Quality Payment
PROGRAM

Merit-based Incentive Payment System (MIPS)

Traditional MIPS Scoring Guide for the 2026 Performance Year

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Already know what MIPS is? Skip ahead by clicking the links in the Table of Contents.

NOTE: Medicare Shared Savings Program Accountable Care Organizations (ACOs) are required to report the Alternative Payment Model (APM) Performance Pathway Plus (APP Plus) quality measure set for the 2026 performance year. ACOs should refer to the 2026 Alternative Payment Model (APM) Performance Pathway (APP) Toolkit (once available) for more information on their reporting requirements.

How to Use This Guide

Please Note: This guide was prepared for informational purposes only and isn't intended to grant rights or impose obligations. The information provided is only intended to be a general summary. It isn't intended to take the place of the written law, including the regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

Table of Contents

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Hyperlinks

Hyperlinks to the Quality Payment Program website are included throughout the guide to direct the reader to more information and resources.

Overview

OVERVIEW

What Is The Merit-based Incentive Payment System?

If you're eligible for MIPS:

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

Quality Payment PROGRAM

To learn more about MIPS eligibility and participation options:

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

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

If you're eligible for MIPS (Continued):

- Your performance across the MIPS performance categories, each with a specific weight, will result in a MIPS final score of 0 to 100 points.
- Your MIPS final score will determine whether you receive a negative, neutral, or positive MIPS payment adjustment.
  - **Positive payment adjustment** for clinicians with a final score **above** the performance threshold (**75 points** in 2026 – 2028 performance years).
  - **Neutral payment adjustment** for clinicians with a final score **equal to** the performance threshold (**75 points** in 2026 – 2028 performance years).
  - **Negative payment adjustment** for clinicians with a final score **below** the performance threshold (**75 points** in 2026 – 2028 performance years).
- Your MIPS payment adjustment is based on your performance during the performance year and applied to payments for your Medicare Part B-covered professional services beginning on January 1 of the payment year.
  - E.g., 2028 is the payment year for the 2026 performance year.

Quality Payment PROGRAM

To learn more about MIPS eligibility and participation options:

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

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

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

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

Getting Started: Reviewing MIPS Terms

Collection Type*

Collection Type is a set of quality measures with comparable specifications and data completeness criteria, identified as:

- Electronic clinical quality measures (eCQMs).
- MIPS clinical quality measures (MIPS CQMs).
- Qualified Clinical Data Registry (QCDR) measures.
- Medicare Part B claims measures (available to small practices).
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey measure (available to groups, virtual groups, and APM Entities with 2 or more clinicians).
- Administrative claims measures.

*The term “Collection Type” is unique to the quality performance category and doesn’t apply to the other 3 performance categories.

Submitter Type

Submitter Type refers to the MIPS eligible clinician, group, virtual group, APM Entity, or third party intermediary (acting on behalf of a MIPS eligible clinician, group, virtual group, or APM Entity) that submits data on measures for the quality and Promoting Interoperability performance categories and activities for the improvement activities performance category.

Submission Type**

Submission Type is the mechanism by which the submitter type submits data to CMS:

- Direct (transmitting data through a computer-to-computer interaction, such as an Application Program Interface, or API).
- Sign in and upload (attaching a file).
- Sign in and attest (manually entering data).
- Medicare Part B claims.

**There isn’t a submission type for the cost performance category because we collect and calculate your cost measures from administrative claims data submitted for payment.

Data Aggregation and Multiple Submissions

Measures and activities submitted via multiple submission types can count toward a single performance category score, but there’s some variation between performance categories. Please see **Data Aggregation and Multiple Submissions** within each performance category section for more information.

- Quality performance category
- Improvement activities performance category
- Promoting Interoperability performance category

Traditional MIPS: Quality Performance Category

Quality Payment PROGRAM

What are the Traditional MIPS Quality Performance Category Requirements?

You can select from 190 available MIPS quality measures finalized for the 2026 performance period, in addition to hundreds of QCDR measures approved by CMS outside of rulemaking.

You'll need to collect and submit data for each quality measure for the entire calendar year of 2026 (January 1 – December 31, 2026.)

We'll aggregate MIPS quality measures collected through multiple collection types into a single quality performance category score.

To meet traditional MIPS quality performance category requirements, an individual, group, virtual group, or APM Entity can:

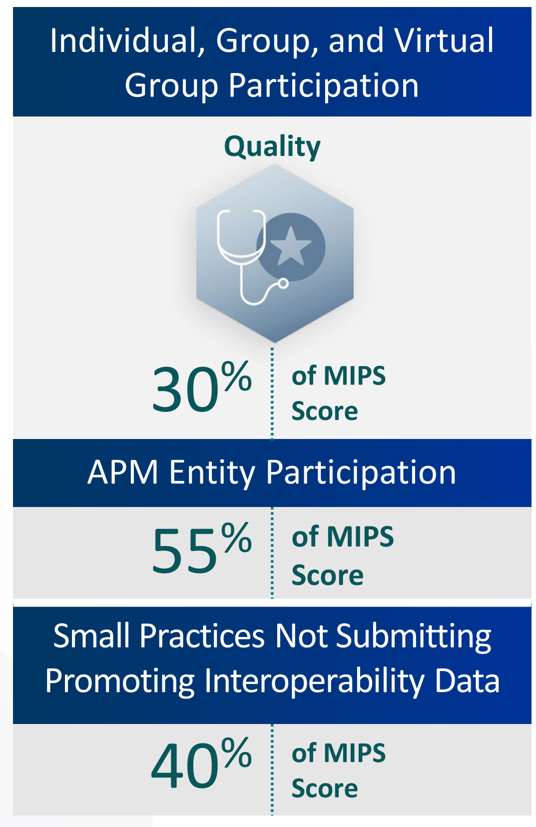
Submit at least 6 MIPS quality measures for the 12-month performance period:

- 1 of these 6 must be an outcome measure OR another high priority measure in the absence of an applicable outcome measure.
- The CAHPS for MIPS Survey measure counts as 1 of the 6 measures for registered groups, virtual groups, and APM Entities and can be used to meet the high priority measure requirement if there aren't any applicable outcome measures.

OR

Submit a defined specialty measure set.

If the specialty measure set has fewer than 6 measures, you'll need to submit all measures within the specialty set to meet quality reporting requirements.



What are the Traditional MIPS Quality Performance Category Requirements? (Continued)

There are also 4 MIPS quality measures that will be automatically evaluated and calculated through administrative claims, if minimum requirements are met:

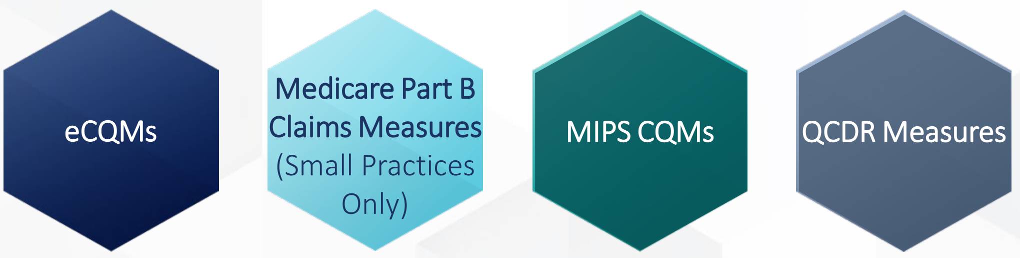
- Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with Heart Failure under MIPS (ZIP, 1MB)
  - This measure has a case minimum of **21 cases** and will only apply to **groups, virtual groups, and APM Entities with at least 1 cardiologist**.
- Risk-Standardized Complication Rate (RSCR) following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) for MIPS (ZIP, 469KB)
  - This measure has a case minimum of **25 cases** and will apply to **individuals, groups, virtual groups, and APM Entities**.
  - This measure has a **3-year performance period** (consecutive 36-month timeframe).
    - For the 2026 MIPS performance period, the Hip Arthroplasty and Knee Arthroplasty Complication Measure's performance period starts on October 1, 2023 (3 years prior to the performance period) and ends on September 30, 2026 (current performance period), with a 3-month numerator assessment period.
- Hospital-wide, 30-Day, All-cause Unplanned Readmission (HWR) Measure for MIPS Groups (ZIP, 792KB)
  - This measure has a case minimum of **200 cases** and will apply to **groups, virtual groups, and APM Entities with at least 16 clinicians**.
- Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (ZIP, 5MB)
  - This measure has a case minimum of **18 cases** and will only apply to **groups, virtual groups and APM Entities with at least 16 clinicians.**

Quality Measure Scoring

How are Quality Measures Assessed and Scored?

Your performance on each quality measure is assessed against a benchmark to see how many points you earn for the measure.

Benchmarks are differentiated by collection type. There may be different benchmarks for the same measure if it can be reported through multiple collection types.



Whenever possible, we use historical data to establish benchmarks. Historical benchmarks for each collection type are based on performance data from a baseline period, the 12-month calendar year that is 2 years prior to the applicable performance period. The historical benchmarks for the 2026 MIPS performance period were established from quality data submitted for the 2024 MIPS performance period.

For more information about the 2026 quality benchmarks, please review the information included in the 2026 Quality Benchmarks.

Did you know? If you submit eCQMs, you need to use Certified Electronic Health Record Technology (CEHRT) to collect the eCQM data. The CEHRT used to collect the data must be certified to meet the Office of the National Coordinator for Health Information Technology (ONC) criteria by the time eCQM data is generated for submission.

A CEHRT ID is required when submitting eCQM data for the quality performance category.

CAHPS for MIPS Survey Measure:

We established historical benchmarks for the summary survey measures (SSMs) in the CAHPS for MIPS Survey measure.

Refer to the 2026 Quality Benchmarks.

Each SSM with a benchmark is awarded 1 to 10 points by comparing performance to the benchmark.

The final CAHPS for MIPS Survey measure score is calculated as the average number of points across all scored SSMs.

Quality Measure Scoring (Continued)

What if a Quality Measure Doesn't Have a Historical Benchmark?

For a measure without a historical benchmark, we'll try to calculate a benchmark based on performance data submitted for the 2026 performance period on those measures.

Performance period benchmarks can be calculated when 20 or more individuals, groups, virtual groups, or APM Entities submit the measure through the same collection type where the measure:

- Meets or exceeds the minimum case volume of 20 eligible cases (has enough data for it to be reliably measured).
- Meets or exceeds the 75% data completeness criteria.
- Has a performance rate greater than 0% (or less than 100% for inverse measures).

Individuals, groups, virtual groups, and APM Entities must be included in MIPS (i.e., not voluntarily reporting) for their data to be used in the creation of a benchmark. This includes individual clinicians, groups, virtual groups and APM Entities that are opt-in eligible and elect to opt-in to MIPS participation.

When calculating performance period benchmarks, we use measure data submitted for traditional MIPS, the APP and MVPs.

Do Administrative Claims Measures Receive a Historical Benchmark?

No, we intend to calculate performance period benchmarks for the 4 administrative claims measures using a methodology updated in the 2026 Physician Fee Schedule Final Rule to align with changes to cost measure scoring. An example of the methodology is provided in the 2026 Quality Payment Program Final Rule Fact Sheet and Policy Comparison Table (PDF, 998KB).

Quality Measure Scoring (Continued)

What Does Data Completeness Mean?

Data completeness refers to the volume of performance data reported for the measure's eligible population.

- When reporting a quality measure, **your submission must identify the total eligible population** (or denominator) as outlined in the measure's specification. (For small practices reporting Medicare Part B claims measures, we identify the eligible population based on the claims you submit.)

To meet data completeness criteria, **you must report performance data (performance met or not met, or denominator exceptions) for at least 75% of the total eligible population (denominator).**

- Incomplete reporting of a measure's eligible population or otherwise misrepresenting a clinician or group's performance (only submitting favorable performance data, commonly referred to as "cherry-picking") wouldn't be considered true, accurate, or complete and may subject you to audit.
- Data completeness is specific to Medicare patients for Medicare Part B claims measures only; QCDR measures, MIPS CQMs and eCQMs should include all-payer data.
- **Measures that don't meet data completeness will earn zero points, unless you're a part of a small practice in which case the measure will earn 3 points.**

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

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

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

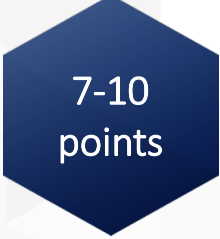
Quality Measure Scoring (Continued)

Measure Achievement Points for the 2026 Performance Period

Measures that can be reliably scored

Measure achievement points are based on your performance for a measure in comparison to a benchmark. A measure can be reliably scored against a benchmark when:

- A benchmark (historical or performance period) is available.
- Data completeness and case minimum criteria are met.



You'll earn 7 – 10 points for new measures in their **first year** of the program that can be reliably scored against a benchmark.

5-10 points

You'll earn 5 – 10 points for new measures in their **second year** of the program that can be reliably scored against a benchmark.

You'll earn 1 – 10 points for measures in their **third year (or later)** of the program that can be reliably scored against a benchmark.

Did you know?
These measure scoring policies for measures in their first and second year **don't** apply to administrative claims measures, measures with substantive changes, or measures that are available through a new collection type.

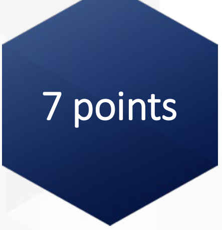
***Exception:** There are specified, topped out measures that are capped at 7 points. These measures are identified in the 2026 Quality Benchmarks see Column V.

Quality Measure Scoring (Continued)

Measure Achievement Points for the 2026 Performance Period (Continued)

Measures that can’t be reliably scored

When a measure meets data completeness criteria but can’t be reliably scored against a benchmark, it means either a benchmark (historical or performance period) is unavailable **OR** the measure didn’t meet case minimum criteria.



