Quality Payment
PROGRAM

# Calendar Year (CY) 2026 Medicare Physician Fee Schedule (PFS) Final Rule: Quality Payment Program (QPP) Fact Sheet and Policy Comparison Table

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## QPP Overview: Finalized Policies

In the CY 2026 Medicare PFS Final Rule, we finalized a limited number of policies for QPP, keeping our focus on stability in the program. Our policies support the continuing transformation of the Merit-based Incentive Payment System (MIPS) through MIPS Value Pathways (MVPs), and center on alignment across programs as well as responsiveness to feedback and concerns raised by interested parties.

### Policy Highlights

#### *MIPS Value Pathways (MVPs) Development & Strategy*

- We finalized **6 new MVPs** to be available for reporting in the CY 2026 performance period:
  - Diagnostic Radiology
  - Interventional Radiology
  - Neuropsychology
  - Pathology
  - Podiatry
  - Vascular Surgery
- We're **modifying all 21 existing MVPs**, in alignment with finalized updates to the quality measure and improvement activity inventories.
- **Groups will attest to their specialty composition (whether they're a single specialty group or multispecialty group that meets the requirements of a small practice) during the MVP registration process.** (i.e., CMS won't

make this determination for them.) We believe this policy will support groups in their transition to MVP reporting and will help them assess their need to participate as subgroups.

- **Multispecialty small practices will still be able to report an MVP as a group,** and they won't be required to form subgroups beginning in the CY 2026 performance period. (i.e., Subgroup reporting will remain optional for multispecialty small practice.)
- **Qualified Clinical Data Registries (QCDRs) and Qualified Registries will have one year after a new MVP is finalized before they're required to fully support that MVP**, to provide more time to implement necessary system updates to capture the measures and activities finalized for inclusion.

### *Performance Threshold*

The performance threshold is the final score needed to avoid a negative MIPS payment adjustment.

- We've set the **performance threshold at 75 points through the CY 2028 performance period**/2030 MIPS payment year, to provide continuity and stability to program participants.

### *MIPS Performance Categories*

**Quality:**

- We finalized **changes to the Alternative Payment Models (APM) Performance Pathway (APP) Plus quality measure set** to maintain alignment with the MIPS quality measure inventory.

**Cost:**

- We **updated candidate event and attribution rules for the Total Per Capita Cost (TPCC) measure**.
- We established a **2-year informational-only feedback period for new cost measures**, allowing clinicians to receive feedback on their score(s) and find opportunities to improve performance before a new cost measure affects their MIPS final score.

**Improvement Activities:**

- We're **adding 3 new improvement activities, modifying 7 improvement activities, and removing 8 improvement activities**.
- We **added a new subcategory titled "Advancing Health and Wellness"** and **removed the "Achieving Health Equity" subcategory**.

**Promoting Interoperability:**

- We **updated the** High Priority Practices Safety Assurance Factors for Electronic Health Record (EHR) Resilience **(SAFER) Guide measure** and the **Security Risk Analysis measure.**
- There's **a new optional/bonus measure for the Public Health and Clinical Data Exchange objective**, specifically the Public Health Reporting Using Trusted Exchange Framework and Common Agreement™ (TEFCA) measure.
- We established **a measure suppression policy for the MIPS Promoting Interoperability performance category** and the **Medicare Promoting Interoperability Program**.
- We're **suppressing the Electronic Case Reporting measure for the current CY 2025 performance period/2027 MIPS payment year** for the **MIPS Promoting Interoperability performance category** and the **Medicare Promoting Interoperability Program**. This policy is due to the Centers for Disease Control and Prevention (CDC) temporarily pausing the onboarding of new healthcare organizations for production of electronic case reporting data and new local public health agencies for receipt of electronic case reporting.

### *Advanced APMs*

- We added a **determination of Qualifying APM Participant (QP) status at the individual level for all eligible clinicians in Advanced APMs**, in addition to determinations at the APM Entity level. As part of the effort to simplify this process, we are also adding a calculation based on Covered Professional Services as the set of services used for QP determinations.

### *Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs)*

- We revised the definition of a "beneficiary eligible for Medicare Clinical Quality Measures for Accountable Care Organizations Participating in the Medicare Shared Savings Program (Medicare CQMs)", for performance year 2025 and subsequent performance years, to reduce ACOs' burden in the patient matching necessary to report Medicare CQMs because the list of beneficiaries eligible for Medicare CQMs will have greater overlap with the list of beneficiaries that are assignable to an ACO.

## QPP Policy Comparison Table: Previous Policies vs. Newly Finalized Policies

- MIPS Overview
- Advanced APMs Overview

## Frequently Asked Questions

### Appendices

- Appendix A: Previously Finalized Policies for the 2026 Performance Period
- Appendix B: New Quality Measures Finalized for the 2026 Performance Period and Future Years
- Appendix C: Quality Measures Finalized for Removal for the 2026 Performance Period and Future Years
- Appendix D: New Improvement Activities Finalized for the 2026 Performance Period and Future Years
- Appendix E: Improvement Activities Finalized for Removal for the 2026 Performance Period and Future Years
- Appendix F: Improvement Activities Previously Finalized for Removal for the 2026 Performance Period and Future Years

The **2026 Finalized MVPs Guide (PDF)** documents information about the newly finalized MVPs and modifications to previously finalized MVPs.

The **Medicare Shared Savings Program Fact Sheet** documents information about finalized policies specific to Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs).

## MIPS Overview

The following table outlines finalized policies applicable to one or more MIPS reporting options. There are 3 MIPS reporting options available:

- Traditional MIPS
- MIPS Value Pathways (MVPs)
- Alternative Payment Model (APM) Performance Pathway (APP)

Refer to the **2026 Finalized MVPs Guide (PDF)** for information about the new and modified MVPs finalized for the CY 2026 performance period.

<table>
<tr><th>POLICY AREA</th><th>EXISTING POLICY</th><th>CY 2026 FINALIZED POLICY</th><th>APPLICABLE MIPS REPORTING OPTION(S)</th></tr>
<tr><td colspan="4">MIPS Value Pathways (MVPs) Development and Strategy</td></tr>
<tr><td>MVP Development and Maintenance</td><td>MVP Inventory<br>There are 21 MVPs finalized for reporting in the CY 2025 performance period.</td><td>MVP Inventory<br>We finalized the addition of 6 new MVPs* to the MVP inventory:<br>• Diagnostic Radiology<br>• Interventional Radiology<br>• Neuropsychology<br>• Pathology<br>• Podiatry<br>• Vascular Surgery<br>We're also finalizing modifications to the 21 previously finalized MVPs.<br>*Refer to the Third Party Intermediaries section for a finalized policy about the timeline for QCDRs and Qualified Registries to fully support newly finalized MVPs.</td><td>• MVPs</td></tr>
</table>

| POLICY AREA | EXISTING POLICY | CY 2026 FINALIZED POLICY | APPLICABLE MIPS REPORTING OPTION(S) |
|---|---|---|---|
| **MVP Reporting: Single Specialty Group** | **Definition/Determination**<br>A single specialty group means a group as defined at § 414.1305 that consists of one specialty type as determined by CMS using Medicare Part B claims. | **Definition/Determination**<br>A single specialty group means a group that consists of clinicians in one specialty type or clinicians involved in a single focus of care.<br>We finalized that **groups will attest to their specialty composition** (whether they're a single specialty group or a multispecialty group that meets the requirements of a small practice) **during the MVP registration process**. (i.e., CMS won't make this determination for them.) | • MVPs |
| **Subgroup Reporting: Multispecialty Groups** | **Definition/Determination**<br>A multispecialty group means a group as defined at §414.1305 that consists of 2 or more specialty types as determined by CMS using Medicare Part B claims. | **Definition/Determination**<br>A multispecialty group means a group that consists of clinicians in 2 or more specialty types **or clinicians involved in multiple foci of care**. | • MVPs |

