Quality Payment
PROGRAM

Merit-based Incentive Payment System (MIPS)

2026 Quality Performance Category Quick Start Guide

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Purpose:

This resource focuses on the quality performance category, providing the high-level requirements and practical information about quality measure selection, data collection, and submission for the 2026 performance period for individual, group, virtual group, subgroup, and Alternative Payment Model (APM) Entity participation. This resource doesn't address quality requirements under the APM Performance Pathway (APP).

Already know what MIPS is?

Skip ahead by clicking the links in the Table of Contents.

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How to Use This Guide

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Click this icon (on the bottom left of each page) **to return to the table of contents.** 

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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Overview

What Is The Merit-based Incentive Payment System?

If you're eligible for MIPS:

- You report measure and activity data for the quality, improvement activities, and Promoting Interoperability performance categories.
  - Exceptions to these reporting requirements include your MIPS reporting option, special status, extreme and uncontrollable circumstances, or hardship exception. Detailed information for each performance year will be available in the Traditional MIPS Scoring Guide, APP Scoring Guide, and MIPS Value Pathways Implementation Guide. These resources are updated annually and will be posted to the QPP Resource Library.
- We collect and calculate data for the cost performance category for you, if applicable.
  - Exceptions include your MIPS reporting option, participation option, extreme and uncontrollable circumstances, and whether or not you meet case minimum for any cost measures.

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To learn more about MIPS eligibility and participation options:

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

What Is The Merit-based Incentive Payment System? (Continued)

If you're eligible for MIPS (Continued):

- Your performance across the MIPS performance categories, each with a specific weight, will result in a MIPS final score of 0 to 100 points.

- Your MIPS final score will determine whether you receive a negative, neutral, or positive MIPS payment adjustment.
  - **Positive payment adjustment** for clinicians with a final score **above** the performance threshold (**75 points** in 2026 – 2028 performance years).
  - **Neutral payment adjustment** for clinicians with a final score **equal to** the performance threshold (**75 points** in 2026 – 2028 performance years).
  - **Negative payment adjustment** for clinicians with a final score **below** the performance threshold (**75 points** in 2026 – 2028 performance years).

- Your MIPS payment adjustment is based on your performance during the performance year and applied to payments for your Medicare Part B-covered professional services beginning on January 1 of the payment year.
  - E.g., 2028 is the payment year for the 2026 performance year.

Quality Payment PROGRAM

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- Check your current participation status using the QPP Participation Status Tool.

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

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

Traditional MIPS	MIPS Value Pathways (MVPs)	APM Performance Pathway (APP)
• The original reporting option for MIPS. • Visit the Ways to Report - Traditional MIPS webpage to learn more.	• This reporting option offers clinicians a more meaningful and reduced grouping of measures and activities relevant to a specialty or medical condition. • Visit the Ways to Report - MIPS Value Pathways (MVPs) webpage to learn more.	• A streamlined reporting option for **clinicians who participate in a MIPS Alternative Payment Model (APM)**. • Visit the Ways to Report - APM Performance Pathway webpage to learn more.
• You select the quality measures and improvement activities that you'll collect and report from all of the quality measures and improvement activities finalized for MIPS.	• You select an MVP that's applicable to your practice. • Then you choose from the quality measures and improvement activities available in your selected MVP. • You'll report a reduced number of quality measures and improvement activities as compared to traditional MIPS.	• You'll report a predetermined set of quality measures. There are 2 quality measure sets available (APP and APP Plus). • MIPS APM participants currently receive full credit in the improvement activities performance category, though this is evaluated on an annual basis.
• You'll report the complete Promoting Interoperability measure set.	• You'll report the complete Promoting Interoperability measure set (the same as reported in traditional MIPS).	• You'll report the complete Promoting Interoperability measure set (the same as reported in traditional MIPS).
• We collect and calculate data for the cost performance category and any applicable administrative claims measures for you.	• We collect and calculate data for the cost performance category and population health measures for you.	• Cost isn't evaluated under the APP.

Individual, Group, Subgroup*, and Virtual Group** Participation

Traditional MIPS and MVP Performance Category Weights in 2026:

Quality

30% | of MIPS Score

Cost

30% | of MIPS Score

Improvement Activities

15% | of MIPS Score

Promoting Interoperability

25% | of MIPS Score

*Available for MVP reporting only.
**Available for traditional MIPS reporting only.