You’ll earn 7 points for new measures in their **first year** of the program that can’t be reliably scored against a benchmark

5 points

You’ll earn 5 points for new measures in their **second year** of the program that can’t be reliably scored against a benchmark.

You’ll earn 0 points for measures in their **third year** (or later) of the program that can’t be reliably scored against a benchmark.
Small practices will continue to earn 3 points.

Did you know?
These measure scoring policies for measures in their first and second year **don’t** apply to administrative claims measures, measures with substantive changes, or measures that are available through a new collection type.

Quality Measure Scoring (Continued)

Measure Achievement Points for the 2026 Performance Period (Continued)

Required but unreported measures

0 (out of 10) **points**

You'll continue to receive 0 points for measures that are required, but unreported.

Note: This includes measures submitted with a denominator/initial patient population but without performance data. (You must report performance data – performance met or performance not met for at least 1 patient – for the measure to be considered reported.)

Measures that don't meet data completeness criteria

0 (out of 10) **points**

If you aren't in a small practice (small practices have 15 or fewer clinicians), you'll continue to receive 0 points for measures that don't meet data completeness requirements.

Note: This scoring policy also applies to measures in their first and second year of the program.

3 points

Small practices will continue to receive 3 points for measures that don't meet data completeness requirements.

Note: This scoring policy also applies to measures in their first and second year of the program.

Quality Measure Scoring (Continued)

Defined Topped Out Measure Benchmarks

We apply an alternative benchmarking methodology to a subset of topped out measures that belong to specialty sets with limited measure choice and a high proportion of topped out measures, in areas that lack measure development.

Measures to which this policy will apply will be evaluated and updated each year through rulemaking.

See Appendix D for quality measures that will be scored according to the new topped out measure benchmarks for the 2026 performance period. These measures are also noted in the 2026 Quality Benchmarks file in Column W identified with the following message “Measure Not Subject to 7 Pt Scoring Cap; Topped-Out Benchmark Applied.”

We’ll apply the following benchmarks:

Performance Rate	Available Points
84 – 85.9%	1 – 1.9
86 – 87.9%	2 – 2.9
88 – 89.9%	3 – 3.9
90 – 91.9%	4 – 4.9
92 – 93.9%	5 – 5.9
94 – 95.9%	6 – 6.9
96 – 97.9%	7 – 7.9
98 – 98.9%	8 – 8.9
99 – 99.99%	9 – 9.9
100%	10

Quality Performance Category Bonus Points

Measure Bonus Points

There are **no measure-level bonus points available.**

Small Practice Bonus

Small practices will continue to receive **6 bonus points**, added to the numerator of the quality performance category, if they report at least one MIPS quality measure.

- This bonus is available to individuals, groups, virtual groups, and APM Entities with the small practice special status.
- This bonus isn't available to small practices that receive a quality performance category score from facility-based measurement.

Complex Organization Adjustment

We'll add **one measure achievement point for each eCQM submitted for an APM Entity or virtual group** that meets data completeness and case minimum requirements. The adjustment may not exceed 10% of the total available measure achievement points in the quality performance category. The complex organization adjustment doesn't apply to clinicians participating as an individual or group.

Quality Performance Category Scoring

What if I Submit More Than 6 Measures?

If you submit more than 6 measures, only 6 of those measures will contribute to the measure achievement points for your quality performance category score.

When determining which submitted measures are included in the top 6:

- We'll select the highest scoring outcome measure.
    - If no outcome measure is available, then we'll select the highest scoring high priority measure.
- We'll then select the next 5 highest scoring measures.
- If you don't submit an outcome or high priority measure, we'll select your 5 highest scoring measures, and you'll receive a score of 0/10 for the missing outcome or high priority measure.

When there are multiple measures with the same score, we'll select measures for the top 6 based on the measure ID (in ascending order).

- **Example:** Your group submits 7 measures, and the 2 lowest scoring measures (after the outcome measure) were Measure 102: Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients and Measure 143: Oncology: Medical and Radiation - Pain Intensity Quantified, both earning 2.2 points. The Prostate Cancer measure will be included in the top 6 because its measure ID (102) has a lower value than the measure ID for the Oncology: Medical and Radiation - Pain Intensity Quantified measure (143).

Remember:

Scoring is determined by comparing the performance rate to the measure's benchmark.

If you submit 2 measures, each with an 85% performance rate, one may earn 4 points while the other earns 10 points, based on the benchmarks for each measure.

Quality Performance Category Scoring (Continued)

How Many Points Can I Earn in the Quality Performance Category?

Maximum Points by Participation Level
Individuals:

60 points
For 6 required MIPS quality measures

70 Points
For 6 required MIPS quality measures + 1 administrative claim measure

Maximum Points by Participation Level
Groups/Virtual Groups/APM Entities:

60 points
For 6 required MIPS quality measures

70 Points
For 6 required MIPS quality measures + 1 administrative claims measure

80 Points
For 6 required MIPS quality measures + 2 administrative claims measures

90 Points
For 6 required MIPS quality measures + 3 administrative claims measures

100 Points
For 6 required MIPS quality measures + 4 administrative claims measures

Individuals, groups, virtual groups, and APM Entities that don’t submit at least 1 available measure will receive 0 points in this performance category unless you qualify for the performance category to be reweighted.

Quality Performance Category Scoring (Continued)

Can the Denominator (Maximum Number of Points) be Lower than 60 Points?

Yes, under certain circumstances your denominator (10 x the number of measures you're required to report) may be lower than 60 points.

IF…	THEN…
You submit a complete specialty measure set with fewer than 6 measures by either Medicare Part B claims or MIPS CQMs.	We'll lower the denominator by 10 points for each measure that isn't available.
You submit fewer than 6 Medicare Part B claims measures or MIPS CQMs **AND** the Eligible Measure Applicability (EMA) process determines no additional measures were available. **How?** We compare the measures you submitted with a predefined list of clinically related measures.	We'll lower the denominator by 10 points for each measure that isn't available. **NOTE:** If we find additional clinically related measures that you didn't report, then we won't remove those measures from the maximum number of points available for the quality performance category and you'll earn a score of 0 out of 10 for each of these measures.
You submit a measure(s) significantly impacted by clinical guideline (or other) changes that CMS believes may result in patient harm or misleading results and 9 months of consecutive, reliable data isn't available. (Refer to Appendix E for suppressed measure scoring examples.) To the extent feasible, we'll identify suppressed measures via QPP listserv by the end of the submission period. Refer to Appendix F for a list of affected measures.	We'll lower the denominator by 10 points for each impacted measure that was submitted and meets data completeness and case minimum requirements. **Why?** So that you receive credit for having reported the measure and aren't penalized for low performance because you're following current clinical guidelines that aren't accounted for in the measure specification or held accountable for measure implementation issues that are outside of your control. However, when 9 consecutive months of data is available, we'll truncate the performance period and score the measure instead of suppressing the measure and reducing the denominator.
Your group, virtual group, or APM Entity registers for the CAHPS for MIPS Survey but doesn't meet the minimum beneficiary sampling requirements **AND** submits fewer than 6 measures.	We'll lower the denominator by 10 points to account for your inability to report the CAHPS for MIPS Survey measure.

Quality Performance Category Scoring (Continued)

What Are the Steps to Score Medicare Part B Claims Measures, QCDR Measures, eCQMs, and/or MIPS CQMs?

Does measure meet data completeness criteria (= or >75%)?

YES → **Does measure meet case minimum criteria (= or >20 cases for most measures)?**

NO → **0 or 3 points** (small practices will receive 3 points, all others will receive 0 points)

Does measure meet case minimum criteria (= or >20 cases for most measures)?

YES → **Is a benchmark available?**

NO → **0 or 3 points** (small practices will receive 3 points, all others will receive 0 points)

→ **7 points** For new measures in their first year of the program.

→ **5 points** For new measures in their second year of the program.

Is a benchmark available?

YES → **1 10 points** based on your performance in comparison to benchmark.

→ **7 10 points** based on performance if 1st year measure can be reliably scored against a benchmark.

→ **5 10 points** based on performance if 2nd year measure can be reliably scored against a benchmark.

→ 0 points Based on no performance data reported (performance met/not met)

NO → **0 or 3 points** (small practices will receive 3 points, all others will receive 0 points)

→ **7 points** For new measures in their first year of the program.

→ **5 points** For new measures in their second year of the program.

Appendix A gives you an example of how to find a benchmark, determine achievement points, and pick the top 6 measures based on the number of points.

Skip ahead to review how we calculate the quality performance category score.

Quality Performance Category Scoring (Continued)

The purpose of this slide is to highlight the difference between concepts impacting measure scoring and performance. Each concept below provides guidance on their function within MIPS. Appendix E provides examples of how suppressed and truncated measures are submitted and scored.

Suppression Scoring Flexibility

- Applied when data is not available for at least 9 consecutive months, or CMS determines that the measure may result in patient harm or misleading results.

Truncation Submission Flexibility

- Applied when there is data available and that be reported without concerns for measure data integrity for 9 consecutive months of the 2026 performance period.
- Timeframe will be specified by CMS in the Truncated and Suppressed MIPS Quality Measures publication, if there are measures identified as being truncated. Measures impacted from ICD-10 coding updates are announced in early October on the QPP Resource Library.
- Doesn't apply to the eCQM collection type.
- Truncation to the 9-month period should be applied to the denominator criteria for the purposes of determining denominator eligibility. The numerator will function as currently specified for those patients that fall into the denominator during the 9-month period.

Benchmark Removal Not a Scoring Flexibility

- Applied when proposed substantive changes are finalized through public notice and comment rulemaking no longer allow for a direct comparison of performance data from prior years to performance data submitted after the implementation of these substantive changes.
- Benchmark removals are proposed and finalized within the upcoming MIPS performance year rules.

Calculating the Quality Performance Category Score

Scoring for Individuals, Groups, Virtual Groups, and APM Entities

For individuals, groups, virtual groups, and APM entities that aren't a small practice, the quality performance category score is calculated as:

For individuals, groups, virtual groups, and APM Entities that are part of a small practice, the quality performance category score is calculated as:

*Total Available Measure Achievement Points the number of required measures (including administrative claims measures) x 10

Calculating the Quality Performance Category Score (Continued)

Scoring for Individuals, Groups, Virtual Groups, and APM Entities (Continued)

- A total of **6 bonus points** will be added to the numerator of the quality performance category for MIPS eligible clinicians in **small practices who submit data on at least 1 quality measure** (these bonus points are available to small practices through individual, group, virtual group, and APM Entity participation).
- Your quality performance category score is then multiplied by the quality performance category weight. The product is then added to the other weighted performance category scores to determine the overall MIPS final score.

The maximum score is 100% of the category weight.

- When the quality performance category is weighted at 30%, the quality performance category can contribute up to 30 points towards your MIPS final score.

Calculating the Quality Performance Category Score (Continued)

Your quality performance category score is multiplied by the category weight and then by 100 to determine the number of points that contribute to your MIPS final score.

Example	Calculation
Example 1 The MIPS eligible clinician, group, or virtual group is scored on all 4 MIPS performance categories.	81.9% x **30%** x 100 = **24.57** Points under the quality performance category contributing to the MIPS final score
Example 2 The MIPS eligible clinician, group, or virtual group can't be scored on the cost performance category.	81.9% x **55%** x 100 = **45.05** Points under the quality performance category contributing to the MIPS final score
Example 3 The MIPS eligible clinician, group, or virtual group is a small practice that receives automatic reweight of the Promoting Interoperability performance category.	81.9% x **40%** x 100 = **32.76** Points under the quality performance category contributing to the MIPS final score

Calculating the Quality Performance Category Score (Continued)

What is Improvement Scoring?

MIPS eligible clinicians can **earn up to 10 additional percentage points** in the quality performance category **based on the rate of their improvement in the quality performance category** from the previous year. The improvement score—calculated at the category level and represents improvement in achievement from one year to the next—may not total more than 10 percentage points. If CMS can't compare data between 2 performance periods, or there's no improvement, the improvement score will be 0%. **The improvement score can't be negative.**

Eligibility for these additional percentage points is determined by meeting the following criteria:

1. Full participation in the quality category for the current performance period:
    - Submits 6 measures (with at least 1 outcome/high priority measure).
    - Submits a complete specialty measure set (which may have fewer than 6 measures; submits all measures in the set).
        - All submitted measures must meet data completeness requirements.
2. Data sufficiency standard is met, meaning there's data available and can be compared:
    - There's a quality performance category achievement score (the score earned by measures based on performance excluding bonus points) for the previous performance period (2025 performance period) and the current performance period (2026 performance period).
    - Data was submitted under the same identifier for the 2 consecutive performance periods, or CMS can compare the data submitted for the 2 performance periods.

Did you know?

Improvement scoring isn't available for clinicians who are scored under facility based measurement in the current performance period or in the performance period immediately prior to the current MIPS performance period.

Calculating the Quality Performance Category Score (Continued)

How is improvement scoring calculated?

Improvement scoring is calculated by comparing the quality achievement percentage score from the previous (2025) performance period to the quality performance category achievement percentage score for the current (2026) performance period.

=

Increase in Quality Performance Category Achievement Score
(From prior performance period to current performance period)

Prior Performance Period Quality Performance Category Achievement Score

× 10%

Calculating the Quality Performance Category Score (Continued)

Scoring Example

A small practice, participating as a group, reports 2 Medicare Part B claims measures and 3 eCQMs. They also registered to administer the CAHPS for MIPS Survey but were unable to administer the survey because they didn't meet the Medicare patient sampling requirements.

