Quality Payment
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Merit-based Incentive Payment System (MIPS)

2026 Quality Benchmarks User Guide with Scoring Examples

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Purpose: This resource focuses on Merit based Incentive Payment System (MIPS) quality benchmarks, providing high level information and scoring examples for the 2026 MIPS performance period.

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Overview

What Are Benchmarks and Why Are They Important?

Benchmarks are the point of comparison we use to score the measures you submit.

- When you submit measures for the MIPS quality performance category, your performance on each measure is assessed against its benchmark to determine how many points the measure earns.

Measures that can be scored against a benchmark generally earn between 1 and 10 points.

A high performance rate doesn't necessarily result in a high measure score.

Measure scores aren't based solely on the performance rate. Measures earn points based on the scoring range your performance rate falls in.

Benchmark Timelines

Historical Benchmarks

Whenever possible, we use historical data to establish benchmarks. Historical benchmarks for the 2026 performance period are based on actual performance data that were submitted to the Quality Payment Program (QPP) for the 2024 performance period.

- We don't create historical benchmarks for administrative claims measures. We only use performance period data for those measures.

Performance Period Benchmarks

Performance period benchmarks are established using data submitted by individual clinicians, groups, and virtual groups that are eligible for MIPS in the 2026 performance period.

- We don't create performance period benchmarks for measures with a historical benchmark.

What Are Benchmarks and Why Are They Important? (Continued)

To establish a historical benchmark:

- The 2024 and 2026 measure specifications must be comparable.
  - While there may be substantive changes to the measure between 2024 and 2026, not all substantive changes are significant enough to require a new benchmark.
- 20 instances of the measure must have been reported in 2024 through the same collection type by individual clinicians, groups, virtual groups, and/or Alternative Payment Model (APM) Entities **AND**
  - The clinician, group, or virtual group was eligible for MIPS according to 2026 eligibility criteria (no changes to low-volume threshold from the 2024 performance year), **AND**
  - The measure met performance year 2026 data completeness (75%) and case minimum requirements (20 cases), **AND**
  - The measure had a performance rate greater than 0% (or less than 100% for inverse measures).

What Are Benchmarks and Why Are They Important? (Continued)

CAHPS for MIPS Survey Measure

We establish benchmarks for the individual scored summary survey measure (SSM) in the CAHPS for MIPS Survey measure.

- These benchmarks are included in the benchmark file that can be downloaded on the Benchmarks page of the QPP website.
- These benchmarks were calculated using historical data from the 2024 performance period.

A range of 1 to 10 points will be assigned to each SSM by comparing performance against the benchmark (similar to other measures).

The final CAHPS for MIPS Survey score will be a simple average number of points across all scored SSMs.

What Are Benchmarks and Why Are They Important? (Continued)

Administrative Claims Measures

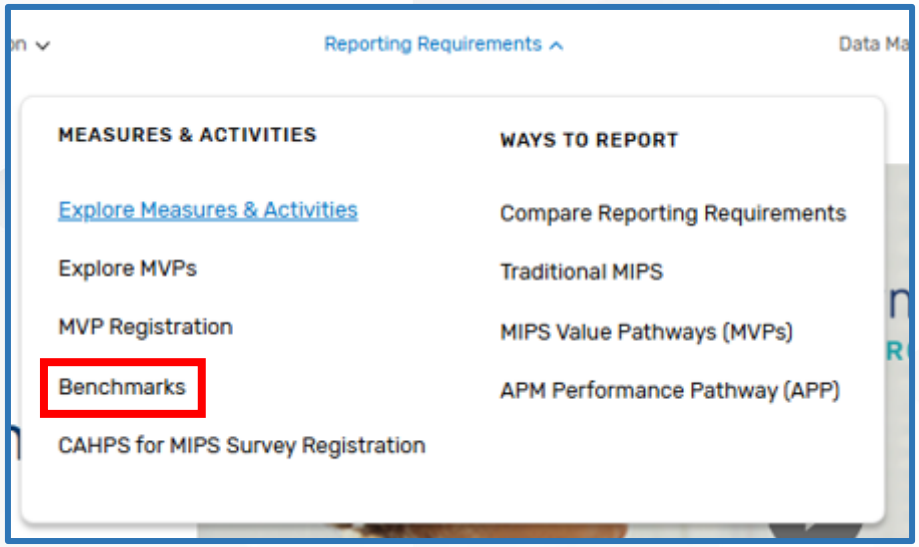
There are up to 4 administrative claims measures available in the 2026 performance period depending on your MIPS reporting option.