APM Entity Participation

Traditional MIPS and MVP Performance Category Weights in 2026:

Quality

55% | of MIPS Score

Cost

0% | of MIPS Score

Improvement Activities

15% | of MIPS Score

Promoting Interoperability

30% | of MIPS Score

Standard Weighting for Small Practices

(Promoting Interoperability Automatically Reweighted to 0%)

Traditional MIPS and MVP Performance Category Weights in 2026:

Quality

40% | of MIPS Score

Cost

30% | of MIPS Score

Improvement Activities

30% | of MIPS Score

Promoting Interoperability

0% | of MIPS Score

Individual, Group, and APM Entity Participation

APM Performance Pathway (APP) Performance Category Weights in 2026:

Quality

50% | of MIPS Score

Cost

0% | of MIPS Score

Improvement Activities

20% | of MIPS Score

Promoting Interoperability

30% | of MIPS Score

This resource examines the quality performance category under traditional MIPS and MVPs.
For more information about the quality performance category **under the APP**, please refer to the APP Quality Requirements webpage.

What's New with Quality in 2026?

Updates to Quality Measure Inventory

1	We added 5 new quality measures and removed 10 quality measures from traditional MIPS.
2	There were 30 existing quality measures with substantive changes, 3 of which won't have a historical benchmark because the changes were so significant that it won't allow for a direct comparison of performance data from prior years to performance data submitted for the 2026 performance period.
3	The data completeness threshold will remain at 75% through the 2028 performance year to provide continuity and stability to program participants.

For more information on the new and removed quality measures, please review the Appendix.

What's New with Quality in 2026 (Continued)

Updates to Quality Measures

1

We finalized *19 quality measures that will receive the topped-out measure benchmarks for the 2026 performance period. These measures belong to specialty sets and MVPs with limited measure choice and represent a high proportion of topped out measures in areas that lack measure development.

- For a list of quality measures subject to the topped-out measure benchmarks for the 2026 performance period, please see Appendix E.

*In the 2026 Medicare Physician Fee Schedule Final Rule, we finalized that Measure 141 would receive the defined topped-out measure benchmark. However, we've since determined that the measure doesn't fully meet topped-out criteria for the 2026 performance period and is therefore eligible to receive a historical benchmark based on 2024 performance.

What's New with Quality in 2026 (Continued)

Updates to Quality Measures (Continued)

3

We updated the benchmarking methodology for administrative claims quality measures to align with the benchmarking methodology for cost measures. The median performance rate for an administrative claims measure will be set at a score derived from the performance threshold provided in the table below.

Points	Cut Offs for Admin Claims-based Measures. *(adjust admin claims scoring methodology)*
1 – 1.9	Median + (2.75 x standard deviation)
2 – 2.9	Median + (2.5 x standard deviation)
3 – 3.9	Median + (2.25 x standard deviation)
4 – 4.9	Median + (2 x standard deviation)
5 – 5.9	Median + (1.5 x standard deviation)
6 – 6.9	Median + (1 standard deviation)
7 – 7.9	Median + (0.5 x standard deviation)
8 – 8.9	Median - (0.5 x standard deviation)
9 – 9.9	Median - (1 x standard deviation)
10	Median - (1.5 x standard deviation)

For example: Under the old methodology, the Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with Heart Failure measure had a performance rate of 70%, resulting in 5 – 5.9 points reflected in red. However, under the new methodology, this measure will earn 7 – 7.9 points reflected in green.

Old Methodology (Performance Rate Ranges)	Point Ranges	New Methodology (Performance Rate Ranges)
81.68 – 75.77%	1.0 – 1.9 points	81.77 – 80.69%
75.76 – 73.44%	2.0 – 2.9 points	80.68 – 79.59%
74.43 – 71.92%	3.0 – 3.9 points	79.58 – 78.49%
71.91 – 70.81%	4.0 – 4.9 points	78.48 – 76.30%
70.80 – 69.72%	5.0 – 5.9 points	76.29 – 74.10%
69.71 – 68.79%	6.0 – 6.9 points	74.09 – 71.92%
68.68 – 67.72%	7.0 – 7.9 points	71.91 – 67.53%
67.71 – 66.51%	8.0 – 8.9 points	67.52 – 65.34%
66.50 – 64.97%	9.0 – 9.9 points	65.33 – 63.15%
64.96% and below	10 points	63.14% and below