Measure Type	Collection Type	Achievement Points
Outcome Measure #1	Medicare Part B claims	7.8
Process Measure	Medicare Part B claims	7.1
Process Measure	eCQM	6.9
Outcome Measure #2	eCQM	8.2
Process Measure	eCQM	6.1
Total Points		36.1 (out of 50)

The group's quality denominator is reduced by 10 points (from 60 to 50 points) because they registered, but didn't meet sampling requirements, for the CAHPS for MIPS Survey.

This example assumes that the group couldn't be scored on any administrative claims measures either.

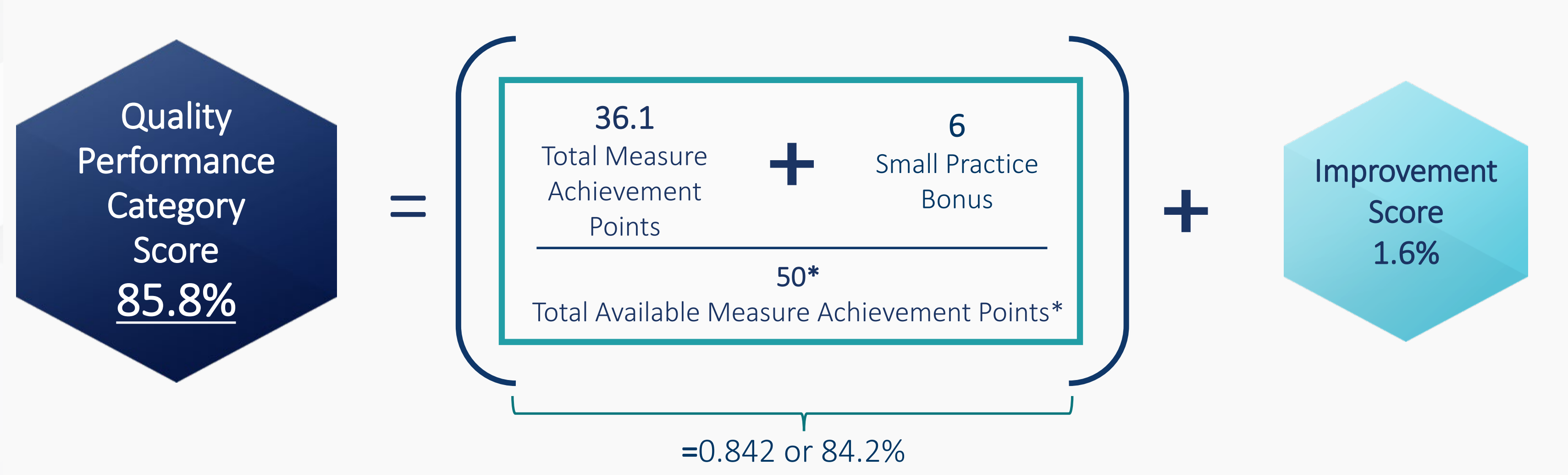
Because they're a **small practice**, they qualify for **6 bonus points**.

They also qualify for **improvement scoring** because their achievement score showed improvement from last year.

- Their 2026 achievement score = 36.1/50 = 72.2%
- Their 2025 achievement score = 62.2%
- The increase in their achievement score = 72.2% - 62.2% = 10%
- Their improvement score = (10% ÷ 62.2%) x 10% = 1.6%

Calculating the Quality Performance Category Score (Continued)

Scoring Example (Continued)



***Why is Their Denominator 50?**

The group registered for, but didn't meet the sampling requirements for, the CAHPS for MIPS Survey measure and submitted less than 6 quality measures, so we reduced the denominator by 1 required measure.

What is Facility-Based Measurement?

Facility-based measurement offers certain MIPS eligible clinicians and groups the opportunity to receive scores in the MIPS quality and cost performance categories based on the total performance score in the Hospital Value-Based Purchasing (VBP) Program earned by their assigned facility.

Facility-based scoring will be used for your quality and cost performance category scores when all the following conditions are met:

- You're identified as facility-based,
- You're attributed to a facility with a Fiscal Year 2027 Hospital VBP Program score (we won't know if a facility has a 2027 score until the end of the 2026 performance period), and
- The facility-based scoring methodology using your Hospital VBP Program score results in a higher final score than your final score calculated without the application of facility-based measurement.

For more information on facility-based scoring, review the **2026 Facility-Based Quick Start Guide** when available on the [QPP Resource Library.]

Reweighting the Quality Performance Category

The quality performance category can be reweighted (and its weight redistributed to other categories) in 3 circumstances for traditional MIPS reporting:

1. **You don't have any available quality measures.**

   NOTE: We anticipate that reweighting of the quality performance category for lack of available measures would be a rare occurrence because there are quality measures applicable and available for most clinicians.
   Please contact QPP Service Center.

2. **Quality is reweighted due to extreme and uncontrollable circumstances.**

   NOTE: This can happen through an approved exception application or if you qualify for a MIPS automatic extreme and uncontrollable circumstance.

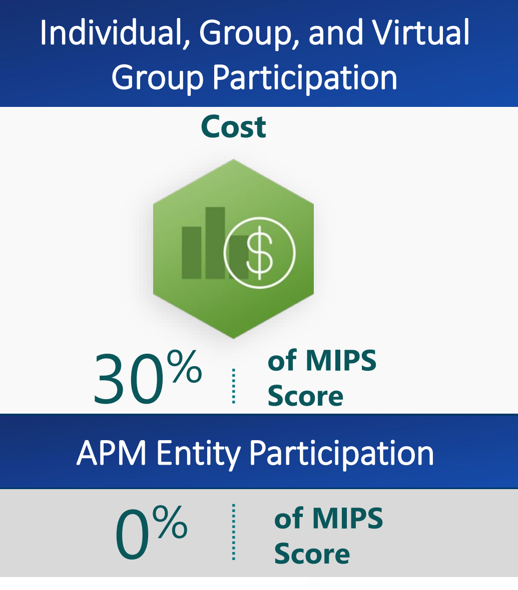
3. **The third party intermediary (QCDR or Qualified Registry) you contracted with failed to submit your quality data.**

   NOTE: You must reach out to the QPP Service Center by November 1, 2027, if your third party intermediary didn't submit your quality data.

Please refer to Appendix B for more information about the redistribution of weights to other performance categories.

Traditional MIPS: Cost Performance Category

What are the Cost Performance Category Data Submission Requirements?



There are no additional data submission requirements for this performance category. We use Medicare administrative claims data to calculate your cost measure performance.

How are MIPS Cost Measures Scored?

For a cost measure to be scored, an individual MIPS eligible clinician, group, or virtual group must meet or exceed the case minimum for that cost measure. Each of the 35 MIPS cost measures can earn a maximum of 10 achievement points. The table on the next page outlines the case minimum for each of the 35 MIPS cost measures.

Beginning with the 2026 performance period, there will be a 2-year informational-only feedback period for new cost measures. During the 2-year informational-only feedback period, clinicians will receive feedback on their measure performance, but the measures won't count towards their cost category score or MIPS final scores. There are no new cost measures for the 2026 performance period, so clinicians won't receive any informational-only feedback in the 2026 performance period feedback.

How are MIPS Cost Measures Scored? (Continued)

MIPS Cost Measure	Population-based Measure Type	Case Minimum
Total Per Capita Cost for All Attributed Beneficiaries (TPCC) Measure	Primary Care	20
Medicare Spending Per Beneficiary (MSPB Clinician) Measure	Inpatient Care	35
	Episode-based Measure Type	
Elective Outpatient Percutaneous Coronary Intervention (PCI) Measure	Procedural	10
Knee Arthroplasty Measure	Procedural	10
Revascularization for Lower Extremity Chronic Critical Limb Ischemia Measure	Procedural	10
Cataract Removal with Intraocular Lens (IOL) Implantation	Procedural	10
Screening/Surveillance Colonoscopy Measure	Procedural	10
Acute Kidney Injury Requiring New Inpatient Dialysis	Procedural	10
Colon and Rectal Resection	Procedural	20
Elective Primary Hip Arthroplasty	Procedural	10
Femoral or Inguinal Hernia Repair	Procedural	10
Hemodialysis Access Creation	Procedural	10
Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels	Procedural	10
Lumpectomy Partial Mastectomy, Simple Mastectomy	Procedural	10
Melanoma Resection	Procedural	10
Non-Emergent Coronary Artery Bypass Graft (CABG)	Procedural	10
Renal or Ureteral Stone Surgical Treatment	Procedural	10

How are MIPS Cost Measures Scored? (Continued)

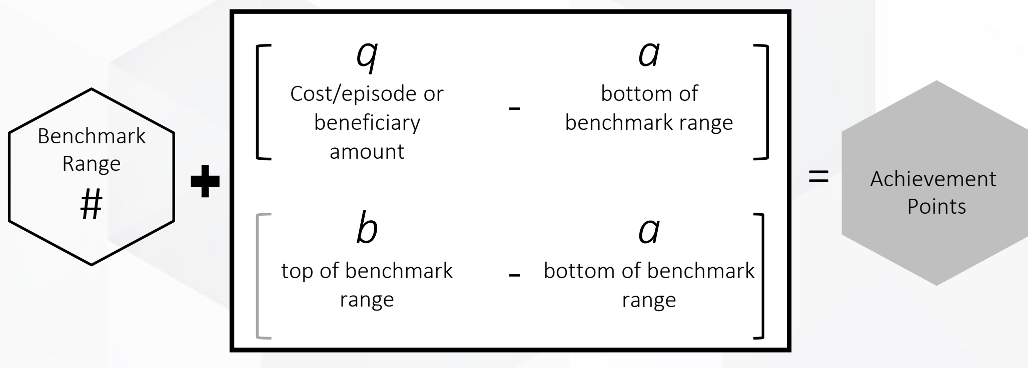
MIPS Cost Measure	Episode-based Measure Type	Case Minimum
Intracranial Hemorrhage or Cerebral Infarction Measure	Acute inpatient medical condition	20
Sepsis	Acute inpatient medical condition	20
Inpatient (IP) Percutaneous Coronary Intervention (PCI)	Acute inpatient medical condition	20
Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation	Acute inpatient medical condition	20
Lower Gastrointestinal Hemorrhage (applies to groups only)	Acute inpatient medical condition	20
Psychoses and Related Conditions	Acute inpatient medical condition	20
Respiratory Infection Hospitalization	Acute inpatient medical condition	20
Diabetes	Chronic Condition	20
Asthma/COPD	Chronic Condition	20
Depression	Chronic Condition	20
Heart Failure	Chronic Condition	20
Low Back Pain	Chronic Condition	20
Emergency Medicine	Care Setting	20
Rheumatoid Arthritis	Chronic Condition	20
Chronic Kidney Disease (CKD)	Chronic Condition	20
End-Stage Renal Disease (ESRD)	Chronic Condition	20
Kidney Transplant Management	Chronic Condition	20
Prostate Cancer	Chronic Condition	20

How are MIPS Cost Measures Scored? (Continued)

To assess your MIPS cost measure performance, we'll:

- Establish a benchmark for each cost measure based on the performance period.
  - There are no historical benchmarks established for cost measures.
- Compare the cost per episode or per beneficiary (expressed as a dollar amount) on each measure to the performance period benchmark(s).
- Assign 1 to 10 achievement points to each measure based on that comparison. The number of achievement points assigned is determined by identifying which benchmark range the individual or group's measure performance falls in between.

Achievement points are awarded to scored measures according to the following formula:



How are MIPS Cost Measures Scored? (Continued)

The cost scoring methodology is based on standard deviation, median, and an achievement point value that is derived from the performance threshold. Specifically, under this scoring methodology, the national median cost for a measure is set at a score equivalent to 10% of the performance threshold established for that MIPS payment year.

- For example, for the 2026 performance period, **a clinician with costs equal to the national median cost for a measure will receive 7.5 achievement points for the cost performance category.**
    - This is calculated by multiplying the performance threshold of 75 by 10 percent.
- The cut-offs for benchmark point ranges will be calculated based on standard deviations from the median cost. These cut-offs are detailed on the next slide.

How are MIPS Cost Measures Scored? (Continued)

Let's look at an example of how a clinician's cost performance is turned into a measure score:

- Dr. Clark's average cost per episode for a cost measure is $1,104, and the national median for this measure is $969.72.
- Her costs are higher than the median cost, within one standard deviation, so she'll receive between 6 and 6.9 points.

Benchmarks	
Points	**Cut Offs**
1 - 1.9	Median cost ($) + (2.75 x standard deviation ($))
2 - 2.9	Median cost ($) + (2.5 x standard deviation ($))
3 - 3.9	Median cost ($) + (2.25 x standard deviation ($))
4 - 4.9	Median cost ($) + (2 x standard deviation ($))
5 - 5.9	Median cost ($) + (1.5 x standard deviation ($))
6 - 6.9	Median cost ($) + (1 standard deviation ($))
7 - 7.9	Median cost ($) + (0.5 x standard deviation ($))
8 - 8.9	Median cost ($) - (0.5 x standard deviation ($))
9 - 9.9	Median cost ($) – (1 x standard deviation ($))
10	Median cost ($) - (1.5 x standard deviation ($))

Dr. Clark's average cost per episode for a cost measure is $1,104.

The **national median cost** for this measure is $969.72.

