of the applicable Medicare Part B patients seen during the performance period to which the measure applies.
QCDR measures, MIPS CQMs, and eCQMs	Jan 1- Dec 31	At least 75 percent of the MIPS eligible clinician, group, virtual group, subgroup, and APM Entity's patients that meet the measure's denominator criteria, regardless of payer.

**Table 2: Summary of Quality Data Submission Criteria for the CY 2026 Performance Period/2028 MIPS Payment Year and CY2027 Performance Period/2029 MIPS Payment Year for Individual Clinicians, Groups, Subgroups, and Non-Shared Savings Program ACO APM Entities**

<b>Clinician Type</b>	<b>Submission Criteria</b>	<b>Measure Collection Types (or Measure Sets) Available for Submission (Excludes Administrative Claims)</b>
Individual Clinicians in Traditional MIPS	Report at least six measures including one outcome measure, or if an outcome measure is not available report another high priority measure; if fewer than six measures apply then report on each measure that is applicable. Clinicians need to meet the applicable data completeness standard for the applicable performance period for each collection type.	Individual MIPS eligible clinicians select their measures from the following collection types - Medicare Part B claims measures (individual clinicians in small practices only), MIPS CQMs, QCDR measures, eCQMs - or reports on one of the specialty measure sets if applicable.
Groups and Virtual Groups in Traditional MIPS	Report at least six measures including one outcome measure, or if an outcome measure is not available report another high priority measure; if fewer than six measures apply then report on each measure that is applicable. Clinicians need to meet the applicable data completeness standard for the applicable performance period for each collection type.	Groups and virtual groups select their measures from the following collection types - Medicare Part B claims measures (small practices only), MIPS CQMs, QCDR measures, eCQMs, or the CAHPS for MIPS survey - or reports on one of the specialty measure sets if applicable.
Non-Shared Savings Program ACO APM Entities in Traditional MIPS	Report at least six measures including one outcome measure, or if an outcome measure is not available report another high priority measure; if fewer than six measures apply then report on each measure that is applicable. Clinicians need to meet the applicable data completeness standard for the applicable performance period for each collection type.	Non-Shared Savings Program ACO APM Entities select their measures from the following collection types - Medicare Part B claims measures (small practices only), MIPS CQMs, QCDR measures, eCQMs, or the CAHPS for MIPS survey - or reports on one of the specialty measure sets if applicable.

<b>Clinician Type</b>	<b>Submission Criteria</b>	<b>Measure Collection Types (or Measure Sets) Available for Submission (Excludes Administrative Claims)</b>
MVP Participant	Select and report four quality measures, including one outcome measure (or, if an outcome measure is not available, one high priority measure included in the MVP). For small practices reporting an MVP with fewer than four Medicare Part B claims measures, they are only required to report the available Medicare Part B claims measures available in the MVP. Clinicians need to meet the applicable data completeness standard for the applicable performance period for each collection type.	MVP Participants (individual MIPS eligible clinician, single specialty group, multispecialty group, subgroup, or non-Shared Savings Program ACO APM Entity that is assessed on an MVP) report on the applicable measures in MVPs included in the MVP Inventory.
APP Quality Measure Set Participant	All participants are scored on six identified quality measures, including three quality measures actively reported by participants, the CAHPS for MIPS survey, and two administrative claims measures. Participants must participate in an MIPS APM.	APP Participants (individual MIPS eligible clinician, groups, subgroups, or non-Shared Savings Program ACO APM Entity) are required to submit measures via the CAHPS for MIPS survey, administrative claims, eCQM, MIPS CQM, and Medicare Part B claims.

### ***Data Submission for Promoting Interoperability and Improvement Activities Performance Categories***

For the CY 2026 performance period/2028 MIPS payment year, eligible clinicians, groups, virtual groups, subgroups, and non-Shared Savings Program ACO APM Entities can submit Promoting Interoperability and improvement activities data through direct, log in and upload, or log in and attest submission types.

Based on updated MIPS submission data from the CY 2023 performance period/2025 MIPS payment year, we estimate that a total of 20,881 respondents (15,396 individual MIPS eligible clinicians, 5,454 groups, 11 non-Shared Savings Program ACO APM Entities, and 20 subgroups) would submit Promoting Interoperability data for the CY 2026 performance period/2028 MIPS payment year. These estimates reflect that certain MIPS eligible clinicians would qualify for automatic reweighting of the Promoting Interoperability performance category to zero percent, including MIPS eligible clinicians who are hospital-based, ambulatory surgical center-based, small practices, and non-patient facing clinicians.

As discussed in Supporting Statement A, a variety of organizations submit Promoting Interoperability data on behalf of clinicians. Clinicians not participating in a MIPS APM may submit data as individuals, or as part of a group, virtual group, or subgroup. In the CY 2017 Quality Payment Program final rule (81 FR 77258 through 77260, 77262 through 77264) and

CY 2019 PFS final rule (83 FR 59822 and 59823), we established that eligible clinicians in MIPS APMs (including the Shared Savings Program) may report for the Promoting Interoperability performance category at the individual or group level. In the CY 2023 PFS final rule (87 FR 70087 and 70088), we finalized a voluntary reporting option for APM Entities to report the Promoting Interoperability performance category at the APM Entity level beginning with the CY 2023 performance period/2025 MIPS payment year.