- Measure ID 484: Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions Measure (ZIP, 5MB)
- Measure ID 479: Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Groups Measure (ZIP, 792KB)
- Measure ID 480: Risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) for MIPS Measure (ZIP, 469KB)
- Measure ID 492: Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with Heart Failure under MIPS (ZIP, 1MB)

Did you know? We score administrative claims measures exclusively against performance period benchmarks. We updated the benchmark methodology in the 2026 Medicare Physician Fee Schedule Final Rule, effective with the 2025 performance period. Learn more.

How to Access and Navigate Benchmarks

- The benchmark file is accessible by selecting the "Reporting Requirements" tab on the QPP website and selecting "Benchmarks" or by visiting the Benchmarks webpage.



- When you download the file, it pulls the benchmark data in real time from an Application Programming Interface (API) used for scoring. **The file you download is current as of the date included in the file name.**

- The benchmark file will download as a comma-separated values (CSV) file, which is similar to the Excel format.

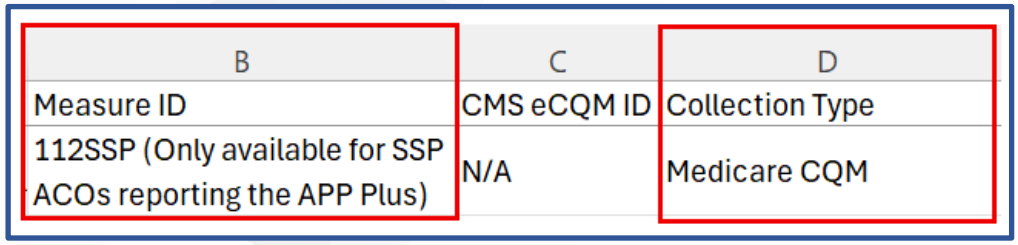
TIP: Select "Don't Convert" if prompted when opening the file.

- You can save the benchmark file in the Excel format and then add filters to help you use the data (see next page).
- We've added the CMS ID for electronic clinical quality measures (eCQMs).
  - The column will list N/A for any measure that isn't an eCQM.

C
CMS eCQM ID
N/A
N/A
CMS122v12
N/A

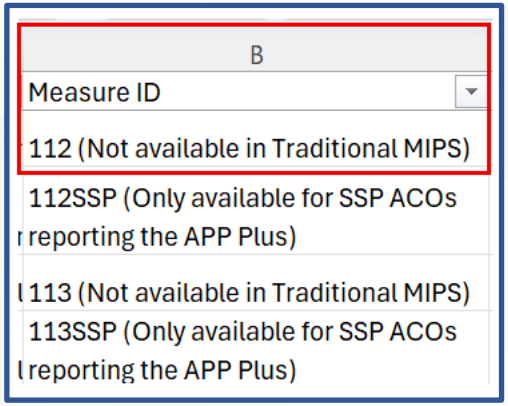
How to Access and Navigate Benchmarks (Continued)

- Medicare CQMs are identifiable by the measure ID in **Column B** and the collection type in **Column D**



B	C	D
Measure ID	CMS eCQM ID	Collection Type
112SSP (Only available for SSP ACOs reporting the APP Plus)	N/A	Medicare CQM

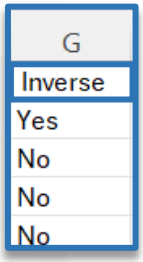
- **Column B** also highlights when a measure isn't available for Traditional MIPS. (These measures may be available for one or more MIPS Value Pathways (MVP), the APP, or APP Plus.)