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Get Started with Quality for Traditional MIPS and MVPs in 5 Steps

Overview

Understand Your Reporting Requirements

Any time

Review & Select Your MIPS Quality Measures

Any time

Collect Your Data

January 1 - December 31, 2026

Submit Your Data

January 4 – March 31, 2027

Review Performance Feedback

Preliminary Feedback: Once Data is Submitted

Final Feedback: Summer 2027

Step 1. Understand Your Reporting Requirements

The quality performance category has a **12-month performance period** (January 1 – December 31, 2026), which means you must collect data for each measure for the full calendar year. Your quality reporting requirements are determined by your MIPS reporting option.

Traditional MIPS	MVPs
Select a minimum of 6 quality measures (including 1 outcome or high priority measure) from the complete MIPS quality measure inventory. **OR** Report 1 **complete specialty measure set.** **Did you know?** • If the specialty set includes fewer than 6 measures, you'll meet reporting requirements if you report all the measures in the specialty set.	**Select a minimum of 4 quality measures** (including 1 outcome or high priority measure) from your chosen MVP. **Did you know?** • For small practices reporting through Medicare Part B claims, if your selected MVP includes fewer than 4 Medicare Part B claims measures available, you don't need to report additional measures to meet quality reporting requirements.

Helpful Hints and Reminders:

- If you report more than the required number of quality measures, we'll pick the highest scored outcome measure and then the next highest scored measures to reach a total of 6 (traditional MIPS) or 4 (MVPs) scored quality measures.
- If you submit the same measure through multiple collection types (i.e., as a Medicare Part B claims measure and as an eCQM), we'll select the higher scoring collection type of the measure based on achievement points.

Did you know? Facility-based clinicians, groups, and virtual groups whose assigned facility has a Fiscal Year (FY) 2027 Hospital Value-Based Purchasing (VBP) Program score may have the option to use their Hospital VBP Program score for the traditional MIPS quality and cost performance categories. For more information on facility-based measurement, please refer to the 2026 Facility-Based Measurement Quick Start Guide that will be available on the QPP Resource Library in Spring 2026.

Step 2. Review & Select Your MIPS Quality Measures

Your quality measure options are determined by your MIPS reporting option.

Traditional MIPS	MVPs
There are 190 MIPS quality measures available (XLSX, 9KB) to report for the 2026 performance period, as well as 198 Qualified Clinical Data Registry (QCDR) measures approved outside the rulemaking process.	Each MVP includes a subset of quality measures that best align with a given specialty or medical condition. Review Explore MVPs for details about the quality measures available in each MVP.

Helpful Hints and Reminders:

- Review your patient population to ensure you'll be able to meet the case minimum requirement (20 cases) on the quality measures you choose to report. You'll earn 0 points for measures that don't the meet case minimum requirement or can't be reliably scored against a benchmark. Small practices will continue to earn 3 points for measures that don't the meet case minimum requirement or can't be reliably scored against a benchmark.
- There are no bonus points available for reporting additional outcome and high priority measures or measures that meet end-to-end electronic reporting criteria.
- You can report measures from multiple collection types to meet quality reporting requirements.
- You can report your quality measures through multiple submission formats (e.g., JSON and QRDA III files).

Step 2. Review & Select Your MIPS Quality Measures (Continued)

Did you know?

- **Collection Type** refers to the way you collect data for a quality measure. While an individual quality measure may be collected in multiple ways, each collection type has its own specification (instructions) for reporting that measure. Follow the measure specifications that correspond with how you choose to collect your quality data.
  - For example: You're looking for a quality measure to report on the Use of High-Risk Medications in the Elderly. This measure is available as both a MIPS Clinical Quality Measure (CQM) and Electronic Clinical Quality Measure (eCQM) (distinct specifications). You would use the measure specification that corresponds with how you choose to collect your data.

Collection Type	Quality Measures Available for 2026	What Do You Need to Know About This Collection Type?
Electronic Clinical Quality Measures (eCQMs)	2026 eCQM specifications 2026 eCQM flows eCQM Implementation and Preparation Checklists	You can report eCQMs if you use technology that meets the Certified Electronic Health Record Technology (CEHRT) certification from the Office of the National Coordinator for Health Information Technology (ONC) by the time eCQM data is generated for submission. You'll need to make sure your CEHRT is updated to collect the most recent version of the measure specification. Please refer to the Implementation Checklist on the Electronic Clinical Quality Improvement (eCQI) website to verify. If you collect data using multiple electronic health record (EHR) systems, you'll need to aggregate your data before it's submitted.

