Quality Payment
PROGRAM

Calendar Year (CY) 2026 Medicare Physician Fee Schedule (PFS) Notice of Proposed Rulemaking: Quality Payment Program (QPP) Fact Sheet and Policy Comparison Table

Table of Contents

QPP Policy Overview: Proposals and Requests for Information

In this Notice of Proposed Rulemaking (NPRM), we're proposing a limited number of policies for QPP, keeping our focus on stability in the program. Our proposals 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.

In addition to policy proposals, we're also including several Requests for Information (RFIs) to obtain feedback from interested parties on a variety of topics before we propose related policies. These RFIs are focused on MIPS Value Pathways (MVPs), a timeline for implementing Fast Healthcare Interoperability Resources (FHIR), and the Promoting Interoperability performance category.

Proposal Highlights

MIPS Value Pathways (MVPs) Development & Strategy

- We're proposing **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 proposing **modifications to all 21 existing MVPs**, in alignment with proposals to update the quality measure and improvement activity inventories.
- We're proposing that **groups would attest to their specialty composition (whether they're a single specialty or multispecialty group that meets the requirements of a small practice) during the MVP registration process.** (i.e., CMS wouldn't make this determination for them.) We believe this proposal would support groups in their transition to MVP reporting and would help these groups assess their need to participate as subgroups.
- We're proposing that **multispecialty small practices would still be able to report an MVP as a group,** and they wouldn't be required to form subgroups beginning in the CY 2026 performance period. (i.e., Subgroup reporting would remain optional for multispecialty small practice.)
- We're proposing that Qualified Clinical Data Registries (**QCDRs**), **and Qualified Registries would 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're proposing to 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're proposing **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're proposing to **update candidate event and attribution rules for the Total Per Capita Cost (TPCC) measure**.
- We're proposing 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 proposing to **add 3 new improvement activities, modify 7 improvement activities, and remove 8 improvement activities**.
- We're proposing **the addition of a new subcategory titled "Advancing Health and Wellness"** and **the removal of the "Achieving Health Equity" subcategory**.

Promoting Interoperability:

- We're proposing **changes to the** High Priority Practices Safety Assurance Factors for Electronic Health Record (EHR) Resilience **(SAFER) Guide measure** and the **Security Risk Analysis measure.**
- We're proposing to **adopt a new optional/bonus measure for the Public Health and Clinical Data Exchange objective**, specifically the Public Health Reporting Using the Trusted Exchange Framework and Common Agreement™ (TEFCA) measure.

- We're proposing to **adopt a measure suppression policy for the MIPS Promoting Interoperability performance category** and the **Medicare Promoting Interoperability Program**.
- We're proposing to **suppress the Electronic Case Reporting measure**, in which the measure would not be scored **for the current CY 2025 performance period/2027 MIPS payment year** for the **MIPS Promoting Interoperability performance category** and the **Medicare Promoting Interoperability Program** 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're proposing to add a **determination of all eligible clinicians in Advanced APMs for Qualifying APM Participant (QP) status at the individual level**, in addition to determinations at the APM Entity level. As part of the effort to simplify this process, we're proposing to use Covered Professional Services as the set of services used for QP determinations.

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

- We're proposing to revise 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, so that the population identified for reporting within the Medicare CQM collection type would have greater overlap with the ACO's assignable beneficiary population.

Requests for Information (RFIs)

Core Elements in an MVP

- We're issuing an RFI on how to encourage MVP reporting on key quality measures that reflect the essential components of an MVP, which in turn may provide patients with more directly comparative clinician performance data on select quality measures.
- We're seeking comments on:
  - A potential Core Elements MVP reporting requirement, which would identify a subset of quality measures in each MVP to comprise the MVP's Core Elements.
  - The intended goals and ideal number of Core Elements in an MVP.
  - The role of measure collection types, the limitations of measure applicability for some clinicians, the policy implementation timeline, and any anticipated impacts on clinicians' transition to MVP reporting.

Well-being and Nutrition Measures

- We're issuing an RFI on well-being and nutrition measures in QPP, which can provide a more comprehensive approach to disease prevention and health promotion.
- We're seeking comments on:
  - Tools and measures that assess overall health, happiness, and satisfaction in life that could include aspects of emotional well-being, social connections, purpose, and fulfillment.

Procedural Codes for MVP Assignment

- We're issuing an RFI to solicit feedback on the use of procedural billing codes to assign clinicians to an MVP. This approach would facilitate specialty reporting of MVPs most relevant to their scope of care.