Benchmarks	
Points	Range of Costs Per Episode
1 - 1.9	$1,341.93 - $1,308.1
2 - 2.9	$1,308.09 - $1,274.26
3 - 3.9	$1,274.25 - $1,240.43
4 - 4.9	$1,240.42 - $1,172.75
5 - 5.9	$1,172.74 - $1,105.08
6 - 6.9	$1,105.07 - $1,037.4
7 - 7.9	$1,037.39 - $902.05
8 - 8.9	$902.04 - $834.38
9 - 9.9	$834.37 - $766.7
10	$766.69

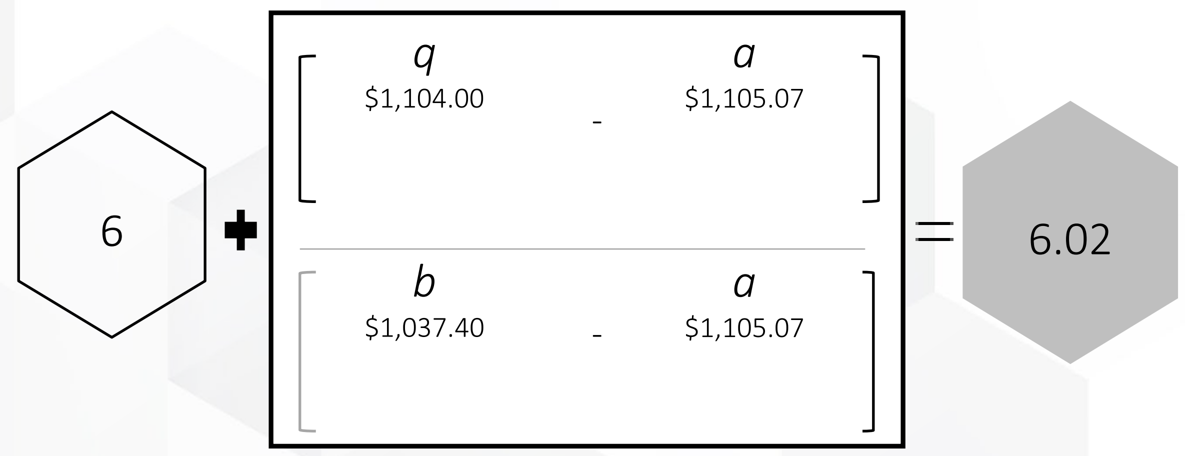
How are MIPS Cost Measures Scored? (Continued)

Let's take a detailed look at how Dr. Clark's scores would be calculated.

q = Cost/episode or beneficiary amount

b = top of benchmark range

a = bottom of benchmark range



Cost Improvement Scoring

How is improvement scoring calculated?

Cost improvement scoring is calculated by comparing the cost performance category score from the previous (2025) performance period to the cost performance category score for the current (2026) performance period.

=

Increase in Cost Performance Category Score
(From prior performance period to current performance period)

Prior Performance Period Cost Performance Category Score

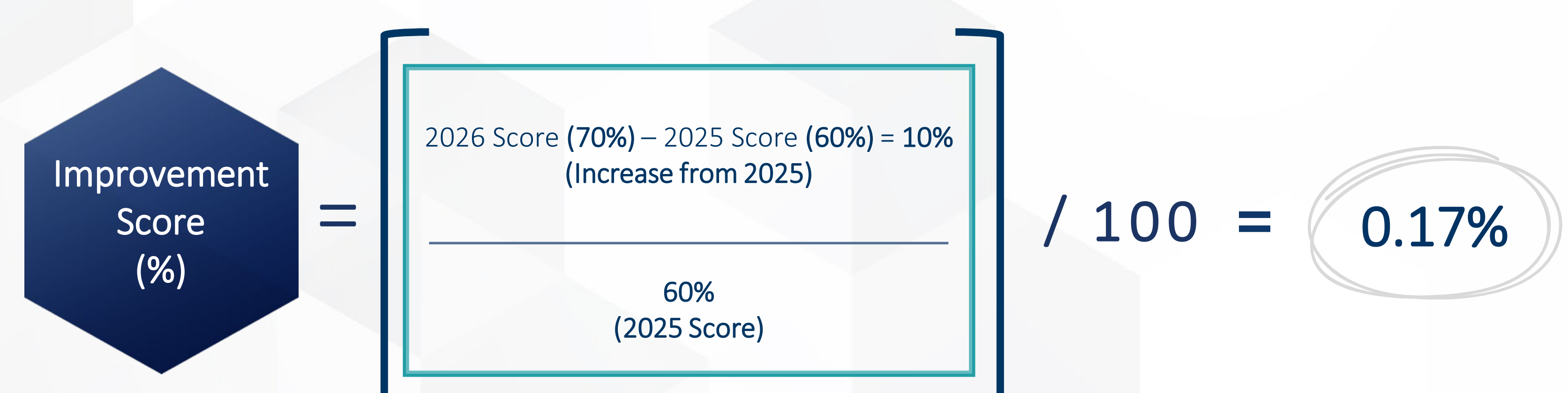
/ 100

Cost Improvement Scoring Example

The following provides an example of how we'll calculate the improvement percent score. We'll continue with the example of a small practice reporting as a group.

- For the **2025 performance period**, the group earned a cost performance category score of 60% (12 out 20 points).
- For the **2026 performance period,** they earned a cost performance category score of 70% (7 out 10 points).

- Your cost improvement score can't be negative if your cost performance decreases, your improvement score will be 0%.
- The cost improvement score is capped at 1%.



Cost Performance Category Scoring

The cost performance category score is the equally weighted average of all scored measures plus the cost improvement score, not to exceed 1 percentage point. The cost performance category score is then multiplied by the category weight to determine the number of points the category contributes to the final score.

*Total Available Measure Points = # of scored cost measures x 10

Scoring Example

Let's continue with the previous example of the small practice reporting as a group. They only met the case minimum for the MSPB-Clinician measure. When evaluated against the performance period benchmark, they earn 7.0 points out of 10 points for the measure.

What is Facility-Based Measurement?

Facility-based measurement offers certain MIPS eligible clinicians and groups the opportunity to receive scores in the MIPS quality and cost performance categories based on the total performance score in the Hospital Value-Based Purchasing (VBP) Program earned by their assigned facility.

Facility-based scoring will be used for your quality and cost performance category scores when all the following conditions are met:

- You're identified as facility-based, and
- You're attributed to a facility with a Fiscal Year 2027 Hospital VBP Program score (we won't know if a facility has a 2027 score until the end of the 2026 performance period), and
- The facility-based scoring methodology using your Hospital VBP Program score results in a higher final score than your final score calculated without the application of facility-based measurement.

For more information on facility-based scoring, including how a group or individual clinician are identified as facility-based, review the **2026 Facility-Based Quick Start Guide** when available on the QPP Resource Library.

Can the Cost Performance Category be Reweighted?

Yes. You won't be scored on this performance category and it will be reweighted to 0% of your final score when:

- You can't be scored on any of the cost measures (you don't meet the case minimum for any of them, or we're unable to establish a benchmark for any of the measures for which you do meet the case minimum).
- You have an approved extreme and uncontrollable circumstance application that includes the cost performance category.
- You qualify for the automatic extreme and uncontrollable circumstance policy.

Please refer to Appendix B for more information on category reweighting, including the extreme and uncontrollable circumstances policy.

Traditional MIPS: Improvement Activities Performance Category

What are the Data Submission Requirements for the Improvement Activities Performance Category?

You can earn up to 40 points in the improvement activities performance category by attesting to 1 or 2 improvement activities.

To report (or "submit") an improvement activity, you simply attest to having completed it. No data needs to accompany the attestation as part of the submission.

You don't have to submit any supporting documentation when you attest to completing an improvement activity, but you must keep documentation of the efforts you (or the group or virtual group) undertook to meet the improvement activity for 6 years subsequent to submission. Documentation guidance for each activity can be found in the 2026 MIPS Data Validation Criteria (ZIP, 992KB) available on the QPP Resource Library.

Data Aggregation and Multiple Submissions

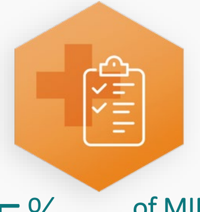
We'll combine improvement activities submitted through attestation, file upload, and/or direct submission into a single performance category score (not to exceed 100%). If you submit the same activity through multiple submission types, the improvement activity will be counted once.

Participating as a Group, Virtual Group or APM Entity

If reporting as a group, virtual group or APM Entity, at least 50% of the clinicians in the group, virtual group, or APM Entity must implement the same activity during any continuous 90-day period (or the period specified in the activity description) in the same performance year to attest to that activity. (These clinicians don't have to perform the activity during the same period.)

Individual, Group, and Virtual Group Participation

Improvement Activities



15% of MIPS Score

APM Entity Participation

15% of MIPS Score

Small Practices Not Submitting Promoting Interoperability Data

(Promoting Interoperability Automatically Reweighted)

30% of MIPS Score

How are Activities Assessed and Scored?

Most clinicians must implement and submit 1 or 2 improvement activities to receive the maximum score of 40 points in this performance category.

Traditional MIPS
Clinicians, groups, virtual groups, and APM Entities with **certain special statuses (small practice, rural, health professional shortage area (HPSA), non-patient facing)** select (from **almost 95 activities**) and perform: • 1 improvement activity (40 points)
All other MIPS eligible clinicians select (from **over 95 activities**) and perform: • 2 improvement activities (20 points each)

Helpful Reminder: If you're reporting measures for the quality performance category in traditional MIPS or an MVP as an APM Entity, you'll also report improvement activities at the APM Entity level.

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

How are Activities Assessed and Scored? (continued)

You can also receive credit in this performance category from your participation in certain improvement activities or payment models:

Other Ways to Earn Improvement Activity Points under Traditional MIPS	Points Received	Action Required?
Electronic submission of participation in a Patient Centered Medical Home or Comparable Specialty accreditation.	40 points	**Yes** – You must attest to this accreditation (IA_PCMH) during the 2026 submission period to receive the points awarded (full credit / 100%) for the improvement activities performance category.
Participate in an APM. [1]	At least 20 points (out of 40 possible)	**Yes** – You must submit data for another MIPS performance category to receive the points awarded (half credit / 50%) for APM participation for the improvement activities performance category. You must attest to an additional activity to achieve the maximum 40 points.

[1] For a list of APMs, refer to the Comprehensive List of APMs.

How are Activities Assessed and Scored? (Continued)

MIPS eligible clinicians, groups, virtual groups, and APM Entities with specific special status designations select and complete one improvement activity, earning 40 points. These points are assigned to activities submitted by clinicians, groups, virtual groups, and APM Entities identified on the QPP Participation Status Tool with the following special status designations:

1) a small practice (15 or fewer National Provider Identifier (NPIs)),

2) non-patient facing,

3) health professional shortage area (HPSA), or

4) rural.

To learn more about available activities, review the 2026 Improvement Activities Inventory (ZIP, 464KB).

Other Factors

These may be automatically received or you may apply for them. Learn more about special statuses and hardship exceptions

Received as an individual

SPECIAL STATUS **Small practice**	Yes

Received as a group

SPECIAL STATUS **Small practice**	Yes

How Many Points Can I Earn in the Improvement Activities Performance Category?

Clinicians, groups, virtual groups, and APM Entities can earn a maximum of 40 points in the improvement activities performance category, though the number of points it contributes to your MIPS final score varies according to the performance category's weight. The improvement activities score, like all performance categories, is capped at 100%.

Can the Maximum Number of Points be Lower than 40?

No, you'll always be scored out of 40 points in the improvement activities performance category, though you may receive more points per activity based on your special status.

How is My Improvement Activities Performance Category Score Calculated?

How is My Improvement Activities Performance Category Score Calculated? (Continued)

Scoring Example

Let's continue our previous example of the small practice reporting as a group. They can't attest to having participated in CAHPS as an improvement activity because they didn't meet patient sampling requirements. They selected 1 improvement activity. Because they're a small practice, they earn 40 points for the activity reported.

Even if you submit additional activities, you can't earn more than 100% in the performance category.

How Does Scoring Work if I'm in a Patient-centered Medical Home?

If you're in a certified or recognized patient-centered medical home or comparable specialty practice, you'll earn full credit (100%) for the improvement activities performance category. You **must attest** (to activity "IA_PCMH") to your status as a patient-centered medical home or comparable specialty practice during the submission period for the 2026 performance year to receive full credit for the improvement activities performance category.

Additional Scoring Scenarios

Scenario 1:

You're a MIPS eligible clinician in a practice with more than 15 clinicians (don't have the "small practice" special status) and complete 1 improvement activity for 20 of 40 points in the performance category.

Scenario 2: (Small Practice)

You're a MIPS eligible clinician in a small practice (15 or fewer clinicians) and complete 1 improvement activity for 40 of 40 points in the performance category. You don't submit Promoting Interoperability data, which means the Promoting Interoperability performance category is automatically weighted at 0% and the improvement activities performance category is weighted at 30%. The 30% weight assumes you can be scored on at least 1 cost measure.

Reweighting the Improvement Activities Performance Category

The improvement activities performance category can be reweighted (and its weight redistributed to other categories) in 2 circumstances for traditional MIPS reporting:

1. **The performance category is reweighted due to extreme and uncontrollable circumstances.**

   NOTE: This can happen through an approved exception application or if you qualify for a MIPS automatic extreme and uncontrollable circumstances.

2. **The third party intermediary (QCDR or Qualified Registry) you contracted with failed to submit your improvement activities data.**

   NOTE: You must reach out to the QPP Service Center by November 1, 2027, if your third party didn't submit your improvement activities data.

Please refer to Appendix B for more information about the redistribution of weights to other performance categories.

Traditional MIPS: Promoting Interoperability Performance Category

Overview

The Promoting Interoperability performance category focuses on the following objectives:

- Electronic Prescribing
- Health Information Exchange (HIE)
- Provider to Patient Exchange
- Public Health and Clinical Data Exchange
- Protect Patient Health Information

The objectives collectively contain a total of 6 to 7 required measures (dependent upon which measure(s) you choose to report for the HIE objective) in addition to required attestations.

- You must collect data for all required measures (unless you can claim an exclusion(s)) for the same **minimum continuous 180-day period in CY 2026**.
- The last 180-day performance period begins on **July 5, 2026**.