<table>
<tr><th>POLICY AREA</th><th>EXISTING POLICY</th><th>CY 2026 FINALIZED POLICY</th><th>APPLICABLE MIPS REPORTING OPTION(S)</th></tr>
<tr><td>Subgroup Reporting: Small Practice Multispecialty Groups</td><td>Participation Options<br>Beginning with the CY 2026 performance period, multispecialty groups interested in reporting an MVP can't register as a group to report an MVP.<br>Multispecialty groups that want to report an MVP must register at the subgroup, individual, or APM Entity level.</td><td>Participation Options<br>We finalized an exception to this policy for multispecialty small practices. Specifically:<br>• Multispecialty groups with the small practice special status (15 or fewer clinicians) may continue to register to report an MVP as a group.<br>• Multispecialty groups with the small practice special status aren't required to register as subgroups if they don't want to report as individuals.<br>We also updated the definition of an MVP Participant to include multispecialty small practices.<br>Specifically, beginning with the CY 2026 performance period, an MVP Participant means an individual MIPS eligible clinician, single-specialty group, multispecialty group that meets the requirements of a small practice, subgroup, or APM Entity.</td><td>• MVPs</td></tr>
</table>

| POLICY AREA | EXISTING POLICY | CY 2026 FINALIZED POLICY | APPLICABLE MIPS REPORTING OPTION(S) |
|---|---|---|---|
| **Quality Performance Category** | | | |
| **Quality Measures** | **Quality Measure Inventory**<br>There are 195 quality measures available for the 2025 performance period, excluding Qualified Clinical Data Registry (QCDR) measures which are approved outside the rulemaking process and are excluded from this total. | **Quality Measure Inventory**<br>We finalized a total of 190 quality measures for the CY 2026 performance period. Note that QCDR measures are approved outside the rulemaking process and are excluded from this total.<br>The updated quality measure inventory reflects:<br>• Addition of 5 quality measures, including 2 eCQMs. (See Appendix B).<br>• Removal of 10 quality measures from the MIPS quality measure inventory. (See Appendix C).<br>• Substantive changes to 30 existing quality measures. | • **Traditional MIPS**<br>• **MVPs**<br>• **APP** |
| **Quality Measures** | **Definition of High Priority Measure**<br>At 42 CFR 414.1305, we define a high priority measure as an “outcome (including intermediate-outcome and patient-reported outcome), appropriate use, patient safety, efficiency, patient experience, care coordination, opioid, or health equity-related quality measure”. | **Definition of High Priority Measure**<br>We're **removing health equity** from the definition of a high priority measure; the revised definition is:<br>• An outcome (including intermediate-outcome and patient-reported outcome), appropriate use, patient safety, efficiency, patient experience, care coordination, or opioid quality measure. | • **Traditional MIPS**<br>• **MVPs** |

| POLICY AREA | EXISTING POLICY | CY 2026 FINALIZED POLICY | APPLICABLE MIPS REPORTING OPTION(S) |
|---|---|---|---|
| **Quality Measures** | **Medicare CQMs (available for Shared Savings Program ACOs only)**<br>For performance year 2024 and subsequent performance years, we established Medicare Clinical Quality Measures for Accountable Care Organizations Participating in the Medicare Shared Savings Program (Medicare CQMs) as a new collection type for Shared Savings Program ACOs.<br>Under the Medicare CQM collection type, an ACO that participates in the Shared Savings Program is required to collect and report data on only the ACO's Medicare fee-for-service beneficiaries that meet the definition of a beneficiary eligible for Medicare CQM at 42 CFR 425.20, instead of its all payer/all patient population. | **Medicare CQMs (available for Shared Savings Program ACOs only)**<br>We revised the definition of a "beneficiary eligible for Medicare CQMs" at 42 CFR 425.20 for performance year 2025 and subsequent performance years, to require at least one primary care service with a date of service during the applicable performance year from an ACO professional who is a primary care physician or who has one of the specialty designations included in § 425.402(c), or who is a physician assistant, nurse practitioner, or clinical nurse specialist.<br><br>Revising the definition of a beneficiary eligible for Medicare CQMs will reduce ACOs' burden in the patient matching necessary to report Medicare CQMs because the list of beneficiaries eligible for Medicare CQMs will have greater overlap with the list of beneficiaries that are assignable to an ACO. | • **APP** |

| POLICY AREA | EXISTING POLICY | CY 2026 FINALIZED POLICY | APPLICABLE MIPS REPORTING OPTION(S) |
|---|---|---|---|
| **Quality Measure Scoring** | **Defined Topped Out Measure Benchmarks**<br>An **alternative benchmarking methodology applies to a subset of topped out measures** (those that belong to specialty sets with limited measure choice and a high proportion of topped out measures, in areas that lack measure development, which precludes meaningful participation in MIPS.) | **Defined Topped Out Measure Benchmarks**<br>We finalized *19 quality measures that will receive the previously defined topped out measure benchmarks for the CY 2026 performance period. These measures belong to specialty sets and MVPs with limited measure choice and a high proportion of topped out measures, in areas that lack measure development, which precludes meaningful participation in MIPS.<br>* **Updated:** 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.<br>Refer to this FAQ for a list of these measures. (FAQ section follows the policy comparison table). | • **Traditional MIPS**<br>• **MVPs** |