- We're seeking comments on:
  - The assignment of MVPs based on procedural codes and the data sources we should consider utilizing to assign clinicians to an MVP.
  - The eligibility determination period to establish procedural code utilization and relevant volume threshold.
  - Anticipated impacts on clinicians' transition to MVP reporting.

Transition Toward Digital Quality Measurement

- We're including an RFI to gather comment on continued advancements to digital quality measurement and the use of the Health Level 7® Fast Healthcare Interoperability Resources® (FHIR®) standard.
- We're seeking comments on:
  - The anticipated approach to FHIR-based electronic clinical quality measure (eCQM) reporting in quality reporting programs.
  - ACO experience with the transition to FHIR-based reporting of eCQMs and opportunities to mitigate reporting burden.

Query of Prescription Drug Monitoring Program (PDMP) Measure

- We're including an RFI to evaluate the current Query of PDMP measure. (PDMPs are electronic databases that monitor the use of controlled substances, including prescription drug usage and prescription drug history. Increased integration of PDMPs into EHRs and EHR systems continues to reduce barriers and burden of PDMP review by incorporating PDMP queries into the provider workflow.)
- We're seeking comments on:
  - Changing the Query of PDMP measure from an attestation-based measure ("Yes" or "No") to a performance-based measure (numerator and denominator), with an alternative measure designed to more effectively assess the degree to which participants are utilizing PDMPs.
  - Expanding the types of drugs to which the Query of PDMP measure could apply.

Performance-Based Measures in the Public Health and Clinical Data Exchange Objective

- We're including an RFI to evaluate the measures under the Public Health and Clinical Data Exchange objective, which don't currently measure the degree to which MIPS eligible clinicians are exchanging the data specified under each measure.
- We're seeking comments on:
  - Whether alternatives to the current attestation-based measures can drive further improvements in the quality and consistency of reporting to public health agencies and associated public health outcomes.

Data Quality

- We're including an RFI to evaluate how clinicians exchange health information.
- We're seeking comments on:
  - The current data environment, including the quality of the data being collected and exchanged and related challenges.

QPP Policy Comparison Table: Current Policies vs. Proposed Policies

- MIPS Overview
- Advanced APMs Overview
- How Do I Comment on the Proposed Rule?

Appendices

- Appendix A: Previously Finalized Policies for the 2026 Performance Period
- Appendix B: New Quality Measures Proposed for the 2026 Performance Period and Future Years
- Appendix C: Quality Measures Proposed for Removal for the 2026 Performance Period and Future Years
- Appendix D: New Improvement Activities Proposed for the 2026 Performance Period and Future Years
- Appendix E: Improvement Activities Proposed 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 Proposed and Modified MVPs Guide (PDF) documents information about the newly proposed MVPs and proposed changes to previously finalized MVPs.

The Medicare Shared Savings Program Proposals Fact Sheet documents information about proposals 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 Proposed and Modified MVPs Guide (PDF) for information about the new and modified MVPs proposed for the CY 2026 performance period.

POLICY AREA	EXISTING POLICY	CY 2026 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
MIPS Value Pathways (MVPs) Development and Strategy			
MVP Development and Maintenance	**MVP Inventory** There are 21 MVPs finalized for reporting in the CY 2025 performance period.	**MVP Inventory** We're proposing to add 6 new MVPs* to the MVP inventory: • Diagnostic Radiology • Interventional Radiology • Neuropsychology • Pathology • Podiatry • Vascular Surgery We're also proposing to modify the 21 previously finalized MVPs. *Refer to the Third Party Intermediaries section for a proposal about the timeline for QCDRs and Qualified Registries to fully support newly finalized MVPs.	• MVPs

POLICY AREA	EXISTING POLICY	CY 2026 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
MVP Reporting: Single Specialty Group	**Definition/Determination** 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** A single specialty group means a group as defined at § 414.1305 that attested in accordance with § 414.1365(b)(2)(iv) and consists of one specialty type or consists of clinicians involved in a single focus of care. We're proposing that **groups would attest to their specialty composition** (whether they're a single specialty or multispecialty group that meets the requirements of a small practice) **during the MVP registration process**. (i.e., CMS wouldn't make this determination for them.)	• MVPs
MVP Reporting: Subgroup	**Definition/Determination** Subgroup means a subset of a group as defined at §414.1305, that it contains at least one MIPS eligible clinician, and is identified by a combination of the group TIN, subgroup identifier, and each eligible clinician's NPI.	**Definition/Determination** Subgroup means a subset of a multispecialty group or a single specialty group as defined at §414.1305 that contains at least one MIPS eligible clinician, identified by a combination of the group TIN, subgroup identifier, and each eligible clinician's NPI.	• MVPs
Subgroup Reporting: Multispecialty Groups	**Definition/Determination** 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** A multispecialty group means a group as defined at §414.1305 that consists of 2 or more specialty types or clinicians involved in multiple foci of care.	• MVPs