B
Measure ID
112 (Not available in Traditional MIPS)
112SSP (Only available for SSP ACOs reporting the APP Plus)
113 (Not available in Traditional MIPS)
113SSP (Only available for SSP ACOs reporting the APP Plus)

How to Access and Navigate Benchmarks (Continued)

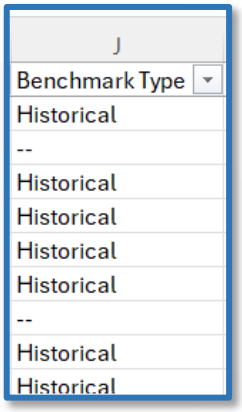
- **Column G** identifies inverse measures. More information on inverse measure benchmarks available here.



G
Inverse
Yes
No
No
No

- **Column J** identifies benchmark type (historical or performance period) because we'll add performance period benchmarks to this same file in summer 2027; we believe this will provide a more complete picture of quality measure benchmarks to the QPP community.

  You'll see "--" when no benchmark is available.
  Measures that show "--" when historical benchmarks are released will be eligible for a performance period benchmark.



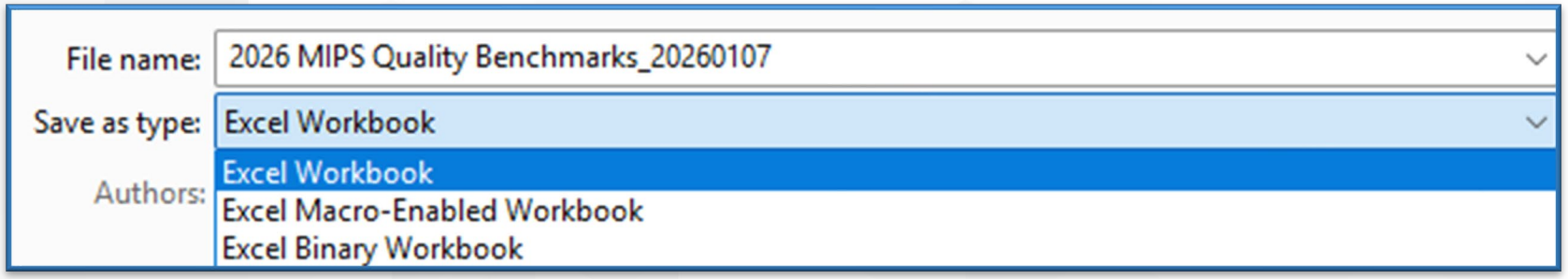
J
Benchmark Type
Historical
--
Historical
Historical
Historical
Historical
--
Historical
Historical

- The 2026 benchmark file includes benchmarks for the CAHPS for MIPS Summary Survey Measures.

How to Access and Navigate Benchmarks (Continued)

How to save a CSV file in Excel

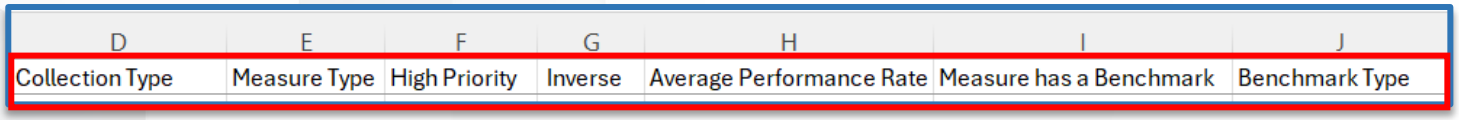
1. In your Excel worksheet, click **File** > **Save as**.
2. Browse for the folder on your computer where you want to save the file.
3. To save as an Excel file, select Excel Workbook (*. xlsx) from the Save as type drop-down menu. To save as a comma-separated file, select CSV (Comma delimited) or CSV UTF-8.
4. Click Save.