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<tr><td>Quality Measure Scoring<br>(continued)</td><td>Defined Topped Out Measure Benchmarks (continued)<br>Specifically, we'll apply the following benchmarks to measures finalized through rulemaking.<br><table>
<tr><th>Performance Rate</th><th>Available Points</th></tr>
<tr><td>84 – 85.9%</td><td>1 – 1.9</td></tr>
<tr><td>86 – 87.9%</td><td>2 – 2.9</td></tr>
<tr><td>88 – 89.9%</td><td>3 – 3.9</td></tr>
<tr><td>90 – 91.9%</td><td>4 – 4.9</td></tr>
<tr><td>92 – 93.9%</td><td>5 – 5.9</td></tr>
<tr><td>94 – 95.9%</td><td>6 – 6.9</td></tr>
<tr><td>96 – 97.9%</td><td>7 – 7.9</td></tr>
<tr><td>98 – 98.9%</td><td>8 – 8.9</td></tr>
<tr><td>99 – 99.99%</td><td>9 – 9.9</td></tr>
<tr><td>100%</td><td>10</td></tr>
</table></td><td></td><td><ul><li>Traditional MIPS</li><li>MVPs</li></ul></td></tr>
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<tr>
<td>Quality Measure Scoring<br>(continued)</td>
<td>Benchmarking Methodology for Scoring Administrative Claims-based Quality Measures<br>Administrative claims-based quality measures are scored against performance period benchmarks, calculated using the same methodology as all other collection types.</td>
<td>Benchmarking Methodology for Scoring Administrative Claims-based Quality Measures<br>We're updating the benchmarking methodology for administrative claims quality measures to align with the benchmarking methodology for cost measures beginning with the CY 2025 performance period/2027 MIPS payment year.<br>The median performance rate for a measure will be set at a score derived from the performance threshold.
<ul>
<li>For the CY 2025 performance period/2027 MIPS payment year, the median will be set at 7.5, the performance threshold equivalent.</li>
<li>The cut-offs for benchmark point ranges will then be calculated based on standard deviations from the median (See table below).</li>
<li>Refer to this FAQ for an example of how this change could affect scores. (FAQ section follows the policy comparison table.)</li>
</ul>
<table>
<tr><th>Points</th><th>Cut Offs for Admin Claims-based Measures. (adjust admin claims scoring methodology)</th></tr>
<tr><td>1 – 1.9</td><td>Median + (2.75 x standard deviation)</td></tr>
<tr><td>2 – 2.9</td><td>Median + (2.5 x standard deviation)</td></tr>
<tr><td>3 – 3.9</td><td>Median + (2.25 x standard deviation)</td></tr>
<tr><td>4 – 4.9</td><td>Median + (2 x standard deviation)</td></tr>
<tr><td>5 – 5.9</td><td>Median + (1.5 x standard deviation)</td></tr>
<tr><td>6 – 6.9</td><td>Median + (1 standard deviation)</td></tr>
<tr><td>7 – 7.9</td><td>Median + (0.5 x standard deviation)</td></tr>
<tr><td>8 – 8.9</td><td>Median - (0.5 x standard deviation)</td></tr>
<tr><td>9 – 9.9</td><td>Median - (1 x standard deviation)</td></tr>
<tr><td>10</td><td>Median - (1.5 x standard deviation)</td></tr>
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<td>
<ul>
<li>Traditional MIPS</li>
<li>MVPs</li>
<li>APP</li>
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<tr>
<td>Alternative Payment Model (APM) Performance Pathway (APP) Plus Quality Measure Set</td>
<td>Alternative Payment Model (APM) Performance Pathway (APP) Plus Quality Measure Set<br>The following measures were finalized for inclusion in the APP Plus quality measure beginning in the identified performance period.
<table>
<tr><th>Measure Name (Quality ID)</th><th>Performance Period</th></tr>
<tr><td>Diabetes: Glycemic Status Assessment Greater Than 9% (Quality #001, previously named Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%))</td><td>2025</td></tr>
<tr><td>Preventive Care and Screening: Screening for Depression and Follow-up Plan (Quality #134)</td><td>2025</td></tr>
<tr><td>Controlling High Blood Pressure (Quality #236)</td><td>2025</td></tr>
<tr><td>CAHPS for MIPS Survey (Quality #321)</td><td>2025</td></tr>
<tr><td>Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible MIPS Clinician Groups (Quality #479)</td><td>2025</td></tr>
<tr><td>Breast Cancer Screening (Quality #112)</td><td>2025</td></tr>
<tr><td>Colorectal Cancer Screening (Quality #113)</td><td>2026</td></tr>
</table>
</td>
<td>APP Plus Quality Measure Set<br>We updated the APP Plus quality measure set under the APP, in alignment with finalized policies for the MIPS quality measure inventory:<br>Specifically, the Screening for Social Drivers of Health measure (Quality ID 487) has been removed from the APP Plus quality measure set.
<table>
<tr><th>Measure Name (Quality ID)</th><th>Performance Period</th></tr>
<tr><td>Diabetes: Glycemic Status Assessment Greater Than 9% (Quality #001, previously named Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%))</td><td>2025</td></tr>
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<table>
<tr><th>Measure Name (Quality ID)</th><th>Performance Period</th></tr>
<tr><td>Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions measure (Quality #484, not included in the Adult Universal Foundation)</td><td>2026</td></tr>
<tr><td>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Quality #305)</td><td>2027</td></tr>
<tr><td>Screening for Social Drivers of Health (Quality #487)</td><td>2028 or the performance period that is one year after the eCQM specification becomes available, whichever is later</td></tr>
<tr><td>Adult Immunization Status (Quality #493)</td><td>2028 or the performance period that is one year after the eCQM specification becomes available, whichever is later</td></tr>
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<tr><td>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Quality #305)</td><td>2027</td></tr>
<tr><td>Adult Immunization Status (Quality #493)</td><td>2028 or the performance period that is one year after the eCQM specification becomes available, whichever is later</td></tr>
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| POLICY AREA | EXISTING POLICY | CY 2026 FINALIZED POLICY | APPLICABLE MIPS REPORTING OPTION(S) |
|---|---|---|---|
| **Cost Performance Category** | | | |
| **Cost Measures** | **Inventory**<br>There is a total of 35 cost measures available in the CY 2025 performance period. | **Inventory**<br>We're not expanding or reducing the existing inventory of 35 cost measures for the CY 2026 performance period, but we're modifying the Total Per Capita Cost (TPCC) measure. | • **Traditional MIPS**<br>• **MVPs** |
| **Cost Measures** | **Total Per Capita Cost (TPCC) Measure**<br>TPCC is a population-based cost measure that assesses the overall cost of care delivered to a patient with a focus on the primary care they receive from their providers. | **Total Per Capita Cost (TPCC) Measure**<br>We've **modified the TPCC measure candidate event and attribution criteria** to limit instances where TPCC is attributed to highly specialized groups based solely on billing of advanced care practitioners.<br>Specifically, we finalized changes that:<br>• Exclude any candidate events initiated by an advanced care practitioner Taxpayer Identification Number-National Provider Identifier (TIN-NPI) if all other non-advanced care practitioner TIN-NPIs in their group are excluded based on the specialty exclusion criteria;<br>• Require the second service used to initiate a second candidate event to be an E/M service or other related primary care service provided within 90 days of the initial candidate event service by a TIN-NPI within the same TIN; and<br>• Require the second service used to initiate a candidate event be provided by a TIN-NPI that has not been excluded from the measure based on specialty exclusion criteria.<br>You can review the TPCC Measure Information Form on the CMS website for details about the modifications to the TPCC measure. | • **Traditional MIPS**<br>• **MVPs** |

| POLICY AREA | EXISTING POLICY | CY 2026 FINALIZED POLICY | APPLICABLE MIPS REPORTING OPTION(S) |
|---|---|---|---|
| **Cost Evaluation** | **Informational-Only Feedback Period**<br>No existing policy | **Informational-Only Feedback Period**<br>We finalized a 2-year informational-only feedback period for new cost measures beginning with the CY 2026 performance period. (Please note that there aren't any new cost measures for implementation in the 2026 performance period.)<br>• MIPS eligible clinicians, groups, virtual groups, and subgroups will **receive informational-only scoring feedback on a new cost measure (or measures) for 2 years before it contributes to their final score**.<br>**Example:**<br>A new cost measure is finalized for the CY 2027 performance period/2029 MIPS payment year. A MIPS eligible group meets the measure's criteria for the CY 2027, 2028, and 2029 performance periods.<br>• The group will receive informational feedback on the measure for the 2027 and 2028 performance periods, but the measure won't contribute to the group's MIPS final scores for the CY 2027 performance period/2029 MIPS payment year or the CY 2028 performance period/2030 MIPS payment year.<br>• The group will be scored on the cost measure for the CY 2029 performance period, and it will contribute to their MIPS final score for the CY 2029 performance period/2031 MIPS payment year. | • **Traditional MIPS**<br>• **MVPs** |

| POLICY AREA | EXISTING POLICY | CY 2026 FINALIZED POLICY | APPLICABLE MIPS REPORTING OPTION(S) |
|---|---|---|---|
| **Improvement Activities Performance Category** | | | |
| **Improvement Activities** | **Inventory**<br>There are 104* improvement activities available for the 2025 performance period.<br>*Please note that on May 6, 2025, we announced the suspension of 8 improvement activities for the 2025 performance period. | **Inventory**<br>We finalized the following changes to the improvement activities inventory for the 2026 performance period:<br>• Addition of 3 new activities (See Appendix D)<br>• Modification of 7 existing activities<br>• Removal of 8 activities (See Appendix E)<br>We've also removed the Achieving Health Equity (AHE) subcategory for improvement activities, replacing it with the new Advancing Health and Wellness (AHW) subcategory. | • **Traditional MIPS**<br>• **MVPs** |