POLICY AREA	EXISTING POLICY	CY 2026 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Subgroup Reporting: Small Practice Multispecialty Groups	**Participation Options** Beginning with the CY 2026 performance period, multispecialty groups interested in reporting an MVP can't register as a group to report an MVP. Multispecialty groups that want to report an MVP must register at the subgroup, individual, or APM Entity level.	**Participation Options** We're proposing an exception to this policy for clinicians in small practices. Specifically, • **Multispecialty groups that are small practices (15 or fewer clinicians) would still be able to register to report an MVP as a group.** • **Multispecialty groups that are small practices wouldn't be required to register as subgroups if they didn't want to report as individuals.** We have a related proposal to **update the definition of an MVP Participant to include small practices.** Specifically, we're proposing that beginning with the CY 2026 performance period, an MVP Participant would mean an individual MIPS eligible clinician, single-specialty group, multispecialty group that meets the requirements of a **small practice**, subgroup, or APM Entity.	• MVPs

POLICY AREA	EXISTING POLICY	CY 2026 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Quality Performance Category			
Quality Measures	**Quality Measure Inventory** 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** We're proposing 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. These proposals reflect: • Addition of 5 quality measures, including 2 eCQMs. (See Appendix B). • Removal of 10 quality measures from the MIPS quality measure inventory. (See Appendix C). • Substantive changes to 32 existing quality measures.	• **Traditional MIPS** • **MVPs** • **APP**
Quality Measures	**Definition of High Priority Measure** 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** We're proposing to **remove health equity** from the definition of a high priority measure, so that the revised definition would be: • An outcome (including intermediate-outcome and patient-reported outcome), appropriate use, patient safety, efficiency, patient experience, care coordination, or opioid quality measure.	• **Traditional MIPS** • **MVPs**

POLICY AREA	EXISTING POLICY	CY 2026 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Quality Measures	**Medicare CQMs (available for Shared Savings Program ACOs only)** 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. 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)** We're proposing to revise the definition of a "beneficiary eligible for Medicare CQMs" at 42 CFR 425.20 for performance year 2025 and subsequent performance years so that the population identified for reporting within the Medicare CQM collection type would have greater overlap with the ACO's assignable beneficiary population. Revising the definition of a beneficiary eligible for Medicare CQMs would reduce ACOs' burden in the patient matching necessary to report Medicare CQMs.	• **APP**
Quality Measure Scoring	**Defined Topped Out Measure Benchmarks** • 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** We're proposing that 19 quality measures 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. • Quality ID 141: Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 20% OR Documentation of a Plan of Care (Medicare Part B Claims)	• **Traditional MIPS** • **MVPs**