As discussed in Supporting Statement A, we estimate that a total of 42,624 respondents (31,193 individually eligible clinicians, 11,402 groups and virtual groups, 9 non-Shared Savings Program ACO APM Entities, and 20 subgroups) would submit data for the improvement activities performance category during the CY 2026 performance period/2028 MIPS payment year, based on updated MIPS submission data from the CY 2023 performance period/2025 MIPS payment year.

## **B2. Procedures for Collection of Information**

There are 25 information collections in the 2026 Quality Payment Program/MIPS PRA package. We do not anticipate using sampling or statistical estimation in all the information collections.

## **B3. Methods to Maximize Response Rates and Deal with Nonresponse**

### ***Quality Performance Category Data Submission***

Additional experience with submissions under MIPS will provide clarification to optimize data completeness thresholds and submission criteria for use in future performance periods. We will continually evaluate our policies and notify the public through future notice and comment rulemaking if we make substantive changes. As we evaluate our policies, we plan to continue a dialogue with interested parties to discuss opportunities for program efficiency and flexibility.

We believe that by continuing to provide virtual group participation as an option, we will experience continued improvement in response rates due to the ability to better pool resources from participating as part of a virtual group, allowing for reporting on six quality measures in traditional MIPS.

### ***Promoting Interoperability Performance Category Data Submission***

The revised scoring methodology finalized in the CY 2019 PFS final rule (83 FR 59791) has provided a simpler, more flexible, less burdensome structure, allowing MIPS eligible clinicians to put their focus back on patients. However, scoring can be affected by special statuses, an approved Promoting Interoperability hardship application, an approved Extreme and Uncontrollable Circumstances application, participation in Advanced APMs, and/or achievement of QP or Partial QP status. The Promoting Interoperability performance category encourages health data exchange through interoperability which will continue to ensure continued high response rates for the Promoting Interoperability performance category.

In the CY 2020 PFS final rule, we required QCDRs and qualified registries to be able to submit data for each of the quality, improvement activities, and Promoting Interoperability performance categories with the stipulation that based on the amendment to § 414.1400(b)(1)(c) a third party could be excepted from this requirement if its MIPS eligible clinicians, groups or virtual groups

fall under the reweighting policies at § 414.1380(c)(2)(i)(A)(4)(i) through (iii) or § 414.1380(c)(2)(i)(C)(1) through (7) or § 414.1380(c)(2)(i)(C)(9)). As a result, MIPS reporting for clinicians who utilized qualified registries or QCDRs that have not previously offered the ability to report performance categories other than quality will be able to report MIPS data in a more streamlined and less burdensome manner.

### ***Improvement Activities Performance Category Data Submission***

User experiences from the CY 2019 performance period/2021 MIPS payment year reflect that the majority of users submit improvement activities data as part of the login and upload or direct submission types which allow data for multiple performance categories (i.e., quality and Promoting Interoperability) to be submitted at once. This results in less additional time required to submit improvement activities data which consists of manually attesting that certain activities were performed. In addition, the same improvement activity may be reported across multiple performance periods so many MIPS eligible clinicians may submit the same information for the CY 2026 performance period/2028 MIPS payment year as they did for previous MIPS performance periods/MIPS payment years. There is also a financial incentive to submit improvement activities data, as clinicians will not receive credit in their MIPS final score otherwise.

In the CY 2025 PFS final rule (89 FR 97710), we finalized two scoring and reporting requirements for the improvement activities performance category beginning with the CY 2025 performance period/2027 MIPS payment year. First, we eliminated the prior differentially weighted model for the improvement activities performance category that established medium- and high-weighted categories. Second, we reduced the number of activities to which clinicians are required to attest to achieve a score in the performance category. As a result, MIPS eligible clinicians who participate in traditional MIPS are required to report two activities and MVP Participants are required to report one activity to achieve 40 points, or full credit. MIPS eligible clinicians who are categorized as small practice, rural, in a provider-shortage area, or non-patient facing are required to report one activity (for either traditional MIPS or MVPs). All MIPS APM participants who report through the APP will receive a full score for the Improvement Activities performance category and therefore do not need to submit additional improvement activity information. We believe these requirements, combined with the financial incentives for submitting improvement activities data, will continue to improve response rates year after year.

### **B4. Test Procedures for Methods to be Undertaken**

We continue to refine our procedures, methods, and testing over time to be more efficient. We do not have any additional testing to describe in this section, including no additional tests that call for answers to identical questions from 10 or more respondents.

As stated above, additional experience with MIPS will provide clarification to optimize reporting thresholds and submission criteria for use in future performance periods across the quality, Promoting Interoperability, and improvement activities performance categories. We will continually evaluate our policies based on our analysis of MIPS and other data.



## **B5. Individuals Consulted on Statistical Aspects and Individuals Collecting or Analyzing Data**

We do not anticipate providing any additional statistical reporting on data other than that presented here for the quality or Promoting Interoperability and improvement activities performance categories.

### ***Quality, Promoting Interoperability, and Improvement Activities Performance Category Data***

We anticipate that a contractor will analyze information collected from individual MIPS eligible clinicians, groups, subgroups, and non-Shared Savings Program ACO APM Entities submitting data to the quality, Promoting Interoperability and improvement activities performance categories.