| POLICY AREA | EXISTING POLICY | CY 2026 FINALIZED POLICY | APPLICABLE MIPS REPORTING OPTION(S) |
|---|---|---|---|
| **Promoting Interoperability Performance Category** | | | |
| **Promoting Interoperability Measure Inventory** | **Protect Patient Health Information Objective, Security Risk Analysis Measure**<br>This measure requires MIPS eligible clinicians to attest "Yes" or "No" to having conducted or reviewed a security risk analysis in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Security Rule. | **Protect Patient Health Information Objective, Security Risk Analysis Measure**<br>We modified this measure **to include a second attestation component that requires MIPS eligible clinicians to attest "Yes" or "No" to having conducted security risk management as required under the risk management component of the HIPAA Security Rule in addition to the existing measure requirement** to attest "Yes" or "No" to having conducted or reviewed a security risk analysis in accordance with the HIPAA Security Rule.<br>• The measure remains required.<br>• A "No" response for the measure will continue to result in a total score of zero points for the Promoting Interoperability performance category. | • **Traditional MIPS**<br>• **MVPs**<br>• **APP** |
| **Promoting Interoperability Measure Inventory** | **High Priority Practices SAFER Guide Measure**<br>The High Priority Practices SAFER Guide measure requires MIPS eligible clinicians to attest "Yes" or "No" to completing an annual self-assessment using the High Priority Practices Guide within the 2016 SAFER Guides. | **High Priority Practices SAFER Guide Measure**<br>We modified the High Priority Practices SAFER Guide measure by **requiring the use of the 2025 SAFER Guides.**<br>A MIPS eligible clinician will attest "Yes" or "No" to completing an annual self-assessment using the High Priority Practices Guide within the 2025 SAFER Guides.<br>• The measure remains required.<br>• A "No" response for the measure will continue to result in a total score of zero points for the Promoting Interoperability performance category. | • **Traditional MIPS**<br>• **MVPs**<br>• **APP** |

| POLICY AREA | EXISTING POLICY | CY 2026 FINALIZED POLICY | APPLICABLE MIPS REPORTING OPTION(S) |
|---|---|---|---|
| **Promoting Interoperability Measure Inventory** | **Public Health and Clinical Data Exchange Objective Optional Bonus Measures**<br>There are 3 optional bonus measures:<br>• Syndromic Surveillance Reporting,<br>• Public Health Registry Reporting, and<br>• Clinical Data Registry Reporting.<br>A maximum of 5 points can be earned if reporting one, more than one, or all optional bonus measures. | **Public Health and Clinical Data Exchange Objective, Adopting the Public Health Reporting Using TEFCA Optional Bonus Measure**<br>We modified the Public Health and Clinical Data Exchange objective by adopting a new **optional bonus measure:** the **Public Health Reporting Using TEFCA** measure.<br>• A MIPS eligible clinician will attest that they're in active engagement (validated data production) with a public health agency to transfer health information using TEFCA.<br>• The measure is **1 of 4 available bonus measures under the Public Health and Clinical Data Exchange objective**, in which a maximum of 5 points can be earned if reporting one, more than one, or all optional bonus measures. | • **Traditional MIPS**<br>• **MVPs**<br>• **APP** |

| POLICY AREA | EXISTING POLICY | CY 2026 FINALIZED POLICY | APPLICABLE MIPS REPORTING OPTION(S) |
|---|---|---|---|
| **Promoting Interoperability Measure Inventory** | **Measure Suppression Policy**<br>No existing policy. | **Measure Suppression Policy**<br>We adopted a measure suppression policy for the MIPS Promoting Interoperability performance category and the Medicare Promoting Interoperability Program.<br>• We established criteria for determining circumstances in which a measure could be suppressed; a suppressed measure won't be assessed for performance for MIPS eligible clinicians meeting the reporting requirements of the MIPS Promoting Interoperability performance category and eligible hospitals and critical access hospitals (CAHs) participating in the Medicare Promoting Interoperability Program, respectively.<br>• The new measure suppression policy provides CMS with the means to address future potential circumstances that would warrant the necessity to suppress a Promoting Interoperability measure from performance.<br>• The measure suppression policy will be effective starting with the CY 2026 performance period/2028 MIPS payment year and the EHR reporting period in CY 2026.<br>• **An identified suppressed measure must be reported**. MIPS eligible clinicians, eligible hospitals, and CAHs that report a suppressed measure will receive the maximum available points for a measure or full credit for a measure. | • **Traditional MIPS**<br>• **MVPs**<br>• **APP** |

| POLICY AREA | EXISTING POLICY | CY 2026 FINALIZED POLICY | APPLICABLE MIPS REPORTING OPTION(S) |
|---|---|---|---|
| **Promoting Interoperability Measure Inventory** | **Public Health and Clinical Data Exchange Objective, Electronic Case Reporting Measure**<br>The measure requires MIPS eligible clinicians to attest "Yes" or "No" to active engagement with a public health agency to electronically submit case reporting of reportable conditions. The measure is a required measure under the Public Health and Clinical Data Exchange objective. MIPS eligible clinicians successfully reporting on all required measures in the Public Health and Clinical Data Exchange Objective receive 25 points toward the Promoting Interoperability performance category score. | **Public Health and Clinical Data Exchange Objective, Electronic Case Reporting Measure**<br>We're suppressing the Electronic Case Reporting measure for the MIPS Promoting Interoperability performance category and the Medicare Promoting Interoperability Program for the **CY 2025 performance period/2027 MIPS payment year and the EHR reporting period in CY 2025**.<br><br>• We're suppressing the measure due to the CDC temporarily pausing the onboarding of new healthcare organizations for production of electronic case reporting data and new local public health agencies for receipt of electronic case reporting data.<br><br>**The measure must still be reported.** MIPS eligible clinicians meeting the requirements of the MIPS Promoting Interoperability performance category and eligible hospitals and CAHs participating the Medicare Promoting Interoperability Program will meet the measure requirements by attesting either "Yes" or "No" to being in active engagement with a public health agency, or by claiming an applicable exclusion. MIPS eligible clinicians, eligible hospitals, and CAHs that report the suppressed Electronic Case Reporting measure will receive full credit for the measure.<br><br>**Note:** MIPS eligible clinicians, eligible hospitals, and CAHs who don't report the Electronic Case Reporting measure (or claim an applicable exclusion) will earn zero points for the Promoting Interoperability performance category. | • **Traditional MIPS**<br>• **MVPs**<br>• **APP** |

| POLICY AREA | EXISTING POLICY | CY 2026 FINALIZED POLICY | APPLICABLE MIPS REPORTING OPTION(S) |
|---|---|---|---|
| **Final Scoring** | | | |
| **Performance Threshold** | **Performance Threshold**<br>We use the mean as the methodology for determining the performance threshold for the CY 2025 performance period/2027 MIPS payment year through the CY 2027 performance period/2029 MIPS payment year. For the CY 2025 performance period/2027 MIPS payment year, the performance threshold was set at 75 points. | **Performance Threshold**<br>We're continuing to use the mean final score from the CY 2017 performance period/2019 MIPS payment year for the CY 2026 performance period/2028 MIPS payment year through the CY 2028 performance period/2030 MIPS payment year.<br>• On this basis, we've **set the performance threshold at 75 points through the CY 2028 performance period/2030 MIPS payment year.** | • **Traditional MIPS**<br>• **MVPs**<br>• **APP** |

| POLICY AREA | EXISTING POLICY | CY 2026 FINALIZED POLICY | APPLICABLE MIPS REPORTING OPTION(S) |
|---|---|---|---|
| **Third Party Intermediaries** | | | |
| **Certified Survey Vendors** | **CAHPS for MIPS Survey Measure Administration**<br>Certified Survey Vendors follow a **phone and mail protocol** for administering the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey. | **CAHPS for MIPS Survey Measure Administration**<br>We **added a web-based survey mode** to the current CAHPS for MIPS Survey administration to increase participation in and responses to the survey and thus increase its usefulness to groups, subgroups, virtual groups, and APM Entities (including Shared Savings Program ACOs). | • **Traditional MIPS**<br>• **MVPs**<br>• **APP** |
| **Certified Survey Vendors** | **CMS-approved Survey Vendor Requirements**<br>An entity applying to become a CMS-approved survey vendor must send an interim survey data file to CMS that establishes the entity's ability to accurately report CAHPS data. | **CMS-approved Survey Vendor Requirements**<br>We **sunset the requirement** that an entity applying to become a CMS-approved survey vendor must **send an interim survey data** file to CMS that establishes the entity's ability to accurately report CAHPS data. | • **Traditional MIPS**<br>• **MVPs**<br>• **APP** |

| POLICY AREA | EXISTING POLICY | CY 2026 FINALIZED POLICY | APPLICABLE MIPS REPORTING OPTION(S) |
|---|---|---|---|
| **Qualified Clinical Data Registries (QCDRs) and Qualified Registries** | **MVP Support**<br>Beginning with the CY 2023 performance period/2025 MIPS payment year, QCDRs and qualified registries must support MVPs that are applicable to the MVP participant on whose behalf they submit MIPS data. | **MVP Support**<br>QCDRs and Qualified Registries must fully support a newly finalized MVP no later than one year after the MVP is finalized.<br>In practice, this means that a QCDR or Qualified Registry will need to fully support the MVPs finalized in this rule that are applicable to their clinicians beginning with the CY 2027 performance period. | • **MVPs** |

