MVP still the future of QPP, while QP eligibility metric gets personal

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Quality Payment Program

CMS continues to push the specialty-specific MIPS Value Pathways (MVP) model to which it hopes to transition the Quality Payment Program (QPP). But there's still no mandatory adoption date, and the 2026 Merit-based Incentive Payment System (MIPS) and Advanced APM policies are pretty close to the current ones—with a major exception for some Advanced APM providers.

As in the proposed rule, CMS mandates big changes within the MVP program. The agency is adding six MVPs—diagnostic radiology, interventional radiology, neuropsychology, pathology, podiatry and vascular surgery—and also modifying all 21 existing MVPs.

Elsewhere in the rule, CMS says it has a goal of "creating additional MVPs relevant to the practices of 80 percent of MIPS eligible clinicians."

"There are a handful of remaining specialties, such as endocrinology, immunology and geriatrics," says Martie Ross, office managing principal for the PYA consultancy in Kansas City and director of the PYA Center for Rural Health Advancement, "but most of the infrastructure is now complete."

And rather than determine the "specialty composition" of a group when it registers for MVP, CMS now requires the group itself to attest to it. Small multispecialty practices that had been required to form subgroups will get the option of reporting as a group instead.

Still, CMS has begged off setting a date for a mandatory switchover from the current models. Darryl Drevna, senior director of regulatory affairs for the American Medical Group Association (AMGA) in Washington, D.C., believes that CMS is moving in the right direction as far as specialty-based quality care measurement.

Drevna notes that in addition to MVPs, which are "requiring multispecialty practices to attest to their specialty composition during registration," CMS is also introducing the Ambulatory Specialty Model (ASM), which is mandatory for orthopedic and cardiology providers in certain areas (*see story*). ASM "really closely mirrors the MVP concept," Drevna says.

Drevna also considers the advanced primary care management codes (*see story*) as a good example as well, if you think of primary care as a specialty, because "they're based on lessons learned from [the discontinued models] CPC+ and Primary Care First, and are part of an effort to move Medicare to value." All in all, Drevna says, "I think CMS is trying to test multiple approaches rather than fully commit to MVP."

A QP leg-up for some

For the majority of participants who have yet to transfer to MVP, the MIPS threshold stays at 75 points through the CY 2028 performance period "to provide continuity and stability to program participants." MIPS scoring weights and metrics in 2026 remain the same as in 2025, and measures get the usual tweaks.

But a major shift is announced in the Advanced APM program that could mean a bigger payday for many providers.

CMS has modified the methodology used to calculate QP status, which determines what clinicians can take part in that program and receive appropriate payment adjustments. Now in addition to calculating and conferring based on APM performance, CMS will "include an individual calculation for all eligible clinicians in Advanced APMs."

Currently, CMS says, "an eligible clinician who has fully engaged with an Advanced APM may still be unable to earn QP status" due to the agency's analysis of claims data, which may require a group to be registered as an APM entity, and the group may not meet program minimums even if an individual clinician within it does so.

But starting in CY 2026, CMS will check provider data and give QP status to those who meet the metrics—and providers will be rewarded accordingly.

Does it matter?

David Halpert, chief of client team at Roji Health Intelligence in Chicago, finds the QP updates “notable” and counsels individual clinicians who get elevated by the change “to recognize what is at stake and actively engage in the value-based care environment.

This and another aspect of the rule should cause performance payments for many providers in Advanced APMs to inch up: In the new bifurcated conversion factor payment under the final rule, providers in APMs (including Advanced APMs) get a higher boost than non-APM providers—3.8% as opposed to 3.3% (*PBN 11/10/25*). This is on top of the extra conversion factor earned by Qualifying APM Participants (QP) as well as non-QP clinicians in Advanced APMs of, respectively, 0.75% and 0.25%.

Paul Schmeltzer of the Clark Hill law firm in Los Angeles says as small as these differences look on paper, over the course of a year of claims they can add up, and push more MIPS providers to join the Advanced APM model. He notes that the MIPS extraordinary performance bonus ended in 2022, and positive MIPS payment adjustments are very low because MIPS performers aren’t penalized enough to fund them.

“If practices aren’t accruing any penalties, MIPS is not creating a bonus incentive for them,” Schmeltzer says. “I look at it like profit sharing in professional sports—if there’s nobody being egregious with overspending, then there’s not going to be a big pool of money at the end for the other owners who’ve have been more reserved to share in. It can nudge them toward participation in advanced APMs.”

That’s all well and good for those providers, Drevna says, but not necessarily great for the value- and team-based model of care that he believes CMS should be moving toward.

“AMGA has always argued that these calculations should be done at the entity level—to make it as administratively simple as possible, for one thing,” Drevna says. “But also, because if you’re looking at an advanced payment model, the whole idea is a team-based approach É I can appreciate CMS wants to reward those clinicians who might qualify on their own. But it’s the team that matters most. If I play baseball and I hit a home run, that’s great for my stats, but if we lose five to one, it doesn’t matter.”

Other changes

For ACOs that use the APM Performance Pathway (APP) to report as MIPS APMs, several new measures are coming: in 2026, Colorectal Cancer Screening and Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions; in 2027, Initiation and Engagement of Substance Use Disorder Treatment; and in 2028 “or the performance year that is one year after eCQM specifications become available for the measure, whichever is later,” Adult Immunization Status.

In keeping with HHS’ wellness agenda, CMS is issuing “an RFI [request for information] on well-being and nutrition measures in QPP.” It also authorizes other RFIs on the Prescription Drug Monitoring Program (PDMP) Measure and measures under the Public Health and Clinical Data Exchange objective (including on whether to change these from yes/no measures); on “how clinicians exchange health information”; and on digital quality measurement advances such as FHIR and how they affect electronic clinical quality measure (eCQM) reporting.

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