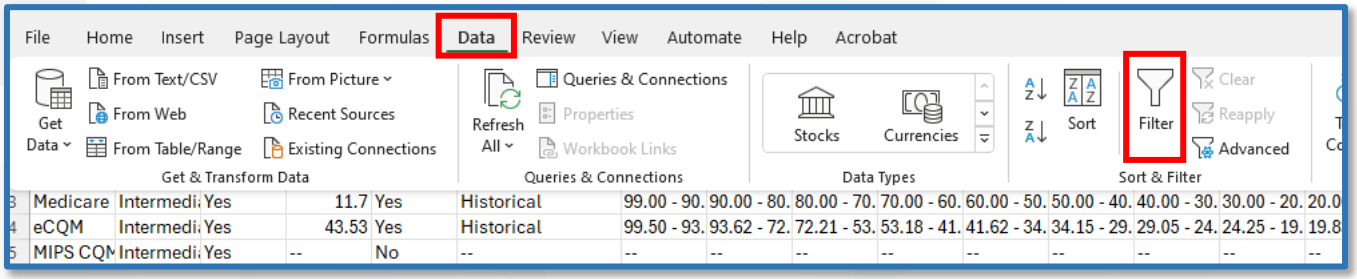


How to Access and Navigate Benchmarks (Continued)

How to add filters to columns in Excel

1. Highlight the top row in the file.
2. Select **Data** > **Filter**.





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Scoring Measures Against a Benchmark

When Are Measures Scored Against a Benchmark?

Quality measures are scored against a benchmark when **all 3 criteria** are met:

1. The measure meets data completeness criteria (75% threshold for the 2026 performance period).
2. The measure meets case minimum criteria (generally 20 cases).
3. A benchmark exists for the measure's collection type.

What If a Measure Doesn't Meet Data Completeness Criteria?

Quality measures that don't meet data completeness criteria aren't eligible for scoring against a benchmark, even if a benchmark exists, and will receive 0 points unless:

- The measure is submitted by a small practice; small practices will continue to earn 3 points for measures that don't meet data completeness criteria.

What If a Measure Doesn't Meet Case Minimum Criteria?

Quality measures that don't meet case minimum aren't eligible for scoring against a benchmark, even if a benchmark exists, and will receive 0 points unless:

- The measure is submitted by a small practice; small practices will continue to earn 3 points for measures that don't meet case minimum criteria.
- The measure is in its 1st or 2nd year in the program; these measures will earn 7 and 5 points, respectively, if data completeness is met. (This policy doesn't apply to administrative claims measures.)
- The measure is submitted under the APM Performance Pathway. In this case, measures that don't meet case minimums are excluded from scoring.

What If a Measure Doesn't Have a Historical Benchmark?

If a quality measure's collection type doesn't have a historical benchmark, **we'll attempt to calculate a benchmark based on data submitted for the 2026 performance period**.

We can establish performance period benchmarks when at least 20 instances of the measure are reported through the same collection type and meet data completeness and case minimum requirements and have a performance rate greater than 0% (or less than 100% for inverse measures).

Performance period benchmarks will be established using data submitted by individual clinicians, groups, and virtual groups that are eligible for MIPS in the 2026 performance period.

- This **includes** individual clinicians and groups that are opt-in eligible and elect to opt-in to MIPS participation.
- Voluntary submissions are **excluded** from benchmark data.

If no historical benchmark exists and no performance period benchmark can be calculated, then the measure will receive 0 points unless:

- The measure is submitted by a small practice; small practices will continue to earn 3 points for measures without a benchmark.
- The measure is in its 1st or 2nd year in the program; these measures will earn 7 and 5 points, respectively, if data completeness is met. (This policy doesn't apply to administrative claims measures.)
- The measure is submitted under the APM Performance Pathway. In this case, measures that do not have a historical benchmark are excluded from scoring.

How Do I Know If A Measure Doesn't Have A Historical Benchmark?

Measures/collection types without historical benchmarks display "No" in the "Measure has a Benchmark" column **(Column I).**

I	J
Measure has a Benchmark	Benchmark Type
Yes	Historical
Yes	Historical
Yes	Historical
No	--
Yes	Historical
Yes	Historical

Column W in the benchmark file contains comments related to the benchmark, scoring information, and/or topped-out measure considerations, if applicable.