## Advanced APMs Overview

| POLICY AREA | EXISTING POLICY | CY 2026 FINALIZED POLICY |
|---|---|---|
| **Qualifying APM Participants (QPs)** | **QP Determinations**<br>• Generally, we make QP determinations at the APM Entity level.<br>• There are limited exceptions where CMS will perform this calculation for an individual clinician.<br>• We generally use Evaluation and Management services to determine which beneficiaries are included in our QP determinations. | **QP Determinations**<br>• We're adding an **individual QP determination calculation for all clinicians** participating in an Advanced APM in addition to determinations at the APM entity level.<br>• We're also creating a uniform calculation methodology by using 2 sets of services for the QP calculations: 1) Evaluation and Management services; and 2) All Covered Professional Services. We will assign QP status based on the most favorable calculation. |

## Frequently Asked Questions (FAQs)

### Are there any proposals that weren't finalized as proposed?

Yes, there are a small number of proposals that we didn't finalize as proposed.

- Of the 32 measures proposed to have substantive changes, we only finalized substantive changes to 30 measures; we didn't finalize the change to measure Q047: Advance Care Plan and will finalize the change to measure Q141: Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 20% OR Documentation of a Plan of Care with a 1-year delay in implementation. In addition, 3 measures are finalized with modification from what was proposed: Q112: Breast Cancer Screening, Q113: Colorectal Cancer Screening, and Q117: Diabetes: Eye Exam.

### Are there any policies previously finalized for the 2026 performance period?

Yes. Please refer to Appendix A for a list of policies previously finalized to be effective beginning in the 2026 performance period.

### What MIPS Value Pathways (MVPs) are available for reporting in 2026?

There are 27 MVPs available to report in the 2026 performance period:

- Diagnostic Radiology (NEW)
- Interventional Radiology (NEW)
- Neuropsychology (NEW)
- Pathology (NEW)
- Podiatry (NEW)
- Vascular Surgery (NEW)
- Adopting Best Practices and Promoting Patient Safety within Emergency Medicine
- Advancing Cancer Care
- Advancing Care for Heart Disease
- Advancing Rheumatology Patient Care
- Complete Ophthalmologic Care
- Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes
- Dermatological Care
- Focusing on Women's Health
- Gastroenterology Care
- Improving Care for Lower Extremity Joint Repair
- Optimal Care for Kidney Health
- Optimal Care for Patients with Urologic Conditions
- Patient Safety and Support of Positive Experiences with Anesthesia
- Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV

- Pulmonology Care
- Quality Care for Patients with Neurological Conditions
- Quality Care for the Treatment of Ear, Nose, and Throat Disorders
- Quality Care in Mental Health and Substance Use Disorders
- Rehabilitative Support for Musculoskeletal Care
- Surgical Care
- Value in Primary Care

### Where can I learn more about the MVP reporting option?

Please visit the MIPS Value Pathways (MVPs) webpage for general information; the 2026 MVPs Implementation Guide will be available in early 2026. You can also learn more about which MIPS reporting option (traditional MIPS, MVPs, APM Performance Pathway (APP)) may be best for you by reviewing the MIPS Reporting Options Comparison Resource.

### Which quality measures are eligible for the topped out measure benchmarks for the 2026 performance period?

As finalized, the following measures will be scored according to the new topped out measure benchmarks:

| 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 | Barret's Esophagus | Medicare Part B Claims Measure, MIPS CQM |
| 250 | Radical Prostatectomy Pathology Reporting | Medicare Part B Claims Measure, MIPS CQM |
| 320 | Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients | Medicare Part B Claims |
| 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 |

| Quality ID | Measure Title | Collection Type |
|---|---|---|
| 395 | Lung Cancer Reporting (Biopsy/Cytology Specimens) | Medicare Part B Claims Measure, MIPS CQM |
| 396 | Lung Cancer Reporting (Resection Specimens) | MIPS CQM |
| 397 | Melanoma Reporting | Medicare Part B Claims Measure, MIPS CQM |
| 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 Measure, 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 |

* 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.

### Are Medicare CQMs eligible for flat benchmarks in the CY 2026 performance period?

Yes, beginning in the CY 2025 performance period/2027 MIPS payment year, Medicare CQMs (only available to Shared Savings Program ACOs) will be scored using flat benchmarks for their first 2 performance periods in MIPS.

| Performance Year | Quality ID for Medicare CQMs eligible for flat benchmarks |
|---|---|
| 2026 | • 112, 113 |
| 2027 | • 113, 305 |
| 2028* | • 305, 493* |

*Quality ID #493: Adult Immunization Status will be eligible for flat benchmarks for 2 years beginning in the CY 2028 performance period or the performance period that is 1 year after the eCQM specification becomes available for the measure, respectively, whichever is later.

### When will measure specifications, supporting documentation, and activity descriptions be available for finalized measures/activities?

Measure specifications, activity descriptions, and supporting documentation (such as single source documentation that lets you search for codes that qualify for a given measure) will be posted on the QPP Resource Library before the performance period begins on January 1, 2026.

(When searching in the QPP Resource Library, scroll past the General and Regulatory Resource sections until you reach the "Full Resource Library." Filter by the 2026 Performance Year and choose "Measure Specifications and Benchmarks" as the Resource type.)

### When will historical quality benchmarks be available for the 2026 performance period?

We anticipate that the historical 2026 quality measure benchmarks will be available on the Benchmarks page of the QPP website in late January 2026.

### Where can I find a list of topped out quality measures for the 2026 performance period?

We identify topped out quality measures, including those capped at 7 points, through the benchmarking process. We anticipate that the 2026 historical quality benchmarks will be available in late January 2026.

### Can you provide an example of how the change to the administrative claims benchmarking methodology will affect scores?

Yes, let's use the Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with Heart Failure under the Merit-based Incentive Payment System measure as an example. Under the old methodology, a performance rate of 70% would have resulted in 5 – 5.9 points, whereas it will earn 7 – 7.9 points under the new methodology.

| 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 |

**What's the maximum negative payment adjustment for the CY 2026 performance period/2028 MIPS payment year?**

As specified in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the maximum negative payment adjustment for the 2022 payment year (2020 performance year) and beyond is **-9%**. The **actual** payment adjustment (positive, neutral, or negative) you'll receive for the 2028 MIPS payment year will be based on your MIPS final score from the 2026 performance period and may be subject to a scaling factor to ensure budget neutrality, as required by MACRA.

**How many points do I need to avoid a negative payment adjustment for the CY 2026 performance period/2028 MIPS payment year?**

The performance threshold is the number against which your final score is compared to determine your payment adjustment. **As finalized in this rule, the performance threshold remains 75 points through the CY 2028 performance period/2030 MIPS payment year.** See the table below for more information about the relationship between 2026 final scores and 2028 payment adjustments.

| Your 2026 Final Score | Payment Impact for MIPS Eligible Clinicians for the 2028 MIPS Payment Year |
|---|---|
| 0.00 – 18.75 points | -9% payment adjustment |
| 18.76 – 74.99 points | Negative payment adjustment (between -9% and 0%) |
| 75.00 points<br>(Performance threshold=75.00 points) | Neutral payment adjustment (0%) |
| 75.01 – 100.00 points | Positive payment adjustment (scaling factor applied to meet statutory budget neutrality requirements) |

**Did you finalize the performance threshold for the next 3 performance periods?**

**Yes.** We finalized the performance threshold (75 points) through the CY 2028 performance period/2030 MIPS payment year.