Step 2. Review & Select Your MIPS Quality Measures (Continued)

Collection Type	Quality Measures Available for 2026	What Do You Need to Know About This Collection Type?
MIPS Clinical Quality Measures (MIPS CQMs)	2026 Clinical Quality Measure Specifications and Supporting Documents (ZIP, 1KB) 2026 Qualified Clinical Data Registries Qualified Posting and 2026 Qualified Registries Qualified Posting on the QPP Resource Library	MIPS CQMs are often collected by third party intermediaries and submitted on behalf of MIPS eligible clinicians. If you choose this collection type, you may choose to work with a QCDR, Qualified Registry, or you can submit them yourself.
Qualified Clinical Data Registry (QCDR) Measures	2026 QCDR Measure Specifications (XLSX, 9KB) 2026 Qualified Clinical Data Registries Qualified Posting	QCDRs are CMS-approved entities with the flexibility to develop and track their own quality measures, which are approved along with the entity during their self-nomination period. These measures can be a great option for clinicians and practices that provide specialized care or who have trouble finding MIPS quality measures that feel relevant to their practice. You'll need to work with a QCDR to report these measures on your behalf.

Step 2. Review & Select Your MIPS Quality Measures (Continued)

Collection Type	Quality Measures Available for 2026	What Do You Need to Know About This Collection Type?
Medicare Part B Claims Measures	2026 Medicare Part B Claims Specifications and Supporting Documents (ZIP, 1KB) 2026 Part B Claims Reporting Quick Start Guide	Medicare Part B claims measures are reported with the clinician's individual (rendering) National Provider Identifier (NPI) when reporting as a group, virtual group, subgroup, or APM Entity. Medicare Part B claims measures are only available for small practices (15 or fewer clinicians).
Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey Measure	2026 CAHPS for MIPS Survey Overview Fact Sheet (available on the Quality Payment Program Resource Library in March 2026)	Groups, virtual groups, subgroups, and APM Entities can register between April 1, 2026, and June 30, 2026, to administer the CAHPS for MIPS Survey measure, a survey measuring patient experience of care within a group, virtual group, subgroup, or APM Entity. This survey measure must be administered by a CMS-approved survey vendor. The survey is administered during October 2026 – January 2027.

Step 2. Review & Select Your MIPS Quality Measures (Continued)

Collection Type	Quality Measures Available for 2026	What Do You Need to Know About This Collection Type?
Administrative Claims Measures	Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-based Incentive Payment System (MIPS) Eligible Clinician Groups (ZIP, 792KB) Risk-Standardized Complication Rate (RSCR) Following Electric Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) for Merit-based Incentive Payment System (ZIP, 469KB) Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (ZIP, 1KB) Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with Heart Failure under the Merit-based Incentive Payment System (ZIP, 1KB)	We calculate administrative claims measures automatically; no additional data submission required outside of routine billing. In traditional MIPS reporting, we evaluate you on every administrative claims measure in the MIPS inventory, and we score you on any measure for which you meet the criteria. In MVP reporting, we evaluate you on the population health measures and assign the higher scoring population measure to your quality score. You also have the option to select an outcomes-based administrative claims measure as 1 of your 4 required measures if available in your selected MVP.

Step 3. Collect Your Data (eCQMs, MIPS CQMs, Medicare Part B Claims Measures, and QCDR Measures)

You should start data collection on **January 1, 2026**, to meet data completeness requirements. If you fail to meet data completeness requirements, you'll receive **zero points** for the measure, unless you're a small practice, in which case you'll receive 3 points.

The **data completeness requirement will remain at a threshold of 75%** for the 2026 performance period.

Data completeness refers to the volume of performance data reported for a quality measure's eligible population. Data completeness only applies to the quality performance category.

- Your submission must identify the total eligible population/denominator for the 12-month performance period as outlined in the measure's specification.
- You must report performance data (performance met or not met, or denominator exceptions) for at least 75% of the total eligible population/denominator.