W
Comments
Insufficient volume of data submitted in PY 2024 to establish historical benchmark.
Substantive changes to specification in PY 2025; PY 2026 measure can't be compared to baseline period (PY 2024) measure.
Substantive changes to specification in PY 2026; PY 2026 measure can't be compared to baseline period (PY 2024) measure.
Measure added in PY 2026; subject to 7-point scoring floor if data completeness is met.
Measure added in PY 2025; subject to 5-point scoring floor if data completeness is met.
Measure Not Subject to 7 Pt Scoring Cap; Topped-Out Benchmark Applied.

How Are Measures Scored Against a Benchmark?

Each benchmark is presented in terms of deciles; the benchmark file displays Deciles 1 – 10 for each measure. Table 3 identifies the range of points generally available for the measure, based on which decile your performance rate falls into.

Table 3: Using Benchmarks to Determine Achievement Points for Measures that Meet Data Completeness and Case Minimum Requirements

Your Performance Rate Falls in the Range of This Decile*	Number of Points Assigned for the 2026 Performance Period
No benchmark (historical or performance period)	0 points (small practices will continue to receive 3 points)
Decile 1	1 – 1.9 points
Decile 2	2 – 2.9 points
Decile 3	3 – 3.9 points
Decile 4	4 – 4.9 points
Decile 5	5 – 5.9 points
Decile 6	6 – 6.9 points
Decile 7	7 – 7.9 points
Decile 8	8 – 8.9 points
Decile 9	9 – 9.9 points
Decile 10	10 points

*Exceptions:

1. Measures that are topped out for 2 consecutive years are capped at 7 points, even if your performance rate falls in Deciles 7 – 10. The benchmark file still displays values for Deciles 7 – 10 even though the measure can't earn more than 7 points.

Defined Topped-Out Measure Benchmarks

More Measures Receiving Topped-Out Measure Benchmarks

Beginning with the 2025 performance period, we established a topped-out measure benchmarking methodology for **a subset of topped-out quality measures** belonging to specialty sets with limited measure choice. Topped-out measures are:

- Quality measures with historically high measure performance with limited opportunity for performance improvement.
- Capped at 7 points when topped-out for 2 consecutive years for a specific collection type.

Clinicians who aren't facing limited measure choice are encouraged to report on other quality measures and potentially earn more than 7 points; however, some clinicians have a limited ability to select alternate measures.

This policy:

- Facilitates fairer scoring policies for all specialties.
- Removes the 7-point cap for specific topped-out measures by collection type, defined through rulemaking.
- Allows specialties impacted by limited measure choice to be scored according to defined topped out measure benchmarks.

Review Appendix A for the list of measures that will be scored according to topped-out measure benchmarks.

Table 1: Topped-Out Measure Benchmarks

Deciles	Points	Non Inverse Measure Performance Rate	Inverse Measure Performance Rate
1	1-1.9	84-85.99%	16 – 14.04%
2	2-2.9	86 – 87.99%	14 – 12.01%
3	3-3.9	88 – 89.99%	12 – 10.01%
4	4-4.9	90 – 91.99%	10 – 8.01%
5	5-5.9	92 – 93.99%	8 – 6.01%
6	6-6.9	94 – 95.99%	6 – 4.01%
7	7-7.9	96 – 97.99%	4 – 2.01%
8	8-8.9	98 – 98.99%	2 – 1.01%
9	9-9.9	99 – 99.99%	1 – 0.1%
10	10	100%	0%

Flat Benchmarks

Medicare CQMs

Medicare CQMs are only available to Medicare Shared Savings Program ACOs within the Alternative Payment Model (APM) Performance Pathway (APP) Plus quality measure set. Beginning with the 2025 performance period, Medicare CQMs will be scored using flat benchmarks for the measures' first 2 performance periods in MIPS.

- Medicare CQMs that were available beginning in 2024 were only eligible for flat benchmarks in 2025 (their 2nd year in MIPS).

Review Appendix B for a list of Medicare CQMs available for the 2026 performance year.