## Contact Us

We encourage clinicians to contact the QPP Service Center. Contact the Quality Payment Program Service Center by email at QPP@cms.hhs.gov, by creating a QPP Service Center ticket, or by phone at 1-866-288-8292 (Monday-Friday, 8 a.m. - 8 p.m. ET). People who are deaf or hard of hearing can dial 711 to be connected to a TRS Communications Assistant. You can also visit the Quality Payment Program website for educational resources, information, and upcoming webinars.

## Version History

| Date | Change 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. |
| 11/03/2025 | Original Posting. |

## Appendix A: Previously Finalized Policies for the 2026 Performance Period

The table below identifies policies finalized in an earlier rule that apply to the CY 2026 performance period.

| Policy Area | Previously Finalized Policy Applicable to the CY 2026 Performance Period |
|---|---|
| **Quality Performance Category** | |
| **Quality Measure Scoring** | Beginning in the CY 2025 performance period/2027 MIPS payment year, Medicare CQMs (only available to Shared Savings Program ACOs) are scored using flat benchmarks for their first 2 performance periods in MIPS. The following Medicare CQMs are eligible for flat benchmarks in the 2026 performance year:<br>• 112, 113 |
| **APM Performance Pathway (APP) Plus Quality Measure Set** | We're incrementally incorporating additional measures into the APP Plus quality measure set. The following quality measures have been added to the 6 existing measures in the APP plus quality measure set beginning with the CY 2026 performance period/2028 MIPS payment year:<br>• Quality #113: Colorectal Cancer Screening<br>• Quality #484: Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions |
| **Promoting Interoperability Performance Category** | |
| **Certified EHR Technology (CEHRT) Requirements** | We updated the CEHRT definition to align with the Office of the National Coordinator for Health IT (ONC)'s regulations. All certification criteria will be maintained and updated at 45 CFR 170.315.<br>We've aligned our definitions of CEHRT for QPP and the Medicare Promoting Interoperability Program with the definitions and requirements ONC currently has in place and may adopt in the future. |
| **Improvement Activities Performance Category** | |
| **Improvement Activities Finalized for Removal** | Please refer to Appendix F for details about improvement activities previously finalized for removal beginning with the CY 2026 performance period. |

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

| Measure Title and Steward | Description | Collection Type | Measure Type | Rationale for Inclusion |
|---|---|---|---|---|
| Q513: Patient Reported Falls and Plan of Care<br>American Academy of Neurology | Percentage of patients (or caregivers as appropriate) with an active diagnosis of a movement disorder, multiple sclerosis, a neuromuscular disorder, dementia, or stroke who reported a fall occurred and those that fell had a plan of care for falls documented at every visit. | MIPS CQM | Process | We are finalizing this process measure because it addresses patient safety by ensuring patients with an active diagnosis of a neurological disorder are screened for falls and had a falls plan of care established. |
| Q512: Prevalent Standardized Kidney Transplant Waitlist Ratio (PSWR)<br>Centers for Medicare & Medicaid Services | The number of prevalent dialysis patients in a practitioner group who are under the age of 75 and were listed on the kidney or kidney-pancreas transplant waitlist or received a living donor transplant. The practitioner group is inclusive of physicians and advanced practice providers. The measure is the ratio-observed number of waitlist events in a practitioner group to its expected number of waitlist events. The measure uses the expected waitlist events calculated from a Cox model, which is adjusted for age, patient comorbidities, and other risk factors at the time of dialysis. | MIPS CQM | Process | We are finalizing the PSWR outcome measure for the CY 2026 performance period/2028 MIPS payment year because it builds on 2 previous measures (Q510 First Year Standardized Waitlist Ratio (FYSWR) and measure Q511: Percentage of Prevalent Patients Waitlisted (PPPW) and Q511, Percentage of Prevalent Patients Waitlisted in Active Status (aPPPW))[1].<br>Measure Q510 focuses on initial waitlist placement or living donor transplant within the first year of dialysis, while Q511 tracks monthly active waitlist status and maintenance for dialysis patients under 75 years old. The new PSWR measure builds upon both Q510 and Q511 by assessing successful placement on the kidney or kidney-pancreas transplant waitlist or receipt of a living donor transplant. |

[1] Please note that we updated these measure titles to clarify the intent of these measures as specific to kidney transplants.

| Measure Title and Steward | Description | Collection Type | Measure Type | Rationale for Inclusion |
|---|---|---|---|---|
| Q514: Diagnostic Delay of Venous Thromboembolism in Primary Care<br>Brigham and Women's Hospital | Percentage of episodes for patients 18 years of age and older with documented Venous Thromboembolism (VTE) symptoms in the primary care setting and who had a diagnosis of VTE that occurs > 24 hours and within 30 days following the index primary care visit where symptoms for the VTE were first present. | eCQM | Intermediate Outcome | We are finalizing this intermediate outcome measure because measuring and reporting delayed VTE diagnosis rates will inform health care providers and facilities about opportunities to improve care, strengthen incentives for quality improvement, and ultimately improve the quality of care received by patients. This measure has the potential to lower health care costs associated with VTE by providing ongoing patient outcome data that can be used to improve VTE diagnostic performance and to reduce complications associated with delayed diagnosis and treatment. |
| Q515: Screening for Abnormal Glucose Metabolism in Patients at Risk of Developing Diabetes<br>American Medical Association | Percentage of adult patients with risk factors for type 2 diabetes who are due for glycemic screening for whom the screening process was completed during the measurement period. | eCQM | Process | We are finalizing this process measure because it is critical to identify patients with prediabetes who may benefit from interventions to prevent type 2 diabetes and to identify patients with undiagnosed type 2 diabetes. Regular glycemic screening is a critical first step to identifying patients with prediabetes and helping patients avoid the disability and costs associated with progression to type 2 diabetes. |

| Measure Title and Steward | Description | Collection Type | Measure Type | Rationale for Inclusion |
|---|---|---|---|---|
| Q516: Hepatitis C Virus (HCV): Sustained Virological Response (SVR)<br>American Gastroenterological Association | Percentage of patients aged greater than or equal to 18 years with active hepatitis C (HCV) with negative/undetectable HCV ribonucleic acid (RNA) at least 20 weeks to 12 months after positive/detectable HCV RNA test result. | MIPS CQM | Outcome | We are finalizing this outcome measure because achieving SVR is the first step toward reducing future HCV morbidity and mortality. Once achieved, SVR is associated with long-term clearance of HCV infection, which is regarded as a virologic ''cure,'' as well as with improved morbidity and mortality. Patients who achieve SVR usually have improvement in liver histology and clinical outcomes. |

## Appendix C: Quality Measures Finalized for Removal in the 2026 Performance Period and Future Years

| Quality ID | Collection Type / Measure Type | High Priority | Measure Title and Description | Measure Steward | Rationale for Removal |
|---|---|---|---|---|---|
| 185 | MIPS CQM/ Process | Yes | Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use: Percentage of patients aged 18 years and older receiving a surveillance colonoscopy, with a history of prior adenomatous polyp(s) in previous colonoscopy findings, which had an interval of three or more years since their last colonoscopy. | American Gastroenterological Association | End of topped out lifecycle |
| 264 | MIPS CQM/ Process | No | Sentinel Lymph Node Biopsy for Invasive Breast Cancer: The percentage of clinically node negative (clinical stage T1N0M0 or T2N0M0) breast cancer patients before or after neoadjuvant systemic therapy, who undergo a sentinel lymph node (SLN) procedure. | American Society of Breast Surgeons | Measure steward requested removal (not aligned with current clinical guidelines) |
| 290 | MIPS CQM/ Process | No | Assessment of Mood Disorders and Psychosis for Patients with Parkinson's Disease: Percentage of all patients with a diagnosis of Parkinson's Disease [PD] who were assessed for depression, anxiety, apathy, AND psychosis once during the measurement period. | American Academy of Neurology | Extremely topped out |