Incomplete reporting of a measure's eligible population or otherwise misrepresenting a clinician or group's performance – only submitting favorable performance data, commonly referred to as "cherry-picking" – wouldn't be considered true, accurate, or complete and may subject you to an audit.

Note: The data completeness threshold will remain at 75% through the 2028 performance period.

Example

There are 200 patients that meet the criteria for a measure's eligible population. When you report the measure, your submission needs to identify the eligible population as 200 patients and report performance data for at least 150 patients (150 is 75% of 200) that are representative of your performance.

- Meets data completeness: Performance Met (100) + Performance Not Met (30) + Denominator Exceptions (30)
  - Performance data reported for 160 (out of 200) patients – 80%
- Doesn't meet data completeness: Performance Met (100) + Performance Not Met (20) + Denominator Exceptions (20)
  - Performance data reported for 140 (out of 200) patients – 70%

Step 3. Collect Your Data (eCQMs, MIPS CQMs, Medicare Part B Claims Measures, and QCDR Measures) (Continued)

Quality Scoring Flexibilities

The following list of reasons could impact a quality measure during the performance period:

- Errors found in the finalized measure specifications.
  - These errors include, but are not limited to:
    - Changes to the active status of codes.
    - The inadvertent omission of codes.
    - The inclusion of inactive or inaccurate codes.
- Updates to ICD-10 codes during the performance period.
  - We publish a list of measures requiring 9 consecutive months of data to be reported on the Quality Payment Program Resource Library by October 1st of the performance period (if technically feasible), but no later than the beginning of the data submission period (for example, January 4, 2027, for the 2026 performance period).
- Clinical guideline changes.
- Updates to measure specifications during the performance period.

For a quality measure impacted by one of the above items, the **quality measure will have a truncated performance period of 9 consecutive months if there are 9 consecutive months of accurate, available data.**

If there aren't 9 consecutive months of available data and revised clinical guidelines, measure specifications, or codes impact a clinician's ability to submit information on the measure, the **measure will be suppressed.**

Step 4. Submit Your Data

We'll assess your performance on the data you submit. If you plan to report an MVP, you're required to include your MVP ID (and subgroup ID if applicable) with your submission.

The data submission period will begin on **January 4, 2027**, and end on **March 31, 2027**. If reporting Medicare Part B claims measures, submission will be continuous throughout the performance period.

Who (Submitter Type)	What (Collection Type)	How (Submission Type)	When
You (Individual, Group, Virtual Group, Subgroup, or APM Entity Representative)	Medicare Part B Claims Measures (small practice only)	Through your routine Medicare Part B billing practices	Throughout the performance period (must be processed by your MAC and received by CMS by March 1, 2027)
	eCQMs	Sign in to the QPP website and upload a QRDA III file	January 4 – March 31, 2027
	MIPS CQMs	Sign in to the QPP website and upload a QPP JSON file	January 4 – March 31, 2027
Third Party Intermediaries QCDRs or Qualified Registries	eCQMs MIPS CQMs QCDR Measures	Sign in to the QPP website and upload a QRDA III or QPP JSON file **OR** Use the QPP Submission Application Programming Interface (API)	January 4 – March 31, 2027
CMS-Approved Survey Vendors	CAHPS for MIPS Survey Measure	Secure method outside of the QPP website	In January 2027 - following data collection (standardized annual timeframe)

Step 4. Submit Your Data (Continued)

Did you know?

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

For example:

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

Note: We'll only calculate a group-level quality performance category score from Medicare Part B claims measures if the practice submits data for another category as a group (signaling their intent to participate as a group).

Exceptions:

When reporting traditional MIPS or an MVP as an APM Entity,

- The Entity will submit quality measures and improvement activities.
- MIPS eligible clinicians in the Entity may submit Promoting Interoperability data as individuals or as a group and we will calculate an average score for this performance category. However, APM Entities also have the option to choose to report Promoting Interoperability data at the APM Entity level.

When reporting an MVP as a subgroup:

- The subgroup collects and aggregates quality measures and improvement activities at the subgroup level.
- The subgroup will submit their affiliated group's Promoting Interoperability data (aggregated for the whole TIN, not just the clinicians in the subgroup).
- CMS will calculate cost and administrative claims quality measures at the affiliate group level.

Step 4. Submit Your Data (Continued)

Did You Know?