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

CEHRT functionality that meets ONC Health IT certification criteria in 45 CFR 170.315 is required for participation in this performance category. For additional information, review the 2026 Promoting Interoperability Performance Category Quick Start Guide (PDF, 1MB).

Promoting Interoperability

25% of MIPS Score

APM Entity Participation

30% of MIPS Score

Small Practices Not Submitting Promoting Interoperability Data (Promoting Interoperability Automatically Reweighted)

0% of MIPS Score

What are the Data Submission Requirements for the Promoting Interoperability Performance Category?

There's a single set of measures and objectives you must report for the 2026 performance period as outlined in the table below. For all required measures, you must submit at least a '1' in the numerator for numerator/denominator measures OR report a "Yes" response for attestation measures (or claim an exclusion, if available and applicable).

Objectives	Measures		Requirements
Electronic Prescribing	e-Prescribing		Required unless an exclusion is claimed
	Query of Prescription Drug Monitoring Program (PDMP)		Required unless an exclusion is claimed
Health Information Exchange	Option 1	Support Electronic Referral Loops by Sending Health Information	Required unless an exclusion is claimed or option 2 or option 3 is reported
		Support Electronic Referral Loops by Receiving and Reconciling Health Information	Required unless an exclusion is claimed or option 2 or option 3 is reported
	Option 2	HIE Bi-Directional Exchange	Required (no exclusion available), unless option 1 or option 3 is reported
	Option 3	Enabling Exchange under the Trusted Exchange Framework and Common Agreement (TEFCA)	Required (no exclusion available), unless option 1 or option 2 is reported
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information		Required (no exclusion available)
Public Health and Clinical Data Exchange	Report the 2 required measures: • Immunization Registry Reporting • Electronic Case Reporting		Required unless an exclusion(s) is claimed
	Bonus (Optional): • Clinical Data Registry Reporting • Public Health Registry Reporting • Syndromic Surveillance Reporting • Public Health Reporting Using TEFCA		Optional measures (no exclusions available)

There are 3 options for clinicians to meet the requirements of the Health Information Exchange objective.

You need to choose and report 1 of these 3 options.

When reporting the required measures in the Public Health and Clinical Data Exchange objective, you'll also need to submit your level of active engagement.

What are the Data Submission Requirements for the Promoting Interoperability Performance Category? (Continued)

In addition to reporting the previously listed measures, you must also:

- Collect your data in CEHRT with the functionality that meets ONC's health IT certification criteria in 45 CFR 170.315 (certified by the last day of the performance period) for a minimum of any continuous 180-day period in 2026.
- Submit a "yes" to the Actions to Limit or Restrict Compatibility or Interoperability of CEHRT Attestation.
- Submit a "yes" for the High Priority Practices Safety Assurance Factors for EHR Resilience (SAFER) Guide under the Protect Patient Health Information objective confirming the completion of an annual self-assessment using the 2025 High Priority Practices SAFER Guide. Additional information is available on the SAFER Guides webpage on HealthIT.gov (please refer to 2025 SAFER Guides).
- Submit a "yes" to the ONC Direct Review Attestation.
- Submit a "yes" that you have completed both components of the Security Risk Analysis Attestation measure in 2026.
- Submit your level of active engagement for the required measures under the Public Health and Clinical Data Exchange objective.
- Provide your CMS Electronic Health Record (EHR) Certification ID from the Certified Health IT Product List.

If any of these requirements **aren't met**, you'll get **0 points** in the Promoting Interoperability performance category.

ALERT: When reporting the required measures in the Public Health and Clinical Data Exchange objective, you'll need to submit a total of 2 entries for each measure: (1) a "yes" or "no" response to the measure, and (2) your level of active engagement (either Pre production and Validation or Validated Data Production).

NOTE: Reporting to a QCDR or Qualified Registry may count for the optional Clinical Data Registry Reporting measure as long as the QCDR or Qualified Registry has publicly declared readiness as a clinical data registry and the registry uses the data for a public health purpose.

Data Aggregation and Multiple Submissions

- When there are **multiple Promoting Interoperability submissions** for an individual, group, virtual group, or subgroup, **we'll score each submission and assign the highest of the scores**.
- A qualifying data submission includes all required performance data, required attestation statements, CEHRT ID, and the start and end date for the performance period.

How are Promoting Interoperability Measures Assessed and Scored?

Each required measure will be scored based on the performance data you report.

- For measures with a numerator and denominator, we calculate the performance rate on the submitted numerator and denominator.
- For measures that require a “yes” or “no” submission such as the Query of PDMP measure, we assign either full points or zero points.
- As a reminder, if you earn 0 points for any required measure or objective, you’ll receive a score of zero for the entire performance category.

Each measure will contribute to your total Promoting Interoperability performance category score.

Each required measure (or objective, in the case of the Public Health and Clinical Data Exchange) has a maximum number of points that can be earned based on performance.

NOTE: If exclusions are claimed, the points for excluded measures will be reallocated to other measures.

How are Promoting Interoperability Measures Assessed and Scored? (Continued)

Objectives	Measures		Required	Available Points	Reporting Requirements
Electronic Prescribing	e-Prescribing		Required	1 – 10 points	Numerator/ Denominator
	Query of Prescription Drug Monitoring Program (PDMP)		Required	10 points	YES
Health Information Exchange	**Option 1**	Support Electronic Referral Loops by Sending Health Information	Required* (unless option 2 or option 3 is reported)	1 – 15 points	Numerator/ Denominator
		Support Electronic Referral Loops by Receiving and Reconciling Health Information		1 – 15 points	Numerator/ Denominator
	Option 2	HIE Bi-Directional Exchange	Required* (unless option 1 or option 3 is reported)	30 points	YES
	Option 3	Enabling Exchange under the Trusted Exchange Framework and Common Agreement (TEFCA)	Required* (unless option 1 or option 2 is reported)	30 points	YES

*For the HIE objective, you have the option to report data for the 2 supporting electronic referral loops measures and associated exclusions OR the HIE Bi Directional Exchange measure OR the Enabling Exchange under TEFCA measure. You need to choose and report 1 of these 3 options.

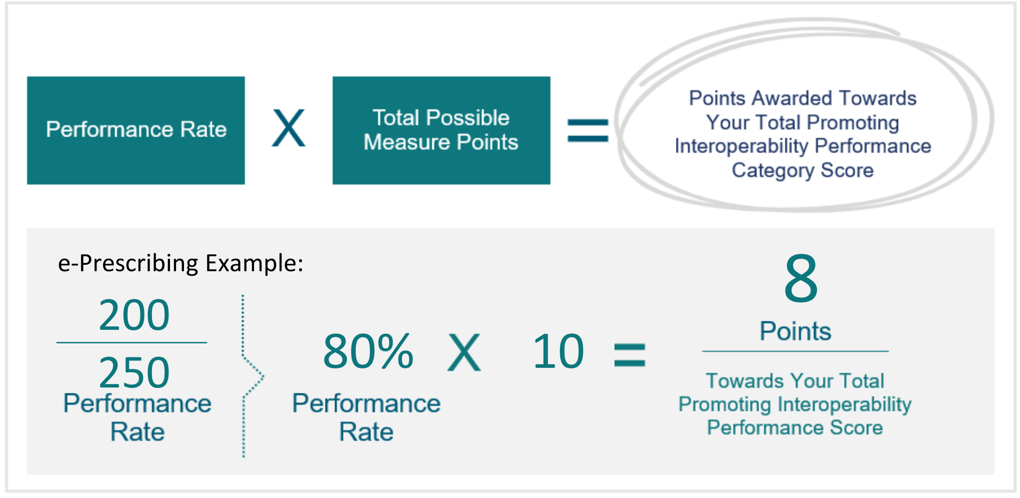
How are Promoting Interoperability Measures Assessed and Scored? (Continued)

Objectives	Measures	Required	Available Points	Reporting Requirements
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	Required	1 – 25 points	Numerator/ Denominator
Public Health and Clinical Data Exchange	Report the 2 required measures: • Immunization Registry Reporting • Electronic Case Reporting	Required	25 points for the entire objective	YES for both required measure (you also must submit your level of active engagement)
	Bonus (Optional): • Clinical Data Registry Reporting • Public Health Registry Reporting • Syndromic Surveillance Reporting • Public Health Reporting Using TEFCA	Optional	5 bonus points (whether reporting 1, 2, 3, or all 4 optional measures)	YES (you also must submit your level of active engagement)

Scoring Promoting Interoperability Measures Submitted with a Numerator/Denominator

For measures submitted with a numerator and denominator, we calculate a score for each measure by dividing the numerator by the denominator you submitted for the measure and then multiplying that performance rate by the maximum points available for the measure.

Below is an example featuring the e-Prescribing measure, which is worth up to 10 points.

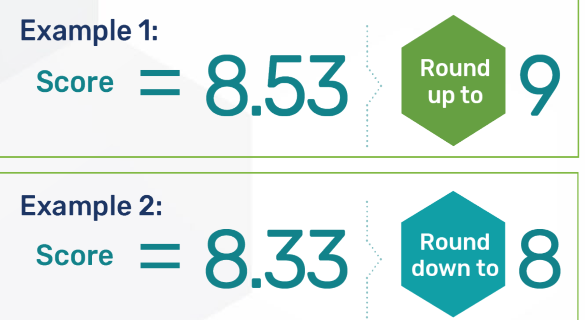


Important to Note:

- You can earn a maximum of 5 bonus points for submitting 1 (or more) of the optional measures in the Public Health and Clinical Data Exchange objective (you'll earn a maximum of 5 bonus points even if you submit more than 1 measure).

When we calculate the performance rates, measure and objective scores, and the Promoting Interoperability performance category score, we generally round to the nearest whole number.

- When a clinician earns a measure score of less than 0.5, the score is rounded up to 1 as long as the numerator includes at least 1 patient. (A numerator of 0 for any measure will result in a score of zero for the entire Promoting Interoperability performance category.)



Scoring Promoting Interoperability Measures Submitted with a Yes/No

For the Query of PDMP measure, you'll receive 10 points for this measure when:

You submit a "Yes" for the required measure.

If you submit an exclusion, the points will be redistributed to another measure or objective.

For the Public Health and Clinical Data Exchange objective, you'll receive 25 points for this objective when:

You submit a "Yes" for the Immunization Registry Reporting measure.*

You submit a "Yes" for the Electronic Case Reporting measure.*

OR

You submit a "yes" for one required measure.

You submit an exclusion for the other required measure.

* If you submit an exclusion for both required measures, the 25 points will be redistributed to the Provide Patients Electronic Access to Their Health Information measure.

For Option 2 or 3 in the HIE objective, you'll receive 30 points for this objective when:

You submit a "Yes" to participating in bi-directional exchange.

OR

You submit a "Yes" to enabling exchange under TEFCA

How Many Points Can I Earn in the Promoting Interoperability Performance Category?

While there are 105 total points available, individuals, groups, and APM Entities can't earn more than 100 points in the Promoting Interoperability performance category. The Promoting Interoperability score, like all performance categories, is capped at 100%.

Can the Denominator (Maximum Number of Points) Be Lower Than 100?

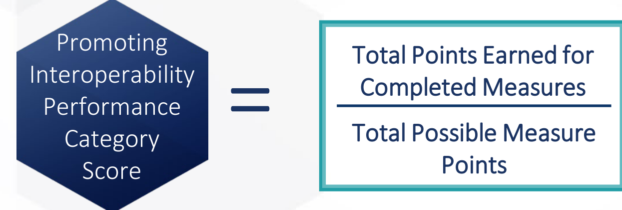
No; you'll always be scored out of 100 points in the Promoting Interoperability performance category. If you qualify for and claim an exclusion(s), those points will be reallocated to another measure or objective instead of being removed from the denominator. Please see Appendix C for detailed information about how points are reallocated when an exclusion(s) is claimed.

How Is the Promoting Interoperability Performance Category Scored?

Individual and Group Participation

We'll add the scores for each of the individual measures (or objectives) and then divide the sum by the total possible achievement points (100 points) to calculate the Promoting Interoperability performance category score.

REMINDER: You'll receive 0 points in the Promoting Interoperability performance category if you fail to: submit a required attestation, report (submit at least 1 in the numerator) on a required measure or claim an exclusion for a required measure (where applicable).



How Is the Promoting Interoperability Performance Category Scored? (Continued)

APM Entity Participation

When reporting traditional MIPS as an APM Entity, Promoting Interoperability data can be reported at the individual, group, virtual group, or APM Entity level.

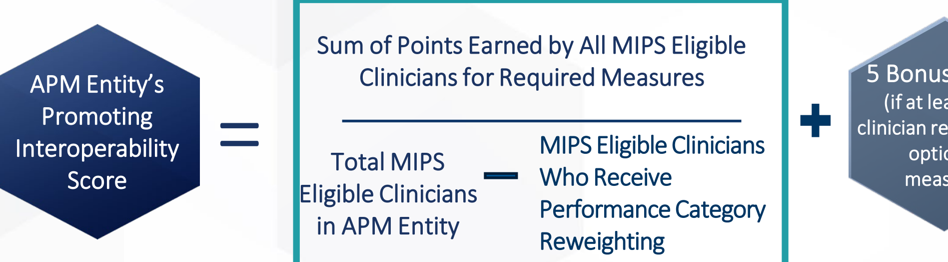
Promoting Interoperability Reported at the APM Entity Level

APM Entities can submit aggregated Promoting Interoperability data at the APM Entity level on behalf of all MIPS eligible clinicians in the Entity. The score is calculated the same way it is calculated for individuals, groups, and virtual groups.