| Quality ID | Collection Type / Measure Type | High Priority | Measure Title and Description | Measure Steward | Rationale for Removal |
|---|---|---|---|---|---|
| 322 | MIPS CQM/ Efficiency | Yes | Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low-Risk Surgery Patients: Percentage of stress single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), multigated acquisition scan (MUGA), cardiac computed tomography angiography (CCTA), or cardiac magnetic resonance (CMR) performed in low-risk surgery patients 18 years or older for preoperative evaluation during the 12-month submission period. | American College of Cardiology Foundation | Extremely topped out |
| 419 | MIPS CQM/ Process | Yes | Overuse of Imaging for the Evaluation of Primary Headache: Percentage of patients for whom imaging of the head (CT or MRI) is obtained for the evaluation of primary headache when clinical indications are not present. | American Academy of Neurology | Extremely topped out |
| 424 | MIPS CQM/ Outcome | Yes | Perioperative Temperature Management: Percentage of patients, regardless of age, who undergo surgical or therapeutic procedures under general or neuraxial anesthesia of 60 minutes duration or longer for whom at least one body temperature greater than or equal to 35.5 degrees Celsius (or 95.9 degrees Fahrenheit) was achieved within the 30 minutes immediately before or 15 minutes immediately after anesthesia end time. | American Society of Anesthesiologists | Extremely topped out |

| Quality ID | Collection Type / Measure Type | High Priority | Measure Title and Description | Measure Steward | Rationale for Removal |
|---|---|---|---|---|---|
| 443 | MIPS CQM/ Process | Yes | Non-Recommended Cervical Cancer Screening in Adolescent Females: The percentage of adolescent females 16–20 years of age who were screened unnecessarily for cervical cancer. | National Committee for Quality Assurance (NCQA) | Measure steward is no longer able to maintain the quality measure |
| 487 | MIPS CQM/ Process | Yes | Screening for Social Drivers of Health: Percent of patients 18 years and older screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. | Centers for Medicare & Medicaid Services | Removal of a process measure that would no longer be considered a high-priority measure and aligns with removal across other CMS programs |
| 498 | MIPS CQM/ Process | Yes | Connection to Community Service Provider: Percent of patients 18 years or older who screen positive for one or more of the following health related social needs (HRSNs): food insecurity, housing instability, transportation needs, utility help needs, or interpersonal safety; and had contact with a Community Service Provider (CSP) for at least one of their HRSNs within 60 days after screening. | OCHIN | Removal of a process measure that would no longer be considered a high-priority measure and aligns with removal across other CMS programs |
| 508 | MIPS CQM/ Process | No | Adult COVID-19 Vaccination Status: Percentage of patients aged 18 years and older seen for a visit during the performance period that are up to date on their COVID-19 vaccinations as defined by CDC recommendations on current vaccination. | Centers for Medicare & Medicaid Services | Removal of a process measure that aligns with removal across other CMS programs |

## Appendix D: New Improvement Activities Finalized for the 2026 Performance Period and Future Years

| Activity Title | Subcategory | Activity Description |
|---|---|---|
| Improving Detection of Cognitive Impairment in Primary Care | Population Management | To increase the detection rate of cognitive impairment, in particular in early stages, the MIPS-eligible clinician must perform the following activities:<br>• Determine his/her baseline detection rates for MCI, dementia and cognitive impairment at either stage using the tool provided for this Improvement Activity<br>• If either of the three rates are below 1.0:<br>++ Increase the uptake of the Annual Wellness Visit<br>++ Ensure that each Annual Wellness Visit contains a structured cognitive assessment<br>++ Include a question about subjective memory concerns to the collection of vital signs during intake for patients 65+, and conduct a structured cognitive assessment in those with concerns<br>• Remeasure detection rates for MCI, dementia, and cognitive impairment at either stage quarterly<br>++ Of note, this Improvement Activity focuses on Medicare patients aged 65 and older, given the strong correlation of cognitive impairment with age. |

| Activity Title | Subcategory | Activity Description |
|---|---|---|
| Integrating Oral Health Care in Primary Care | Population Management | MIPS eligible clinicians will include an oral health risk assessment and intraoral screening as part of a patient's primary care management. The clinician will provide education and counseling to the patient to include the importance of oral health and the impact of oral health on systemic diseases. For patients without a dental home and/or those with oral health needs, a dental referral will be provided.<br>To receive credit for this activity, a MIPS eligible clinician must complete two Smiles for Life (https://www.smilesforlifeoralhealth.org) trainings: ("The Oral Examination" and "Geriatric Oral Health"). These are one-time, free, online training 60-minute certification courses. Smiles for Life oral health education has been adopted by Medicaid in several states to improve oral health access, outcomes, and referrals for children through educating medical providers.<br>The MIPS eligible clinician must include one or more of the following activities in addition to completing the training:<br>• Create a dental referral network list by specialty and accepted insurances.<br>• Include applicable oral health screening questions in the patient health intake forms (dentist of record, date of the last dental exam, and personal oral hygiene routine).<br>• Identify an applicable caries risk assessment to be used. Example caries-risk-assessment-checklist-d1.png (768×1024) (formsbirds.com)<br>• Include Intraoral health screening and referral to dental provider as part of a patient's primary care management.<br>• Provide education and counseling to patients about the importance of oral health and impact on systemic disease.<br>• Refer patients without a dental home and/or those who have untreated dental disease indicated by health history, caries risk assessment, Intraoral health screening, medications and/or concerns reported by patient.<br>• Include a description of the findings found in all dental referrals.<br>++ Documents with appropriate procedure and diagnostic codes to track services provided and referrals to validate performance of the improvement activity. |
| Patient Safety in Use of Artificial Intelligence (AI) | Patient Safety and Practice Assessment | Develop a new data-collection field within patient safety reporting systems for AI-attributable events, which would include both actual harm as well as near misses. When an event is identified, a process to identify the cause and plan for future mitigation is documented. AI-attributable events are defined broadly to include not only automated or semi-automated devices, but any electronic tool that is being used to support clinical decision making. |

## Appendix E: Improvement Activities Finalized for Removal in the 2026 Performance Period and Future Years

| Activity ID | Subcategory | Activity Title and Description |
| --- | --- | --- |
| IA_ AHE_5 | Achieving Health Equity | **MIPS Eligible Clinician Leadership in Clinical Trials or CBPR**<br>Lead clinical trials, research alliances, or community-based participatory research (CBPR) that identify tools, research, or processes that focus on minimizing disparities in healthcare access, care quality, affordability, or outcomes. Research could include addressing health-related social needs like food insecurity, housing insecurity, transportation barriers, utility needs, and interpersonal safety. |
| IA_AHE_8 | Achieving Health Equity | **Create and Implement an Anti-Racism Plan**<br>Create and implement an anti-racism plan using the CMS Disparities Impact Statement or other anti-racism planning tools. The plan should include a clinic-wide review of existing tools and policies, such as value statements or clinical practice guidelines, to ensure that they include and are aligned with a commitment to anti-racism and an understanding of race as a political and social construct, not a physiological one.<br>The plan should also identify ways in which issues and gaps identified in the review can be addressed and should include target goals and milestones for addressing prioritized issues and gaps. This may also include an assessment and drafting of an organization's plan to prevent and address racism and/or improve language access and accessibility to ensure services are accessible and understandable for those seeking care. The MIPS eligible clinician or practice can also consider including in their plan ongoing training on anti-racism and/or other processes to support identifying explicit and implicit biases in patient care and addressing historic health inequities experienced by people of color. More information about elements of the CMS Disparities Impact Statement is detailed in the template and action plan document at https://www.cms.gov/about-cms/agency-information/omh/downloads/disparities-impact-statement-508-rev102018.pdf. |