<table>
<tr><th>POLICY AREA</th><th>EXISTING POLICY</th><th>CY 2026 PROPOSED POLICY</th><th>APPLICABLE MIPS REPORTING OPTION(S)</th></tr>
<tr>
<td>Quality Measure Scoring
(continued)</td>
<td>Defined Topped Out Measure Benchmarks (continued)
Specifically, we'll apply the following benchmarks:
<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>Defined Topped Out Measure Benchmarks
(continued)
Quality ID 143: Oncology: Medical and Radiation - Pain Intensity Quantified (eCQM, MIPS CQM)
Quality ID 144: Oncology: Medical and Radiation - Plan of Care for Pain (MIPS CQM)
Quality ID 249: Barrett's Esophagus (Medicare Part B Claims, MIPS CQM)
Quality ID 250: Radical Prostatectomy Pathology Reporting (Medicare Part B Claims, MIPS CQM)
Quality ID 320: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients (Medicare Part B Claims)
Quality ID 350: Total Knee or Hip Replacement: Shared Decision-Making: Trial of Conservative (Non-surgical) Therapy (MIPS CQM)
Quality ID 351: Total Knee or Hip Replacement: Venous Thromboembolic and Cardiovascular Risk Evaluation (MIPS CQM)
Quality ID 360: Optimizing Patient Exposure to Ionizing Radiation: Count of Potential High Dose Radiation Imaging Studies: Computed Tomography (CT) and Cardiac Nuclear Medicine Studies (MIPS CQM)
Quality ID 364: Optimizing Patient Exposure to Ionizing Radiation: Appropriateness: Follow-up CT Imaging for Incidentally Detected Pulmonary Nodules According to Recommended Guidelines (MIPS CQM)
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Traditional MIPS
MVPs
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POLICY AREA	EXISTING POLICY	CY 2026 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Quality Measure Scoring *(continued)*		**Defined Topped Out Measure Benchmarks** *(continued)* • Quality ID 395: Lung Cancer Reporting (Biopsy/Cytology Specimens) (Medicare Part B Claims, MIPS CQM) • Quality ID 396: Lung Cancer Reporting (Resection Specimens) (MIPS CQM) • Quality ID 397: Melanoma Reporting (Medicare Part B Claims, MIPS CQM) • Quality ID 405: Appropriate Follow-up Imaging for Incidental Abdominal Lesions (MIPS CQM) • Quality ID 406: Appropriate Follow-up Imaging for Incidental Thyroid Nodules in Patients (Medicare Part B Claims, MIPS CQM) • Quality ID 430: Prevention of Post-Operative Nausea and Vomiting (PONV) - Combination Therapy (MIPS CQM) • Quality ID 440: Skin Cancer: Biopsy Reporting Time - Pathologist to Clinician (MIPS CQM) • Quality ID 463: Prevention of Post-Operative Vomiting (POV) - Combination Therapy (Pediatrics) (MIPS CQM) • Quality ID 477: Multimodal Pain Management (MIPS CQM)	• **Traditional MIPS** • **MVPs**

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<tr><th>POLICY AREA</th><th>EXISTING POLICY</th><th>CY 2026 PROPOSED POLICY</th><th>APPLICABLE MIPS REPORTING OPTION(S)</th></tr>
<tr>
<td>Quality Measure Scoring</td>
<td>Benchmarking Methodology for Scoring Administrative Claims-based Quality Measures
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
We’re proposing to update 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.
This means that the median performance rate for a measure would be set at a score derived from the performance threshold.

For example, for the CY 2025 performance period/2027 MIPS payment year, the median would be set at 7.5, the performance threshold equivalent.
The cut-offs for benchmark point ranges would then be calculated based on standard deviations from the median (See table below).

<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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Traditional MIPS
MVPs
APP

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<tr><th>POLICY AREA</th><th>EXISTING POLICY</th><th>CY 2026 PROPOSED POLICY</th><th>APPLICABLE MIPS REPORTING OPTION(S)</th></tr>
<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
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>
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<td>
APP Plus Quality Measure Set
We’re proposing to update the APP Plus quality measure set under the APP, in alignment with proposals for the MIPS quality measure inventory.
If finalized for removal from the MIPS quality measure inventory, the Screening for Social Drivers of Health measure (Quality ID 487) would be removed from the APP Plus quality measure set as well.
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<tr><th>POLICY AREA</th><th>EXISTING POLICY</th><th>CY 2026 PROPOSED POLICY</th><th>APPLICABLE MIPS REPORTING OPTION(S)</th></tr>
<tr><td>Alternative Payment Model (APM) Performance Pathway (APP) Plus Quality Measure Set (continued)</td><td>Alternative Payment Model (APM) Performance Pathway (APP) Plus Quality Measure Set (continued)
<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 eCQM specification becomes available, whichever is later</td></tr>
</table></td><td></td><td></td></tr>
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POLICY AREA	EXISTING POLICY	CY 2026 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Cost Performance Category			
Cost Measures	**Inventory** There is a total of 35 cost measures available in the CY 2025 performance period.	**Inventory** We're not proposing to expand or reduce the existing inventory of 35 cost measures for the CY 2026 performance period. We're proposing to modify the Total Per Capita Cost (TPCC) measure.	• **Traditional MIPS** • **MVPs**
Cost Measures	**Total Per Capita Cost (TPCC) Measure** 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** We're proposing to **modify the TPCC measure candidate event and attribution criteria.** Specifically, we're proposing to: • 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; • 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 • 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. You can review the TPCC Measure Information Form on the CMS website for details about the proposed modifications to the TPCC measure.	• **Traditional MIPS** • **MVPs**