Promoting Interoperability Reported at the Individual or Group Level

- The APM Entity's Promoting Interoperability performance category score is an average of the highest score attributed to each MIPS eligible clinician in the APM Entity based on the required measures from their individual or group reporting.
- The APM Entity can also earn the bonus points if at least one individual or group in the APM Entity reports any of the optional measures in the Public Health and Clinical Data Exchange objective (5 bonus points), but the Promoting Interoperability performance category score can't exceed 100%.

REMINDER: You'll contribute 0 points toward your APM Entity's Promoting Interoperability performance category score if you fail to: submit a required attestation, report (submit at least 1 in the numerator) on a required measure or claim an exclusion for a required measure (where applicable).



Scoring Example

Let's continue our example of the small practice participating as a group. While small practices qualify for automatic reweighting of the Promoting Interoperability performance category, this small practice was able and chose to submit data for this performance category. The group has EHR technology that meets ONC Health IT certification criteria in 45 CFR 170.315 and completed the required attestations and measures.

Objective	Measures	Numerator / Denominator (Performance Rate)	Maximum Points	Points Earned
Electronic Prescribing	e-Prescribing	Exclusion claimed	10 points → 0 points	N/A
	Query of Prescription Drug Monitoring Program (PDMP)	Reported "yes" to PDMP measure	10 points	10
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	180 / 250 (0.72)	15 points → 20 points (5 points re-allocated from e-Prescribing)	0.72 x 20 = 14.4 points
	Support Electronic Referral Loops by Receiving and Reconciling Health Information	176 / 200 (0.88)	15 points → 20 points (5 points re-allocated from e-Prescribing)	0.88 x 20 = 17.6 points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	187 / 220 (0.85)	25 points	0.85 x 25 = 21.25 points
Public Health and Clinical Data Exchange	Report the 2 required measures: • Immunization Registry Reporting • Electronic Case Reporting	• Reported "yes" to Immunization Registry Reporting measure • Claimed exclusion for Electronic Case Reporting measure	25 points	25 points (this objective is all or nothing)
	Bonus (optional) measures: • Public Health Registry Reporting • Clinical Data Registry Reporting • Syndromic Surveillance Reporting	Reported "yes" to the optional Public Health Registry Reporting measure	5 points	5 points
Required Measure Point Total				88.25 points
Optional Measure Point Total				5 points
Promoting Interoperability Performance Category Score				93.25 points / 100 points 93.%

Additional Scoring Scenarios

Scenario 1

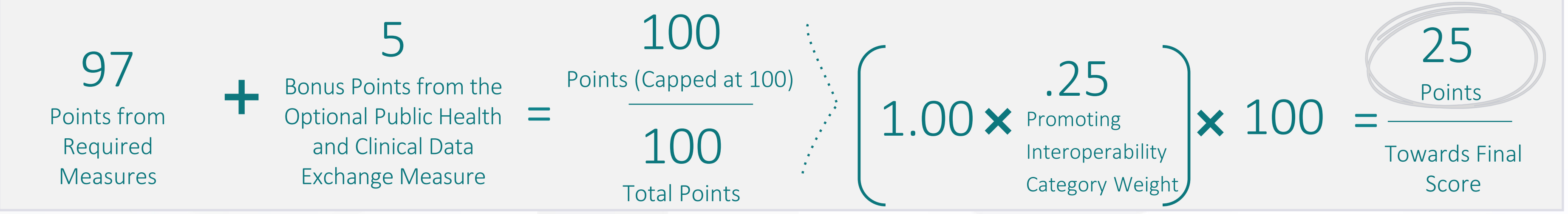
If a clinician receives 83 points from the required Promoting Interoperability measures and 5 bonus points for submitting data on one of the optional Public Health and Clinical Data Exchange measures, then they would receive 22 points towards their MIPS final score for the Promoting Interoperability performance category. That's 1.25 more points towards their MIPS final score than they would have, if they didn't report the optional measure.

83 Points from Required Measures + 5 Bonus Points from the Optional Public Health and Clinical Data Exchange Measure = 88 Points / 100 Total Points

(.88 × .25 Promoting Interoperability Category Weight) × 100 = 22 Points Towards Final Score

Scenario 2

A clinician receives 97 points from the required Promoting Interoperability measures and 5 bonus points for submitting data on one of the optional Public Health and Clinical Data Exchange measures. Adding the 5 bonus points to the points they received for their required measures equals 102 points. Since the performance category is capped at 100, the clinician would receive 100 points, which equals 25 points towards their MIPS final score for the Promoting Interoperability performance category.



Can the Promoting Interoperability Performance Category be Reweighted?

Yes. There are 4 ways the Promoting Interoperability performance category could be reweighted to 0% of your final score.

Note that a qualifying Promoting Interoperability data submission (all required data, measures, and attestations) will override any automatic or approved reweighting.

1. You request reweighting for multiple performance categories through the MIPS Extreme and Uncontrollable Circumstances (EUC) Exception application. Please check the 2026 Extreme and Uncontrollable Circumstances Exception Application Guide or the QPP Exception Applications webpage for more information.

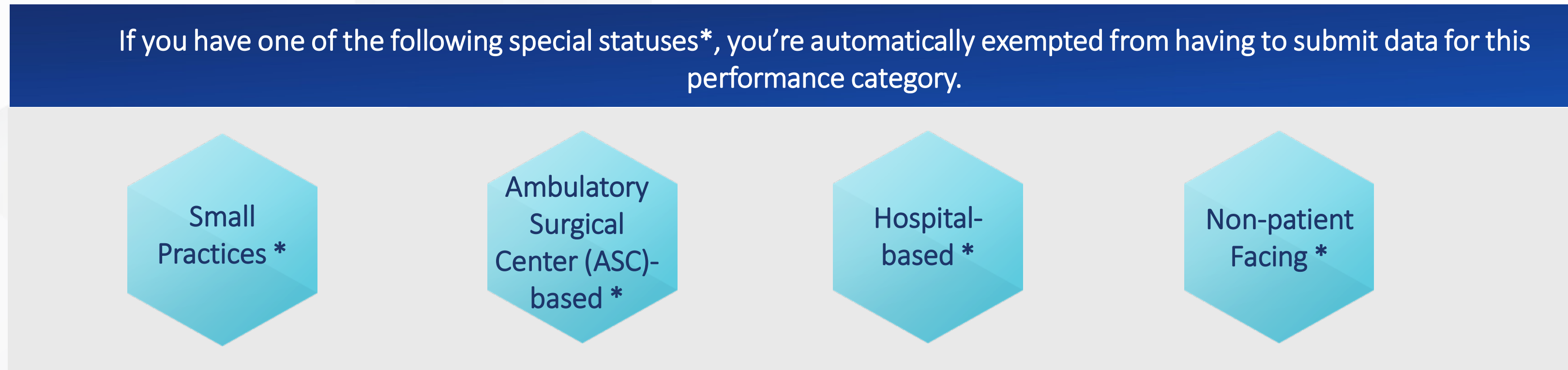
2. You submit a 2026 Promoting Interoperability Hardship Exception application, citing one of the following specified reasons for review and approval:

   - Insufficient internet connectivity
   - Extreme and uncontrollable circumstances
   - Lack of control over the availability of CEHRT
   - Decertified EHR (decertified under the ONC Health IT Certification Program)

   If we approve your application, then the Promoting Interoperability performance category will be reweighted, unless you submit data for this performance category. Learn more about Hardship Exceptions.

Can the Promoting Interoperability Performance Category be Reweighted?

3. You qualify for **automatic reweighting** because of your special status* (see the Other Reporting Factors on the QPP Participation Status Tool):



4. The third party intermediary (QCDR or Qualified Registry) you contracted with failed to submit your Promoting Interoperability data.

   NOTE: You must reach out to the QPP Service Center by November 1, 2027, if your third party didn't submit your Promoting Interoperability data.

Can the Promoting Interoperability Performance Category be Reweighted? (Continued)

Check the **Other Reporting Factors** section on the QPP Participation Status Tool and review the Special Statuses page of the QPP website.

Check '**Clinician Level**' if you're **reporting as an individual**

Other Reporting Factors

Learn more about how other reporting factors are determined and special statuses.

Clinician Level

SPECIAL STATUS **Hospital-based**	Yes

Check '**Practice Level**' if you're **reporting as a group**

Other Reporting Factors

Learn more about how other reporting factors are determined and special statuses.

Clinician Level

SPECIAL STATUS **Hospital-based**	Yes

Practice Level

SPECIAL STATUS **Hospital-based**	Yes

NOTE: You can still report even if you qualify for reweighting.

A qualifying data submission (submitting all required data, attestations, and measures) will override reweighting, and the clinician will receive a Promoting Interoperability score. A partial submission (missing 1 or more required data elements) won't be scored and won't override previously approved reweighting.

How Does Reweighting Work if We're Participating as an APM Entity?

Individual MIPS eligible clinicians and groups in the APM Entity that qualify for automatic reweighting or have an approved MIPS Promoting Interoperability hardship exception don't need to submit data for the Promoting Interoperability performance category.

They'll be excluded from the calculation when determining the APM Entity's score, but they'll still receive the APM Entity's score for this performance category.

In rare instances, the Promoting Interoperability performance category can be reweighted for the entire Entity for the 2026 performance period. This could occur when all of the clinicians within the APM Entity qualify for reweighting either individually or as a group (depending on how data was reported) for the Promoting Interoperability performance category.

MIPS Final Score

How is My Final Score Calculated?

We multiply your performance category score by the category's weight, and multiply that by 100, to determine the number of points that contribute to your final score for each performance category. Then we add the points for each performance category to any complex patient bonus you may have received to arrive at your final score.

Individuals, Groups, and Virtual Groups

Quality		Cost		Improvement Activities		Promoting Interoperability		Complex Patient Bonus	
Up to **30** points toward your MIPS final score	+	Up to **30** points toward your MIPS final score	+	Up to **15** points toward your MIPS final score	+	Up to **25** points toward your MIPS final score	+	Up to **10** points toward your MIPS final score	MIPS final scores range from 0 to 100 points

The MIPS final score can't exceed 100 points.

APM Entities

Quality		Cost		Improvement Activities		Promoting Interoperability		Complex Patient Bonus	
Up to **55** points toward your MIPS final score	+	**0** points toward your MIPS final score	+	Up to **15** points toward your MIPS final score	+	Up to **30** points toward your MIPS final score	+	Up to **10** points toward your MIPS final score	MIPS final scores range from 0 to 100 points

How is My Final Score Calculated? (Continued)

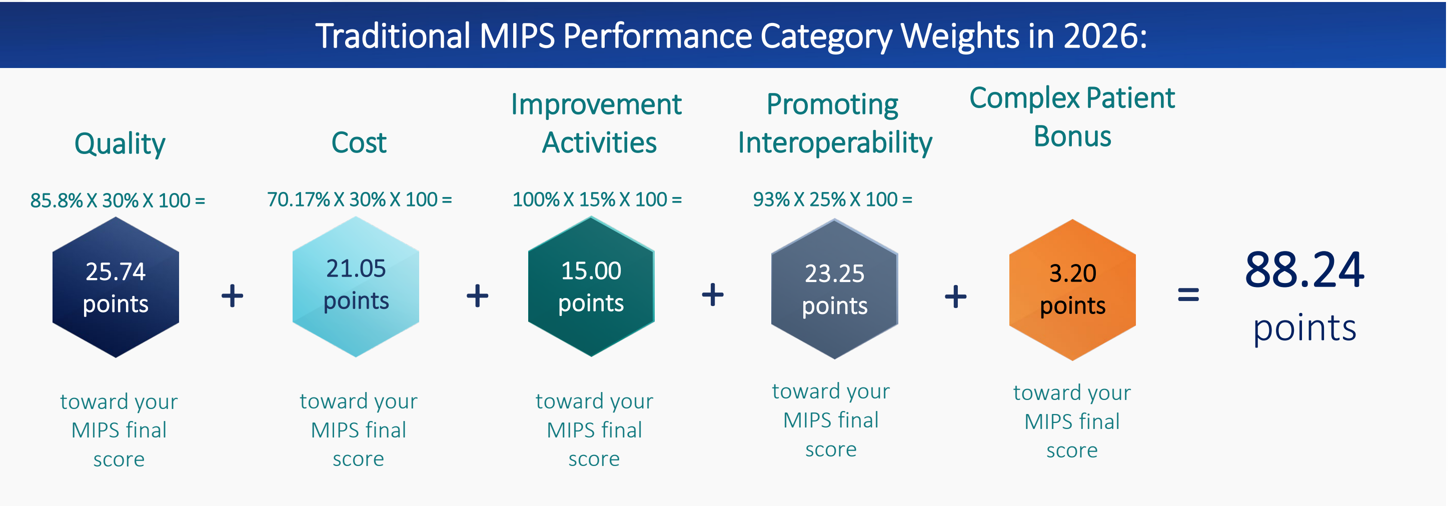
Small Practices

Standard Performance Category Weights for Small Practices (Promoting Interoperability Automatically Reweighted)			
Individual, Group and Virtual Group Participation			
Quality	**Cost**	**Improvement Activities**	**Promoting Interoperability**
40% of MIPS Score	30% of MIPS Score	30% of MIPS Score	0% of MIPS Score
APM Entity Participation (with Small Practice Status)			
50% Quality	0% Cost	50% Improvement Activities	0% Promoting Interoperability

How is My Final Score Calculated? (Continued)

Scoring Example 1

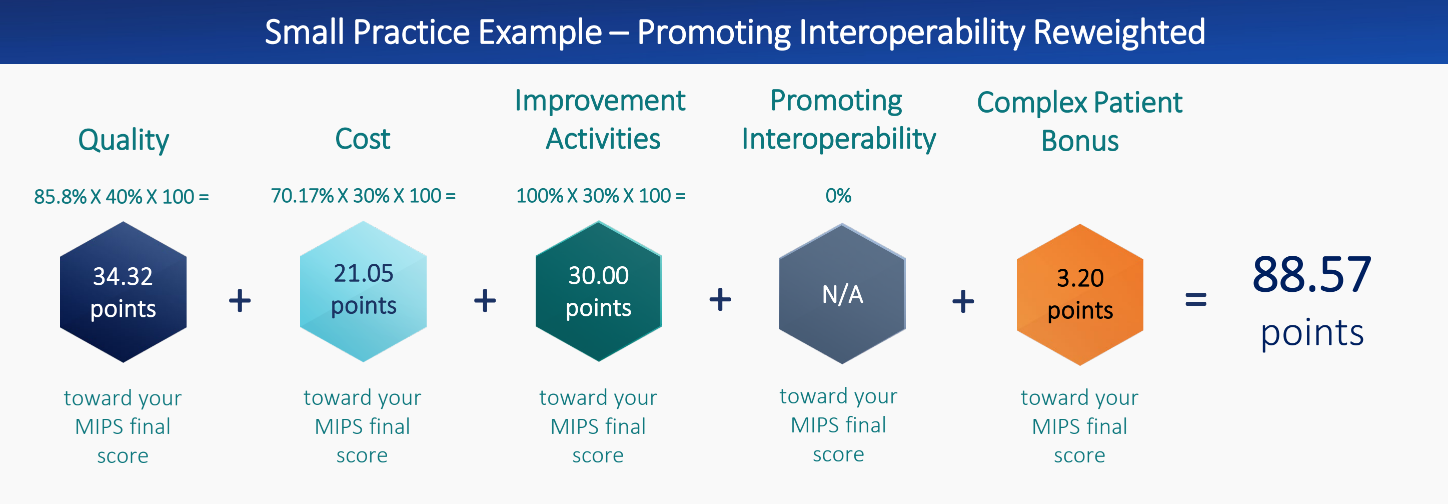
Let's continue our example of the small practice reporting as a group and review how the final score is calculated. (As a reminder, small practices qualify for automatic reweighting of Promoting Interoperability, but the small practice in this example had CEHRT and chose to report data for this performance category.)