| Activity ID | Subcategory | Activity Title and Description |
|---|---|---|
| IA_AHE_9 | Achieving Health Equity | **Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols**<br>Create or improve, and then implement, protocols for identifying and providing appropriate support to: a) patients with or at risk for food insecurity, and b) patients with or at risk for poor nutritional status. (Poor nutritional status is sometimes referred to as clinical malnutrition or undernutrition and applies to people who are overweight and underweight.) Actions to implement this improvement activity may include, but are not limited to, the following:<br>• Use Malnutrition Quality Improvement Initiative (MQii) or other quality improvement resources and standardized screening tools to assess and improve current food insecurity and nutritional screening and care practices.<br>• Update and use clinical decision support tools within the MIPS eligible clinician's electronic medical record to align with the new food insecurity and nutrition risk protocols.<br>• Update and apply requirements for staff training on food security and nutrition.<br>• Update and provide resources and referral lists, and/or engage with community partners to facilitate referrals for patients who are identified as at risk for food insecurity or poor nutritional status during screening.<br>Activities must be focused on patients at greatest risk for food insecurity and/or malnutrition—for example patients with low income who live in areas with limited access to affordable fresh food, or who are isolated or have limited mobility. |
| IA_AHE_11 | Achieving Health Equity | **Create and Implement a Plan to Improve Care for Lesbian, Gay, Bisexual, Transgender, and Queer Patients**<br>Create and implement a plan to improve care for lesbian, gay, bisexual, transgender, and queer (LGBTQ+) patients by understanding and addressing health disparities for this population. The plan may include an analysis of sexual orientation and gender identity (SO/GI) data to identify disparities in care for LGBTQ+ patients. Actions to implement this activity may also include identifying focused goals for addressing disparities in care, collecting and using patients' pronouns and chosen names, training clinicians and staff on SO/GI terminology (including as supported by certified health IT and the Office of the National Coordinator for Health Information Technology US Core Data for Interoperability [USCDI]), identifying risk factors or behaviors specific to LGBTQ+ individuals, communicating SO/GI data security and privacy practices with patients, and/or utilizing anatomical inventories when documenting patient health histories. |

| Activity ID | Subcategory | Activity Title and Description |
|---|---|---|
| IA_AHE_12 | Achieving Health Equity | **Practice Improvements that Engage Community Resources to Address Drivers of Health**<br>Select and screen for drivers of health that are relevant for the eligible clinician's population using evidence-based tools. If possible, use a screening tool that is health IT-enabled and includes standards-based, coded questions/fields for the capture of data. After screening, address identified drivers of health through at least one of the following:<br>• Develop and maintain formal relationships with community-based organizations to strengthen the community service referral process, implementing closed-loop referrals where feasible; or<br>Work with community partners to provide and/or update a community resource guide for to patients who are found to have and/or be at risk in one or more areas of drivers of health; or<br>• Record findings of screening and follow up within the electronic health record (EHR); identify screened patients with one or more needs associated with drivers of health and implement approaches to better serve their holistic needs through meaningful linkages to community resources.<br>Drivers of health (also referred to as social determinants of health [SDOH] or health-related social needs [HSRN]) prioritized by the practice might include, but are not limited to, the following: food security; housing stability; transportation accessibility; interpersonal safety; legal challenges; and environmental exposures. |
| IA_PM_26 | Population Management | **Vaccine Achievement for Practice Staff: COVID-19, Influenza, and Hepatitis B**<br>Demonstrate that the MIPS eligible clinician's practice has achieved and/or maintained a vaccination rate of 60 percent of clinical practice staff for COVID-19, and 80 percent for influenza. Demonstrate vaccination, immunity, or non-responder status to hepatitis B for 95 percent of clinical practice staff. Vaccination recommendations are from Centers for Disease Control and Prevention; staff with contraindications to the vaccinations, as determined by the CDC, are excluded from the requirements.<br>Vaccines and Immunizations \| CDC. |
| IA_PM_6 | Population Management | **Use of Toolsets or Other Resources to Close Health and Health Care Inequities Across Communities**<br>Address inequities in health outcomes by using population health data analysis tools to identify health inequities in the community and practice and assess options for effective and relevant interventions such as Population Health Toolkit or other resources identified by the clinician, practice, or by CMS. Based on this information, create, refine, and implement an action plan to address and close inequities in health outcomes and/or health care access, quality, and safety. |

| Activity ID | Subcategory | Activity Title and Description |
|---|---|---|
| IA_ERP_3 | Emergency Response and Preparedness | **COVID-19 Clinical Data Reporting with or without Clinical Trial**<br>To receive credit for this improvement activity, a MIPS eligible clinician or group must: (1) participate in a COVID-19 clinical trial utilizing a drug or biological product to treat a patient with a COVID-19 infection and report their findings through a clinical data repository or clinical data registry for the duration of their study; or (2) participate in the care of patients diagnosed with COVID-19 and simultaneously submit relevant clinical data to a clinical data registry for ongoing or future COVID-19 research. Data would be submitted to the extent permitted by applicable privacy and security laws. Examples of COVID-19 clinical trials may be found on the U.S. National Library of Medicine website at https://clinicaltrials.gov/ct2/results?cond=COVID-19. In addition, examples of COVID-19 clinical data registries may be found on the National Institute of Health website at https://search.nih.gov/search?utf8=%E2%9C%93&affiliate=nih&query=COVID19+registries&commit=Search.<br>For purposes of this improvement activity, clinical data registries must meet the following requirements: (1) the receiving entity must declare that they are ready to accept data as a clinical registry; and (2) be using the data to improve population health outcomes. Most public health agencies and clinical data registries declare readiness to accept data from clinicians via a public online posting. Clinical data registries should make publicly available specific information on what data the registry gathers, technical requirements, or specifications for how the registry can receive the data, and how the registry may use, re-use, or disclose individually identifiable data it receives. For purposes of credit toward this improvement activity, any data should be sent to the clinical data registry in a structured format, which the registry is capable of receiving. A MIPS-eligible clinician may submit the data using any standard or format that is supported by the clinician's health IT systems, including but not limited to, certified functions within those systems. Such methods may include, but are not limited to, a secure upload function on a web portal, or submission via an intermediary, such as a health information exchange. To ensure interoperability and versatility of the data submitted, any electronic data should be submitted to the clinical data registry using appropriate vocabulary standards for the specific data elements, such as those identified in the United States Core Data for Interoperability (USCDI) standard adopted in 45 CFR 170.213. |

## Appendix F: Improvement Activities Previously Finalized for Removal for the 2026 Performance Period and Future Years

| Activity ID | Subcategory | Activity Title and Description |
|---|---|---|
| IA_PM_12 | Population Management | **Population Empanelment**<br>Empanel (assign responsibility for) the total population, linking each patient to a MIPS eligible clinician or group or care team. Empanelment is a series of processes that assign each active patient to a MIPS eligible clinician or group and/or care team, confirm assignment with patients and clinicians, and use the resultant patient panels as a foundation for individual patient and population health management. Empanelment identifies the patients and population for whom the MIPS eligible clinician or group and/or care team is responsible and is the foundation for the relationship continuity between patient and MIPS eligible clinician or group /care team that is at the heart of comprehensive primary care. Effective empanelment requires identification of the "active population" of the practice: those patients who identify and use your practice as a source for primary care. There are many ways to define "active patients" operationally, but generally, the definition of "active patients" includes patients who have sought care within the last 24 to 36 months, allowing inclusion of younger patients who have minimal acute or preventive health care |
| IA_CC_1 | Care Coordination | **Implementation of Use of Specialist Reports Back to Referring Clinician or Group to Close Referral Loop**<br>Performance of regular practices that include providing specialist reports back to the referring individual MIPS eligible clinician or group to close the referral loop or where the referring individual MIPS eligible clinician or group initiates regular inquiries to specialist for specialist reports which could be documented or noted in the EHR technology. |
| IA_CC_2 | Care Coordination | **Implementation of Improvements that Contribute to More Timely Communication of Test Results**<br>Timely communication of test results defined as timely identification of abnormal test results with timely follow-up. |
| IA_BMH_8 | Behavioral and Mental Health | **Electronic Health Record Enhancements for BH Data Capture**<br>Enhancements to an electronic health record to capture additional data on behavioral health (BH) populations and use that data for additional decision-making purposes (e.g., capture of additional BH data results in additional depression screening for at-risk patient not previously identified). |