POLICY AREA	EXISTING POLICY	CY 2026 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Cost Evaluation	**Informational-Only Feedback Period** No existing policy	**Informational-Only Feedback Period** We're proposing a 2-year informational-only feedback period for new cost measures beginning with the CY 2026 performance period. (Please note that we're not proposing any new cost measures for implementation in the 2026 performance period.) • Under this proposal, MIPS eligible clinicians, groups, virtual groups, and subgroups would **receive informational-only scoring feedback on a new cost measure (or measures) for 2 years before it contributes to their final score**. **Example:** 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. • The group would receive informational feedback on the measure for the 2027 and 2028 performance periods, but the measure wouldn'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. • The group would be scored on the cost measure for the CY 2029 performance period, and it would contribute to their MIPS final score for the CY 2029 performance period/2031 MIPS payment year.	• **Traditional MIPS** • **MVPs**

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

POLICY AREA	EXISTING POLICY	CY 2026 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Promoting Interoperability Performance Category			
Promoting Interoperability Measure Inventory	**Protect Patient Health Information Objective, Security Risk Analysis Measure** This measure requires MIPS eligible clinicians to attest "Yes" or "No" to having conducted or reviewed a security risk analysis in accordance with the HIPAA Security Rule.	**Protect Patient Health Information Objective, Security Risk Analysis Measure** We're proposing to modify 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. • The measure would remain required. • A "No" response for the measure would continue to result in a total score of zero points for the Promoting Interoperability performance category.	• **Traditional MIPS** • **MVPs** • **APP**
Promoting Interoperability Measure Inventory	**High Priority Practices Safety Assurance Factors for Electronic Health Record (EHR) Resilience (SAFER) Guide Measure** 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** We're proposing to modify the High Priority Practices SAFER Guide measure by **requiring the use of the 2025 SAFER Guides.** A MIPS eligible clinician would attest "Yes" or "No" to completing an annual self-assessment using the High Priority Practices Guide within the 2025 SAFER Guides. • The measure would remain required. • A "No" response for the measure would continue to result in a total score of zero points for the Promoting Interoperability performance category.	• **Traditional MIPS** • **MVPs** • **APP**

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

POLICY AREA	EXISTING POLICY	CY 2026 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Promoting Interoperability Measure Inventory	**Measure Suppression Policy** No existing policy.	**Measure Suppression Policy** We're proposing to adopt a measure suppression policy for the MIPS Promoting Interoperability performance category and the Medicare Promoting Interoperability Program. • CMS would establish criteria for determining circumstances in which a measure could be suppressed and subsequently not scored for MIPS eligible clinicians and eligible hospitals and critical access hospitals (CAHs) participating in the Medicare Promoting Interoperability Program, respectively. • The proposed measure suppression policy would provide CMS with the means to address future potential circumstances that would warrant the necessity to suppress a Promoting Interoperability measure from scoring. • The proposed policy would be effective starting with the CY 2026 performance period/2028 MIPS payment year and the EHR reporting period in CY 2026.	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2026 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Promoting Interoperability Measure Inventory	**Public Health and Clinical Data Exchange Objective, Electronic Case Reporting Measure** 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** We're proposing that we would suppress the Electronic Case Reporting measure for the MIPS Promoting Interoperability performance category and the Medicare Promoting Interoperability Program, in which the measure would not be scored for the Public Health and Clinical Data Exchange objective for the **CY 2025 performance period/2027 MIPS payment year and the EHR reporting period in CY 2025**. • 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. Modifying the scoring requirements for the Public Health and Clinical Data Exchange objective would prevent undue penalties for MIPS eligible clinicians because of circumstances that are outside of their control.	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2026 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Final Scoring			
Performance Threshold	**Performance Threshold** 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** We're proposing to continue using 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. • On this basis, we are proposing to **set the performance threshold at 75 points through the CY 2028 performance period/2030 MIPS payment year.**	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2026 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Third Party Intermediaries			
Certified Survey Vendors	**CAHPS for MIPS Survey Measure Administration** 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** We're proposing to **add 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** • **MVPs** • **APP**
Certified Survey Vendors	**CMS-approved Survey Vendor Requirements** 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** We're proposing to **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** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2026 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Qualified Clinical Data Registries (QCDRs) and Qualified Registries	**MVP Support** 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** We're proposing to provide flexibility for a QCDR or Qualified Registry to fully support a newly finalized MVP no later than one year after the MVP is finalized. In practice, if the 6 proposed MVPs are finalized for implementation in the CY 2026 performance period, a QCDR or Qualified Registry would need to fully support the MVPs that are applicable to their clinicians beginning with the CY 2027 performance period.	• **MVPs**