How is My Final Score Calculated? (Continued)

Scoring Example 2

Now let's look at what the small practice's final score would have been if they **didn't** report data for the Promoting Interoperability performance category. This performance category will automatically be weighted at 0% unless data is submitted. Small practices have a different redistribution of performance category weights when Promoting Interoperability is reweighted. See Appendix B, Table 2.



What is the Complex Patient Bonus?

The complex patient bonus awards up to 10 bonus points based on the medical complexity and social risk of your patients. These bonus points are added to the MIPS final score for qualifying MIPS eligible clinicians, groups, virtual groups and APM Entities.

The complex patient bonus is composed of 2 distinct calculations which are added together:

- The first calculation looks at **medical complexity** as determined by the average Hierarchical Condition Categories (HCC) risk score of your Medicare patient population.
- The second calculation looks at **social risk** as determined by the proportion of your Medicare patient population that's dually eligible for both Medicare and Medicaid.

We'll calculate the HCC risk scores and dual eligibility ratio for the unique Medicare patients treated during the second 12-month segment (October 1, 2025 – September 30, 2026) of the 2026 MIPS determination period.

The complex patient bonus is limited to MIPS eligible clinicians, groups, virtual groups and APM Entities that submit data for at least one performance category and that have at least one risk indicator (either average HCC risk score or dual eligibility ratio) at or above the median risk indicator calculated for all MIPS eligible clinicians, groups, virtual groups and APM Entities from the previous performance year.

We'll evaluate each MIPS eligible clinician, group, virtual group, or APM Entity that submits data for their eligibility to receive the complex patient bonus**, but only the MIPS eligible clinicians, groups, virtual groups, and APM Entities that meet the eligibility criteria will receive the bonus.**

Eligibility for the Complex Patient Bonus

Step 1

We'll identify the **median HCC risk score** and **median dual eligibility ratio** based on the complex patient bonus included in the final score attributed to each MIPS eligible clinician (whether participating as an individual, group, virtual group or APM Entity) in the **2025 performance year.**

Step 2

We'll calculate the **average HCC risk score and dual eligibility ratio** for each MIPS eligible clinician, group, virtual group and APM Entity for the **2026 performance year**.

- **Average HCC risk score** = sum of HCC risk scores for the unique Medicare patients treated*/number of unique Medicare patients treated*
- **Dual eligibility ratio** = unique Medicare patients treated* who were dually eligible for Medicare and full- or partial-Medicaid benefits/unique Medicare patients treated*

*Medicare patients must have been treated between October 1, 2025, and September 30, 2026, to be included in these calculations.

Step 3

We'll **compare your average** HCC risk score and dual eligibility ratio (calculated in Step 2) **to the median values** identified in Step 1.

- **If either (or both) of your risk indicators is at or above the median identified in step 1, you're eligible to receive the complex patient bonus.**

Did you know? A patient's HCC risk score is based on:

- Age and gender.
- Diagnoses from the previous year.
- Whether they're eligible for Medicaid, first qualified for Medicare on the basis of disability, or live in an institution (usually a nursing home).

Calculating the Complex Patient Bonus for the 2026 Performance Year

Step 1

We'll identify the **mean HCC risk score** and **mean dual eligibility ratio** based on the 2025 complex patient bonus included in the 2025 final score attributed to each MIPS eligible clinician (whether participating as an individual, group, virtual group or APM Entity).

(This is different than the median calculated to determine eligibility.)

We'll calculate a **standardized** score for the medical complexity component.

- **Medical component standardized score** = (your 2026 average HCC risk score **MINUS** the 2025 mean HCC risk score from step 1)/ standard deviation for the 2025 mean HCC risk score from step 1.

We'll calculate the **medical complexity component** contribution to your complex patient bonus.

- **Medical complexity complex patient bonus points** = 1.5 + 4 x (standardized score from step 2)

We'll calculate a **standardized** score for the social risk component.

- **Social component standardized score** = (your 2026 dual eligibility ratio **MINUS** the 2025 mean dual eligibility ratio from step 1)/ standard deviation for the 2025 mean dual eligibility ratio from step 1

We'll calculate the **social risk component contribution** to your complex patient bonus.

- **Social risk complex patient bonus points** = 1.5 + 4 x (standardized score from step 4)

We'll calculate your total complex patient bonus

- **Complex patient bonus** = Medical complexity points (step 3) + Social risk points (step 5)

If only 1 of the 2 risk indicators – medical complexity or social risk – was at or above the median when we determined your eligibility for the complex patient bonus, then the other will contribute 0 points toward your complex patient bonus.

MIPS Payment Adjustment

How Does My MIPS Final Score Determine My Payment Adjustment?

Your MIPS final score will be between 0 and 100 points. Each final score will correlate to a payment adjustment, but in most cases, we can't project what this correlation will be.

Why? MIPS is required by law to be a budget neutral program, which generally means that the amount of the payment adjustments is dependent on the overall participation and performance of clinicians in the program for that year.

2026 Final Score	2028 Payment Adjustment
0.00 – 18.75 points	-9% payment adjustment
18.76 – 74.99 points	Negative payment adjustment (less than -9% and greater than 0%)
75.00 points (Performance threshold=75.00 points)	Neutral payment adjustment (0%)
75.01 –100.00 points	Positive payment adjustment (scaling factor applied to meet statutory budget neutrality requirements)

How Does My MIPS Final Score Determine My Payment Adjustment? (Continued)

MIPS Payment Adjustment

- Clinicians with a final score **at** the performance threshold of **75 points** earn a **neutral** adjustment.
- Clinicians with a final score **above** the performance threshold of **75 points** earn a **positive** adjustment (subject to a scaling factor).
- Clinicians with a final score **below** the performance threshold of **75 points** will be subject to a **negative** adjustment. The maximum negative adjustment is -9%.

MIPS payment adjustments are calculated to ensure budget neutrality. The final MIPS payment adjustments will be determined by the distribution of final scores across MIPS eligible clinicians and the performance threshold.

- More MIPS eligible clinicians with final scores above the performance threshold means the scaling factors would decrease (lower positive adjustment amounts) because more MIPS eligible clinicians receive a positive MIPS payment adjustment.
- More MIPS eligible clinicians with final scores below the performance threshold means the scaling factors would increase (higher positive adjustment amounts) because more MIPS eligible clinicians would have negative MIPS payment adjustments and relatively fewer MIPS eligible clinicians would receive positive MIPS payment adjustments.

Help and Version History

Where Can You Go for Help?

Contact the Quality Payment Program Service Center by emailing QPP@cms.hhs.gov, creating a QPP Service Center ticket, or calling 1-866-288-8292 (Monday through Friday,
8 a.m. - 8 p.m. ET). Please consider calling during non-peak hours, before 10 a.m. and 2 p.m. ET.

- People who are deaf or hard of hearing can dial 711 to be connected to a TRS Communications Assistant.

Visit the Quality Payment Program website for other help and support information, to learn more about MIPS, and to check out the resources available in the Quality Payment Program Resource Library.

Visit the Small Practice page of the Quality Payment Program website where you can sign up for the monthly QPP Small Practices Newsletter and find resources and information relevant for small practices.

Version History

If we need to update this document, changes will be identified here.

DATE	DESCRIPTION
03/30/2026	Original Version.

Appendices

Appendix A: Scoring Quality Measures

This example can help you find a benchmark, figure achievement points, and pick the top 6 measures based on the number of points.

1. **Find the benchmark and figure achievement points based on collection type for the measure.**
   - Achievement points are figured by mapping the performance rate to the benchmark for the measure, specific to collection type.
   - **Example:** A group submits Measure 226 as a MIPS CQM.

Measure Reported	Type of Measure	Collection Type	Measure Performance Rate	Cases Reported
Measure 226 – Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Process	MIPS CQM	90.26 (mapped to highlighted decile below)	90

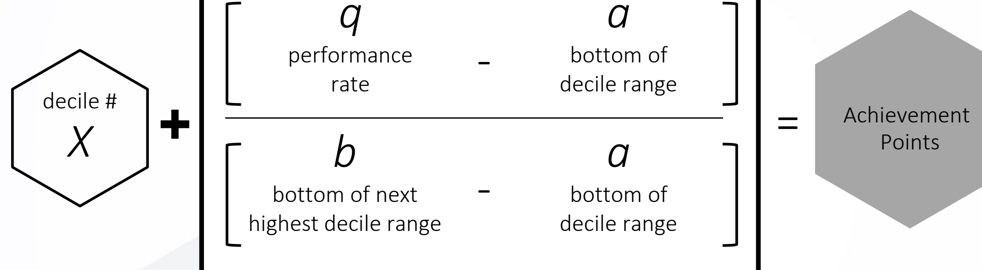
Measure ID #	Collection Type	Decile 1	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
226	MIPS CQM	4.17 – 41.66	41.67 – 74.99	75.00 – 90.76	90.77 – 98.64	98.65 – 99.99	--	--	--	--	100
226	Medicare Part B Claims	8.51 – 79.99	80.00 – 95.64	95.65 – 99.99	--	--	--	--	--	--	100
226	eCQM	4.17 – 19.22	19.23 – 33.32	33.33 – 46.57	46.58 – 61.56	61.57 – 75.96	75.97 – 87.40	87.41 – 94.73	94.74 – 98.81	98.82 – 99.99	100

Appendix A: Scoring Quality Measures (Continued)

2. **Figure achievement points in a decile.**
   - Determine the decile that the performance rate falls in:
   - Measure performance rate = 90.26

Measure Name	Controlling High Blood Pressure
Measure ID#	226
Collection Type	MIPS CQM
Decile 1	4.17 – 41.66
Decile 2	41.67 – 74.99
Decile 3	75.00 – 90.76
Decile 4	90.77 – 98.64
Decile 5	98.65 – 99.99
Decile 6	--
Decile 7	--
Decile 8	--
Decile 9	--
Decile 10	100

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



NOTE: Partial achievement points are truncated to the hundredths digit for partial points.

$$3 + \frac{[90.26 - 75.00]}{[90.77 - 75.00]} = 0.968... = 3.97$$

...which is truncated to 0.97

Appendix A: Scoring Quality Measures (Continued)

3. **Repeat assignment of achievement points for each submitted measure.**
   - **Example:** A group (not a small practice) submits 5 MIPS CQMs and 3 eCQMs meeting data completeness for all measures

Measures Reported	Collection Type	Types of Measure	Measure Performance Rate	Cases Reported	Achievement Points	Comments
Measure 236 Controlling High Blood Pressure	MIPS CQM	Outcome	72.33	86	8.23	Compare to benchmark; required outcome measure.
Measure 226 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	MIPS CQM	Process	90.26	90	3.97	Compare to benchmark.
Measure 117 Diabetes: Eye Exam	eCQM	Process	84.55	112	6.23	Compare to benchmark.
Measure 117 Diabetes: Eye Exam	MIPS CQM	Process	61.40	18	0.00	Doesn’t meet case minimum.
Measure 374 Closing the Referral Loop: Receipt of Specialist Report	eCQM	Process	82.77	90	9.20	Compare to benchmark.
Measure 126 Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy - Neurological Evaluation	MIPS CQM	Process	93.51	107	4.96	Compare to benchmark.
Measure 102 Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	eCQM	Process	89.99	32	0.00	No historical benchmark available. Earns 0 points (unless a performance period benchmark is created following submission period).
Measure 509 Melanoma: Tracking and Evaluation of Recurrence	MIPS CQM	Process	29.87	22	5.00	Measure in its second year in the program, earns 5 points (unless a performance period benchmark is created following submission period).

Appendix A: Scoring Quality Measures (Continued)

4. **Sort and group measures based on achievement.**

- First identify the highest scoring outcome measure based on achievement points, then identify the next 5 highest scoring measures based on achievement points.