You can't combine performance data submitted between different reporting options into a single final score or submit performance data for one category and count it for both traditional MIPS and MVP reporting options.

For example, Promoting Interoperability data can't be reported for traditional MIPS and count towards the Promoting Interoperability category for an MVP. The Promoting Interoperability data may be the same, however, there must be 2 separate submissions: one for traditional MIPS and one for MVP reporting (with the appropriate MVP identifier and subgroup identifier, if applicable).

Reporting an MVP?

Each MVP submission must include the related MVP ID, signaling your intent to report the measure data for your selected MVP. **Any data submitted without the necessary MVP ID will be attributed to traditional MIPS instead of the MVP**. If participating through a subgroup, you'll also need to include the subgroup identifier given to you by CMS for your MVP submission.

For a list of MVP identifiers to add to your MVP submission, please review Appendix D.

Step 5. Review Your Performance Feedback

- Measure- and activity-level scores will be available starting on **January 4, 2027,** once data has been submitted.
- Your MIPS final score will be available in **summer 2027**, and payment adjustment information will be available approximately 30 days later.
- The Targeted Review period will open when final scores are released and close 30 days after the release of your payment adjustment information.
- You can review your performance feedback by signing in to QPP website.
- In addition to your final score and payment adjustment, MVP participants will receive "MVP Comparative Feedback." MVP comparative feedback will highlight how your performance compares at the category level to other clinicians reporting the same MVP.

Small Practice Bonus Points

- Small practices (15 or fewer clinicians, reporting individually, as a group, virtual group, subgroup, or APM Entity) that submit at least one quality measure will continue to earn 6 bonus points
- These points will be added to their quality performance category score when performance feedback is released.

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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
03/02/2026	Updated to remove the defined topped-out measure benchmark for Measure 141 as it's since been determined that the measure doesn't fully meet topped-out criteria for the 2026 performance period and is therefore eligible to receive a historical benchmark based on 2024 performance.
12/19/2025	Original Version.

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Appendix

Appendix A: New Quality Measures Finalized for the 2026 Performance Period and Future Years

MIPS Quality ID	MIPS Quality Measure Title	Collection Type	Measure Type
512	Prevalent Standardized Kidney Transplant Waitlist Ratio (PSWR)	MIPS CQM	Process
513	Patient Reported Falls and Plan of Care	MIPS CQM	Process
514	Diagnostic Delay of Venous Thromboembolism in Primary Care	eCQM	Intermediate Outcome
515	Screening for Abnormal Glucose Metabolism in Patients at Risk of Developing Diabetes	eCQM	Process
516	Hepatitis C Virus (HCV): Sustained Virological Response (SVR)	MIPS CQM	Outcome

Appendix B: Quality Measures Finalized for Removal for the 2026 Performance Period and Future Years

MIPS Quality ID	MIPS Quality Measure Title	Collection Type	Measure Type
185	Colonoscopy Interval for Patients with a History of Adenomatous Polyps	MIPS CQM	Process
264	Sentinel Lymph Node Biopsy for Invasive Breast Cancer	MIPS CQM	Process
290	Assessment of Mood Disorders and Psychosis for Patients with Parkinson's Disease	MIPS CQM	Process
322	Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low-Risk Surgery Patients	MIPS CQM	Efficiency
419	Overuse of Imaging for the Evaluation of Primary Headache	MIPS CQM	Process
424	Perioperative Temperature Management	MIPS CQM	Outcome
443	Non-Recommended Cervical Cancer Screening in Adolescent Females	MIPS CQM	Process
487	Screening for Social Drivers of Health	MIPS CQM	Process
498	Connection to Community Service Provider	MIPS CQM	Process
508	Adult COVID-19 Vaccination Status	MIPS CQM	Process

Appendix C: Measures with Substantive Changes Finalized for the 2026 Performance Period, Resulting in No Historical Benchmark for the 2026 Performance Period

MIPS Quality ID	MIPS Quality Measure Title	Collection Type	Measure Type
493	Adult Immunization Status	MIPS CQM	Process
500	Acute Posterior Vitreous Detachment Appropriate Examination and Follow-up	MIPS CQM	Process
501	Acute Posterior Vitreous Detachment and Acute Vitreous Hemorrhage Appropriate Examination and Follow-up	MIPS CQM	Process