Table 2: Flat Benchmarks for Medicare CQMs

Decile	Points	Non Inverse Medicare CQMs Performance Rate	Inverse Medicare CQMs Performance Rate
1	1-1.9	< 10.00	99.00 – 90.01
2	2-2.9	10.00 – 19.99	90.00 – 80.01
3	3-3.9	20.00 – 29.99	80.00 – 70.01
4	4-4.9	30.00 – 39.99	70.00 – 60.01
5	5-5.9	40.00 – 49.99	60.00 – 50.01
6	6-6.9	50.00 – 59.99	50.00 – 40.01
7	7-7.9	60.00 -69.99	40.00 – 30.01
8	8-8.9	70.00 – 79.99	30.00 – 20.01
9	9-9.9	80.00 – 89.99	20.00 – 10.01
10	10	> = 90.00	<= 10.00

Reminder: CMS Web Interface measures are no longer available as a collection type as of PY 2025.

Benchmarks with Less than 10 Deciles

Some benchmarks don't include a range of performance rates for every decile. This occurs when a large percentage of clinicians in the historical benchmark data set have the maximum achievable performance rate. These benchmarks are identifiable when one or more of the deciles between Decile 1 and Decile 9 display "--" while Decile 10 is identified at 100% (or 0% for inverse measures). The higher the percentage of individual clinicians, groups, and virtual groups that reach the maximum achievable performance rate, the more deciles that will show a value of "--".

For example, in the benchmark results for the HIV Viral Suppression (Measure ID 338, MIPS CQM) presented in Table 4, historical benchmarking identified that the top 70% of clinicians performed at the maximum rate. Therefore, clinicians submitting through this collection type who performed above the 7th decile would receive the maximum performance score of 10 points.

Table 4: Example of a Measure Benchmark with Less than 10 Deciles

K	L	M	N	O	P	Q	R	S	T
Decile 1	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
76.60 - 89.18	89.19 - 90.92	90.93 - 93.15	93.16 - 95.11	95.12 - 98.71	98.72 - 99.47	99.48 - 99.99	--	--	100

Administrative Claims Measures

We updated 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.

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

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Scoring Examples

Example 1

Measure 009 (CMS128v14) submitted as an eCQM

Dr. Johnson submits data for Measure 009 (eCQM) that results in a performance rate of 75.28% and 9.2 points.

Why?

This performance rate falls in Decile 9, which means a measure score of 9.0 – 9.9 points. See formula below for partial point calculation.

Scoring Example 1.

Apply the following formula based on the measure performance and decile range:

$$\text{Achievement points} = X + \frac{(q-a)}{(b-a)}$$

$$\text{Achievement points} = 9 + \frac{(75.28-72.12)}{(86.67-72.12)}$$

$$\frac{(75.28-72.12)}{(86.67-72.12)} = 0.217182\ldots$$

Which is rounded to 0.2

$$\textbf{\textit{Achievement points}} = 9.2$$

X = decile #
q = performance rate
a = bottom of decile range
b = bottom of next decile range

Note: Partial achievement points are rounded to the tenths digit for partial points between 0.01 to 0.89. Partial achievement points above 0.9 are truncated to 0.9.

Note: This scoring example assumes data completeness and case minimum have been met.

Example 2

Measure 317 submitted as Medicare Part B Claims measure

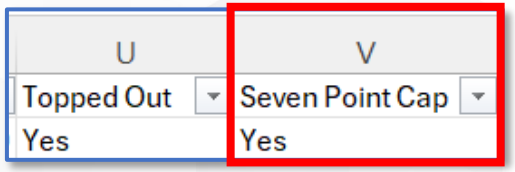
Dr. Johnson submits data for Measure 317 (Medicare Part B Claims measure) that results in a performance rate of 100% and 7.0 points. This scoring example assumes data completeness and case minimum have been met.

Why?

- This performance rate falls in Decile 10, which would generally mean a measure score of 10 points.
- However, it's a topped-out measure that is also capped at 7 points.

Column U identifies measures that are topped-out.

Column V identifies measures that are capped at 7 points.



U	V
Topped Out	Seven Point Cap
Yes	Yes

Note: Measures that are topped-out for 2 consecutive years for a specific collection type are capped at 7 points, even if your performance rate falls in Deciles 7 – 10. The benchmark file still displays values for Deciles 7 – 10 even though the measure can't earn more than 7 points.