Advanced APMs Overview

POLICY AREA	EXISTING POLICY	CY 2026 PROPOSED POLICY
Qualifying APM Participants (QPs)	**QP Determinations** • Generally, we make QP determinations at the APM Entity level. • There are limited exceptions where CMS will perform this calculation for an individual clinician. • We generally use Evaluation and Management services to determine which beneficiaries are included in our QP determinations.	**QP Determinations** • We're proposing to add an **individual QP determination calculation for all clinicians** participating in an Advanced APM in addition to determinations at the APM entity level. • We're also proposing to create a uniform calculation methodology by expanding the types of services we include in the QP calculations from a set of Evaluation and Management services to all Covered Professional Services.

How Do I Comment on the CY 2026 Proposed Rule?

The proposed rule includes directions for submitting comments. We must receive comments within the 60-day comment period.

When commenting, refer to file code: CMS-1832-P.

We don't accept FAX transmissions.

Use 1 of the 3 following ways to officially submit your comments:

- **Electronically:** www.regulations.gov
- **Regular mail:** Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1807-P, P.O. Box 8016, Baltimore, MD 21244-8016.
- **Express or overnight mail:** Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1832-P, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.

You can access the proposed rule through the "Regulatory Resources" section of the QPP Resource Library.

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
07/11/2025	Original Version.

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) will be 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: • 112, 113
APM Performance Pathway (APP) Plus Quality Measure Set	We're incrementally incorporating additional measures into the APP Plus quality measure set. In addition to the 6 measures in the existing APP plus quality measure set, the following quality measures will be added beginning with the CY 2026 performance period/2028 MIPS payment year: • Quality #113: Colorectal Cancer Screening • 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. 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 Proposed for the 2026 Performance Period and Future Years

Measure Title and Steward	Description	Collection Type	Measure Type	Rationale for Inclusion
Patient Reported Falls and Plan of Care 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 proposing 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.
Prevalent Standardized Kidney Transplant Waitlist Ratio (PSWR) 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 proposing 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]. 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 in this Notice of Proposed Rulemaking we've proposed to update 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
Diagnostic Delay of Venous Thromboembolism in Primary Care 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 proposing 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.
Screening for Abnormal Glucose Metabolism in Patients at Risk of Developing Diabetes 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 proposing 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
Hepatitis C Virus (HCV): Sustained Virological Response (SVR) 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 proposing 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 Proposed 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 Proposed 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: • Determine his/her baseline detection rates for MCI, dementia and cognitive impairment at either stage using the tool provided for this Improvement Activity • If either of the three rates are below 1.0: ++ Increase the uptake of the Annual Wellness Visit ++ Ensure that each Annual Wellness Visit contains a structured cognitive assessment ++ 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 • Remeasure detection rates for MCI, dementia, and cognitive impairment at either stage quarterly ++ Of note, this Improvement Activity focuses on Medicare patients aged 65 and older, given the strong correlation of cognitive impairment with age.
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. 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. The MIPS eligible clinician must include one or more of the following activities in addition to completing the training: • Create a dental referral network list by specialty and accepted insurances. • 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). • Identify an applicable caries risk assessment to be used. Example caries-risk-assessment-checklist-d1.png (768×1024) (formsbirds.com)

Activity Title	Subcategory	Activity Description
		• Include Intraoral health screening and referral to dental provider as part of a patient's primary care management. • Provide education and counseling to patients about the importance of oral health and impact on systemic disease. • 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. • Include a description of the findings found in all dental referrals. ++ 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 Proposed 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** 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** 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. 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** 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: • 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. • 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. • Update and apply requirements for staff training on food security and nutrition. • 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. 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** 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** 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: • Develop and maintain formal relationships with community-based organizations to strengthen the community service referral process, implementing closed-loop referrals where feasible; or 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 • 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. 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** 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. Vaccines and Immunizations | CDC.
IA_PM_6	Population Management	**Use of Toolsets or Other Resources to Close Health and Health Care Inequities Across Communities** 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** 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. 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** 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** 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** 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** 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).