Appendix D: MVP Identifiers

MVP Identifier	MVP
G0057	Adopting Best Practices and Promoting Patient Safety within Emergency Medicine
M001	Advancing Cancer Care
G0055	Advancing Care for Heart Disease
G0053	Advancing Rheumatology Patient Care
G0054	Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes
G0058	Improving Care for Lower Extremity Joint Repair
M0002	Optimal Care for Kidney Health
G0059	Patient Safety and Support of Positive Experiences with Anesthesia
M0004	Quality Care for Patients with Neurological Conditions
M0005	Value in Primary Care

Appendix D: MVP Identifiers (Continued)

MVP Identifier	MVP
M1366	Focusing on Women's Health
M1367	Quality Care for the Treatment of Ear, Nose, and Throat Disorders
M1368	Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV
M1369	Quality Care in Mental Health and Substance Use Disorders
M1370	Rehabilitative Support for Musculoskeletal Care
M1420	Complete Ophthalmologic Care
M1421	Dermatological Care
M1422	Gastroenterology Care
M1423	Optimal Care for Patients with Urologic Conditions
M1424	Pulmonology Care

Appendix D: MVP Identifiers (Continued)

MVP Identifier	MVP
M1425	Surgical Care
M1498	**New:** Diagnostic Radiology
M1499	**New:** Interventional Radiology
M1500	**New:** Neuropsychology
M1501	**New:** Pathology
M1502	**New:** Podiatry
M1503	**New:** Vascular Surgery

Appendix E: Quality Measures Subject to the Topped-Out Measure Benchmarks Policy

MIPS Quality ID	Measure Title	Collection Type
*141 - UPDATED	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 20% OR Documentation of a Plan of Care	Medicare Part B Claims
143	Oncology: Medical and Radiation – Pain Intensity Quantified	eCQM, MIPS CQM
144	Oncology: Medical and Radiation – Plan of Care for Pain	MIPS CQM
249	Barrett's Esophagus	Medicare Part B Claims, MIPS CQM
250	Radical Prostatectomy Pathology Reporting	Medicare Part B Claims, MIPS CQM
320	Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	Medicare Part B Claims

*In the 2026 Medicare Physician Fee Schedule Final Rule, we finalized that Measure 141 would receive the defined topped-out measure benchmark. However, we've since determined that the measure doesn't fully meet topped-out criteria for the 2026 performance period and is therefore eligible to receive a historical benchmark based on 2024 performance.

Appendix E: Quality Measures Subject to the Topped-Out Measure Benchmarks Policy (Continued)

MIPS Quality ID	Measure Title	Collection Type
350	Total Knee or Hip Replacement: Shared Decision-Making: Trial of Conservative (Non-surgical) Therapy	MIPS CQM
351	Total Knee or Hip Replacement: Venous Thromboembolic and Cardiovascular Risk Evaluation	MIPS CQM
360	Optimizing Patient Exposure to Ionizing Radiation: Count of Potential High Dose Radiation Imaging Studies: Computed Tomography (CT) and Cardiac Nuclear Medical Studies	MIPS CQM
364	Optimized Patient Exposure to Ionizing Radiation: Appropriateness: Follow-up CT imaging for Incidentally Detected Pulmonary Nodules According to Recommended Guidelines	MIPS CQM
395	Lung Cancer Reporting (Biopsy/Cytology Specimens)	Medicare Part B Claims, MIPS CQM
396	Lung Cancer Reporting (Resection Specimens)	MIPS CQM
397	Melanoma Reporting	Medicare Part B Claims, MIPS CQM

Appendix E: Quality Measures Subject to the Topped-Out Measure Benchmarks Policy (Continued)

MIPS Quality ID	Measure Title	Collection Type
405	Appropriate Follow-up Imaging for Incidental Abdominal Lesions	MIPS CQM
406	Appropriate Follow-up Imaging for Incidental Thyroid Nodules in Patients	**Medicare Part B Claims,** MIPS CQM
430	Prevention of Post-Operative Nausea and Vomiting (PONV) - Combination Therapy	MIPS CQM
440	Skin Cancer: Biopsy Reporting Time Pathologist to Clinician	MIPS CQM
463	Prevention of Post-Operative Vomiting (POV) Combination Therapy (Pediatrics)	MIPS CQM
477	Multimodal Pain Management	MIPS CQM