The 7-point cap doesn't apply to measures that are subject to the topped-out measure benchmarking methodology. These measures are identified in Appendix A.

Example 3

Measure 005 submitted as a MIPS CQM

Dr. Johnson submits data for Measure 005 (MIPS CQM) that results in a performance rate of 40.52% and 1.0 point. This scoring example assumes data completeness and case minimum have been met.

Why?
This performance rate is below Decile 1 and earns the 1-point floor for measures that can be scored against a benchmark.

Example 4

Measure 370 submitted as a MIPS CQM

Dr. Johnson submits data for Measure 370 (MIPS CQM) that results in a performance rate of 99.99% and 0.0 points **at the point of submission**. This scoring example assumes data completeness and case minimum have been met.

Why?
There is no historical benchmark for Measure 370 (submitted as a MIPS CQM). **Column W on the 2026 Quality Benchmarks file will identify the reason for no historical benchmark.** Measures without a benchmark will earn 0 points – 3 points for a small practice – unless a performance period benchmark can be created for use in PY 2026. We'll attempt to create a performance period benchmark following the data submission period. If we can create one based on submission data, the measure will be eligible for up to 10 points (provided that data completeness and case minimum are met).

Exception: This policy doesn't apply to measures in their 1st or 2nd year in the program.

Example 5

Measure 513 submitted as a MIPS CQM

Dr. Johnson submits data for Measure 513 (MIPS CQM) that results in a performance rate of 52.99% and **7.0 points at the point of submission**. This scoring example assumes data completeness and case minimum have been met.

Why?
There's a 7-point scoring floor for measures added to the program in PY 2026.

- **If a performance period benchmark can be created,** Dr. Johnson would be **eligible to earn 7 – 10 points** based on their performance in comparison to the performance period benchmark.
- Column W in the 2026 Quality Benchmarks file identifies which measures were newly added to the program in 2026.

Example 6

Measure 509 submitted as a MIPS CQM

Dr. Johnson submits data for Measure 509 (MIPS CQM) that results in a performance rate of 41.99% and **5.0 points at the point of submission**. This scoring example assumes data completeness and case minimum have been met.

Why?
There's a 5-point scoring floor for measures in their 2nd year of the program in PY 2026.

- **If a performance period benchmark can be created,** Dr. Johnson would be **eligible to earn 5 – 10 points** based on their performance in comparison to the performance period benchmark.
- Column W in the 2026 Quality Benchmarks file identifies which are in their 2nd year of the program in 2026.

Example 7

Measure 249 submitted as a MIPS CQM

Dr. Johnson submits data for Measure 249 (MIPS CQM), a topped-out measure, that results in a performance rate of 88.00% and 3.0 points at the point of submission. This scoring example assumes data completeness and case minimum have been met.

Why?

This measure was defined in rulemaking as belonging to a specialty set with limited measure choice and is subject to the defined topped-out measure benchmarking methodology. **Column W** indicates that the measure isn't capped at 7 points and the topped-out measure benchmark has been applied.

U	V	W
Topped Out	Seven Point Cap	Comments
Yes	No	Measure Not Subject to 7 Pt Scoring Cap; Topped-Out Benchmark Applied.

Example 8

Measure 112 submitted as a Medicare CQM

A Shared Savings Program ACO submits data for Measure 112 (Medicare CQM) that results in a performance rate of 50.00% and 6.0 points at the point of submission. This scoring example assumes data completeness and case minimum have been met.

Why?

Medicare CQMs are scored using flat benchmarks for the measures' first 2 performance periods in MIPS. The measure was available as a Medicare CQM beginning in 2025 will only be eligible for a flat benchmark in 2026 (it's 2nd year in MIPS).

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Frequently Asked Questions

Which Measures Have Flat Benchmarks?

We apply **flat benchmarks** to Measures 001 and 236, as finalized through previous rulemaking, when the top decile for a historical benchmark is greater than 90% (or less than 10% for inverse measures). The 2026 benchmark file includes the following:

- **Measure 001:** We've assigned flat benchmarks to the **MIPS CQM and Medicare Part B claims collection types,** because they met the criteria above.
- **Measure 236:** We've assigned flat benchmarks to the **MIPS CQM and Medicare Part B claims collection types,** because they met the criteria above.