The following measures contribute achievement points toward the quality performance category score.			
Measures Sorted by Performance	Collection Type	Performance Rate	Achievement Points
1. Outcome/High-priority: **Measure 236**	MIPS CQM	72.33	8.23
2. **Measure 374**	eCQM	82.77	9.20
3. **Measure 117**	eCQM	84.55	6.23
4. **Measure 509**	MIPS CQM	29.87	5.00
5. **Measure 126**	MIPS CQM	93.51	4.96
6. **Measure 226**	MIPS CQM	90.26	3.97

- Identify measures that won’t contribute any points to the quality performance category score.

The following measure don’t contribute achievement points toward the quality performance category score.				
Measures Sorted by Performance	Collection Type	Performance Rate	Achievement Points	Comment
Measure 117	MIPS CQM	61.40	0.00	Not one of the top 6 scored measures
Measure 102	eCQM	89.99	0.00	Not one of the top 6 scored measures

Appendix B: Reweighting the Performance Categories

Table 1. Performance Category Weight Redistribution (Excluding Small Practices)

Table 1 outlines the performance category weights when 0, 1, or 2 performance categories are reweighted to 0% based on any circumstances described throughout this guide, including the Extreme and Uncontrollable Circumstances policy.

Performance Category Redistribution for the 2026 Performance Year/2028 MIPS Payment Year				
Reweighting Scenario	Quality	Cost	Improvement Activities (IA)	Promoting Interoperability (PI)
No Reweighting Needed				
General weighting for all 4 performance categories	**30%**	**30%**	**15%**	**25%**
Reweighting 1 Performance Category				
No Cost: Cost → Quality and PI	55%	0%	15%	30%
No Promoting Interoperability: PI → Quality	55%	30%	15%	0%
No Quality: Quality → PI	0%	30%	15%	55%
No Improvement Activities: IA → Quality	45%	30%	0%	25%
Reweighting 2 Performance Categories				
No Cost and No Promoting Interoperability Cost and PI → Quality	85%	0%	15%	0%
No Cost and No Quality Cost and Quality → PI	0%	0%	15%	85%
No Cost and No Improvement Activities Cost and IA → Quality and PI	70%	0%	0%	30%
No Promoting Interoperability and No Quality PI and Quality → Cost and IA	0%	50%	50%	0%
No Promoting Interoperability and No Improvement Activities PI and IA → Quality	70%	30%	0%	0%
No Quality and No Improvement Activities Quality and IA → PI	0%	30%	0%	70%

NOTE: If you have multiple performance categories reweighted to 0% so that a single performance category is weighted as 100% of your final score, you'll receive a score equal to the performance threshold regardless of any data submitted or not submitted.

Appendix B: Reweighting the Performance Categories

Table 2. Performance Category Weight Redistribution for Small Practices

Table 2 outlines the performance category weights when 0, 1, or 2 performance categories are reweighted to 0% based on any circumstances described throughout this guide, including the Extreme and Uncontrollable Circumstances policy.

Performance Category Redistribution for the 2026 Performance Year/2028 MIPS Payment Year				
Reweighting Scenario	Quality	Cost	Improvement Activities (IA)	Promoting Interoperability (PI)
No Reweighting Needed				
General weighting for all 4 performance categories	**30%**	**30%**	**15%**	**25%**
Reweighting 1 Performance Category				
No Cost: Cost → Quality and PI	55%	0%	15%	30%
No Promoting Interoperability: PI → Quality and IA	40%	30%	30%	0%
No Quality: Quality → PI	0%	30%	15%	55%
No Improvement Activities: IA → Quality	45%	30%	0%	25%
Reweighting 2 Performance Categories				
No Cost and No Promoting Interoperability Cost and PI → Quality and IA	50%	0%	50%	0%
No Cost and No Quality Cost and Quality → PI	0%	0%	15%	85%
No Cost and No Improvement Activities Cost and IA → Quality and PI	70%	0%	0%	30%
No Promoting Interoperability and No Quality PI and Quality → Cost and IA	0%	50%	50%	0%
No Promoting Interoperability and No Improvement Activities PI and IA → Quality	70%	30%	0%	0%
No Quality and No Improvement Activities Quality and IA → PI	0%	30%	0%	70%

NOTE: If you have multiple performance categories reweighted to 0% so that a single performance category is weighted as 100% of your final score, you'll receive a score equal to the performance threshold regardless of any data submitted or not submitted.

Appendix C: Reallocation of Points for Promoting Interoperability Measure(s)

When an Exclusion is Claimed

The table below outlines where points are redistributed when an exclusion is claimed.

<table>
<tr><th>Objectives</th><th colspan="2">Measures</th><th>Exclusion Available</th><th>When the Exclusion is Claimed...</th></tr>
<tr><td rowspan="2">Electronic Prescribing</td><td colspan="2">e-Prescribing</td><td>Yes</td><td>...the 10 points are redistributed equally among the measures associated with the Health Information Exchange objective:
• 5 points to the Support Electronic Referral Loops by Sending Health Information measure
• 5 points to the Support Electronic Referral Loops by Receiving and Incorporating Health Information measure
OR
... the 10 points are redistributed to the HIE Bi-Directional Exchange measure
OR
...the 10 points are redistributed to the Enabling Exchange under the Trusted Exchange Framework and Common Agreement (TEFCA) measure</td></tr>
<tr><td colspan="2">Query of Prescription Drug Monitoring Program (PDMP)</td><td>Yes</td><td>...the 10 points are redistributed to the e-Prescribing measure</td></tr>
<tr><td rowspan="4">Health Information Exchange</td><td rowspan="2">Option 1</td><td>Support Electronic Referral Loops by Sending Health Information</td><td>Yes</td><td>...the 15 points are redistributed to the Provide Patients Electronic Access to their Health Information measure</td></tr>
<tr><td>Support Electronic Referral Loops by Receiving and Reconciling Health Information</td><td>Yes</td><td>...the 15 points are redistributed to the Support Electronic Referral Loops by Sending Health Information measure</td></tr>
<tr><td>Option 2</td><td>HIE Bi-Directional Exchange</td><td>No</td><td>N/A</td></tr>
<tr><td>Option 3</td><td>Enabling Exchange under TEFCA</td><td>No</td><td>N/A</td></tr>
</table>

Appendix C: Reallocation of Points for Promoting Interoperability Measure(s) (Continued)

When an Exclusion is Claimed (Continued)

Objectives	Measures	Exclusion Available	When the Exclusion is Claimed…
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	No	N/A
Public Health and Clinical Data Exchange	Report the 2 required measures: • Immunization Registry Reporting • Electronic Case Reporting	Yes	…the 25 points are still available in this objective if you claim an exclusion for one of the required measures and submit a 'yes' attestation for the other required measure in the objective. …the 25 points are redistributed to the Provide Patients Electronic Access to Their Health Information measure if you claim 2 exclusions.
	Bonus (optional): • Public Health Registry Reporting • Clinical Data Registry Reporting • Syndromic Surveillance Reporting • Public Health Reporting Using TEFCA	N/A	N/A

NOTE: Even if you claim 1 or 2 exclusions for the Immunization Registry Reporting and Electronic Case Reporting measures, you can still earn a total of 5 bonus points by reporting 1, 2, 3 or 4 of the optional Public Health and Clinical Data Exchange measures (Public Health Registry Reporting, Clinical Data Registry Reporting, Syndromic Surveillance Reporting, or Public Health Reporting Using TEFCA).

Appendix D: Quality Measures Subject to Defined Topped Out Measure Benchmarks

This table identifies quality measures that will be scored according to the defined topped out measure benchmarks. This list will be updated annually through rulemaking.

Quality ID	Measure Title	Collection Type
143	Oncology: Medical and Radiation – Pain Intensity Quantified	eCQM, MIPS CQM
144	Oncology: Medical and Radiation – Plan of Care for Pain	MIPS CQM
249	Barret’s Esophagus	Medicare Part B Claims Measure, MIPS CQM
250	Radical Prostatectomy Pathology Reporting	Medicare Part B Claims Measure, MIPS CQM
320	Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	Medicare Part B Claims Measure
350	Total Knee or Hip Replacement: Shared Decision-Making: Trial of Conservative (Non-surgical) Therapy	MIPS CQM
351	Total Knee or Hip Replacement: Venous Thromboembolic and Cardiovascular Risk Evaluation	MIPS CQM
360	Optimizing Patient Exposure to Ionizing Radiation: Count of Potential High Dose Radiation Imaging Studies: Computed Tomography (CT) and Cardiac Nuclear Medical Studies	MIPS CQM
364	Optimized Patient Exposure to Ionizing Radiation: Appropriateness: Follow-up CT imaging for Incidentally Detected Pulmonary Nodules According to Recommended Guidelines	MIPS CQM

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

Appendix D: Quality Measures Subject to Defined Topped Out Measure Benchmarks (Continued)

This table identifies quality measures that will be scored according to the defined topped out measure benchmarks. This list will be updated annually through rulemaking.

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

Appendix E: Suppressed and Truncated Measures Scoring Examples

Suppressed Measures: Submission and Scoring Examples

MIPS eligible clinicians, groups, virtual groups, and APM Entities must submit data for all 6 measures (or all measures within a specialty measure set with fewer than 6 measures) to meet the reporting requirements for the quality performance category. When you submit one or more suppressed measures, your quality performance category score is based on the measures you submitted that aren't suppressed. Suppressed measures must still meet data completeness and case minimum requirements.

The suppressed measure scoring policy is intended to hold clinicians harmless if they've collected data for a suppressed measure and don't have enough measures to meet the requirement to report 6 measures. The purpose of submitting a suppressed measure is to ensure the clinician gets credit for having met reporting requirements, even though the measure won't be scored.

If you have 6 non-suppressed measures available, you should submit those without submitting any suppressed measures.

Example 1

You're reporting eCQMs collected in your CEHRT and have performance data for 6 measures. One of the measures you intend to submit has been suppressed for the 2026 performance period. (If any measures are suppressed for the 2026 performance period, they'll be identified in Appendix F.)

You submit the 5 measures that weren't suppressed and don't submit the one measure that was suppressed.

- **5 submitted measures**: Are scored according to their benchmark (provided that data completeness and case minimum requirements are met).
- **1 unsubmitted (suppressed) measure:** Receives 0 out of 10 points because it wasn't submitted (6 measures are required to be submitted, including suppressed measures, to meet the reporting requirements for the quality performance category).
- **Quality denominator:** 60 points/not reduced. No suppressed measures were submitted.

Appendix E: Suppressed and Truncated Measures Scoring Examples

Example 2

Two of the 6 measures you intend to report have been suppressed for the 2026 performance period. (If any measures are suppressed for the 2026 performance period, they'll be identified in Appendix F.)

You submit the 6 measures, including the 2 measures that were suppressed.

- **4 submitted (not suppressed) measures:** Scored according to their benchmark (provided that data completeness and case minimum requirements are met).
- **2 submitted, suppressed measures:** Excluded from scoring because the measures were suppressed.
- **Quality denominator:** Reduced by 20 points (10 points for each submitted, suppressed measure). Quality denominator is 40 points unless you can be scored on any administrative claims measures.

Example 3

You're working with a qualified registry to report your quality measures.

Your registry submits 9 measures on your behalf, including 2 measures that are suppressed. (If any measures are suppressed for the 2026 performance period, they'll be identified in Appendix F).

- **Quality denominator**: Reduced by 20 points (10 points for each submitted, suppressed measure).
- **Quality numerator:** The 4 highest scoring measures out of the 7 measures that weren't suppressed.

Example 4

You submit 6 suppressed measures.

- The quality performance category isn't reweighted; you would receive a quality performance category score of zero points, regardless of whether you submitted additional measures that aren't suppressed.

TIP: If you submitted 6 suppressed measures because there were no other measures available, you can submit a Targeted Review (when final performance feedback is available) to request reweighting of the entire quality performance category.

Appendix E: Suppressed and Truncated Measures Scoring Examples

Truncated Measures: Submission and Scoring Examples

A truncated measure will have performance assessed based on data from 9 consecutive months of the 2026 performance period. Measure data must be truncated prior to submission for MIPS CQMs. Truncated measures must still meet data completeness and case minimum requirements.

Example 1

One of the 6 MIPS CQMs you intend to submit has been truncated for the 2026 performance period. (If any measures are truncated for the 2026 performance period, they'll be identified in Appendix F).

You or your third party truncated the measure to 9 consecutive months of data (as specified in the truncation announcement) prior to submission. You submit the 6 measures.

- **6 submitted (non-truncated and truncated) measures:** Scored according to their benchmark (provided that data completeness and case minimum requirements are met).
- **Quality denominator:** Quality denominator is 60 points unless you can be scored on any administrative claims measures. We don't reduce the quality denominator for truncated measures.

Example 2

A small practice is reporting 6 Medicare Part B claims measures, one of which has been truncated for the 2026 performance period. (If any measures are truncated for the 2026 performance period, they'll be identified in Appendix F).

You continue reporting the measures via Medicare Part B claims. We'll truncate the affected measure to 9 consecutive months of data (as specified in the truncation announcement) for you.

- **6 submitted (non-truncated and truncated) measures:** Scored according to their benchmark (provided that data completeness and case minimum requirements are met).
- **Quality denominator:** Quality denominator is 60 points unless you can be scored on any administrative claims measures. We don't reduce the quality denominator for truncated measures.

Appendix F: Quality Measures with MIPS Scoring or Submission Changes

This appendix identifies any measures affected by specification or coding issues, clinical guideline changes during the 2026 performance period, or specifications determined during or after the performance period to have substantive changes.

- At the time of publication, no measures have been identified for suppression or truncation for the 2026 performance period
- This **appendix** will be updated if measures are identified for suppression or truncation in the 2026 performance period.