We're also **applying flat benchmarks to Medicare CQMs** for their **first 2 performance periods** in MIPS. Review Appendix B for a list of Medicare CQMs available for the 2026 performance year.

How Do Benchmarks Work for Inverse Measures?

For **inverse measures,** better performance is indicated by a lower performance rate. This is reflected in the benchmark file, where lower performance rates are found in higher deciles (e.g., Measure 001).

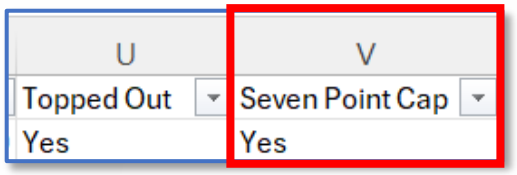
Are All Topped-Out Measures Capped At 7 Points?

No. A measure is capped at 7 points when it is topped-out through the same collection type for 2 (or more) consecutive years. The 7-point cap is applied in the 2nd year the measure is identified as topped-out.

Example 1: Measure ID 130, Documentation of Current Medications in the Medical Record (all collection types)

This measure has been topped-out for at least 2 consecutive years. A maximum of 7 points is available for the measure, even if your performance rate is found in Deciles 7 – 10.

The benchmark file still displays values for Deciles 7 – 10 even though the measure can't earn more than 7 points.



U	V
Topped Out	Seven Point Cap
Yes	Yes

Topped-out measures aren't capped at 7 points when:

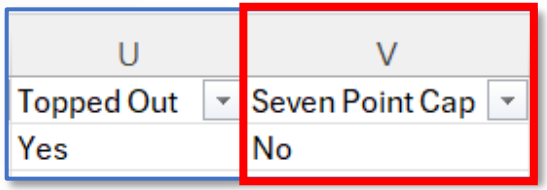
- It's not in its 2nd consecutive year of being topped-out.
- The measure is subject to the defined topped-out measure benchmarking methodology (identified through rulemaking).
- The measure is submitted for the APM Performance Pathway (APP) or APP Plus.

A measure may be topped-out without being capped at 7 points. A "Yes" in the Seven Point Cap column (column V) of the benchmark file indicates the measure is capped at 7 points.

Example 2: Measure ID 317, Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented (MIPS CQM)

Even though it's topped-out, it's not capped at 7 points because it wasn't topped-out last year.

A maximum of 10 points is available for this measure.



U	V
Topped Out	Seven Point Cap
Yes	No

Quality Payment
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Help and Version History

Where Can You Go for Help?

Contact the Quality Payment Program (QPP) Service Center by emailing us at QPP@cms.hhs.gov, submitting 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 deaf or hard of hearing can dial 711 to be connected to a Telecommunications Relay Services (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
01/29/2026	Original Version.

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Appendices

Quality Measures Scored According to Topped-Out Measure Benchmarks

MIPS Quality ID	Measure Title	Collection Type
141	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
350	Total Knee or Hip Replacement: Shared Decision-Making: Trial of Conservative (Non-surgical) Therapy	MIPS CQM

Quality Measures Scored According to Topped-Out Measure Benchmarks (Continued)

MIPS Quality ID	Measure Title	Collection Type
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	Optimizing Patient Exposure to Ionizing Radiation: 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
405	Appropriate Follow-up Imaging for Incidental Abdominal Lesions	MIPS CQM

Quality Measures Scored According to Topped-Out Measure Benchmarks (Continued)

MIPS Quality ID	Measure Title	Collection Type
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

Medicare CQMs Available within the APP Plus Quality Measure Set

The table below lists the Medicare CQMs available to Shared Savings Program ACOs within the APP Plus Quality measure set for the 2026 performance year. These measures will receive a flat benchmark for the Medicare CQM collection type in the 2026 performance period as finalized in the CY 2026 Medicare PFS Final Rule.

MIPS Quality ID	Measure Title
112	Breast Cancer Screening
113	Colorectal Cancer Screening