

**Physician Fee Schedule Proposed Rule for 2026
Summary Part III: Quality Payment Program (QPP)**

Medicare and Medicaid Programs; CY 2026 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program
[CMS-1832-P]

On July 16, 2025, the Centers for Medicare & Medicaid Services (CMS) published in the Federal Register (90 FR 32352) a proposed rule relating to the Medicare physician fee schedule (PFS) for CY 2026¹ and other revisions to Medicare Part B policies. If finalized, policies in the proposed rule generally would take effect on January 1, 2026. **The 60-day comment period ends at close of business on September 12, 2025.**

HFMA is providing a summary in three parts. Part I covers sections I through III.G (except for Section II.H: Outpatient Therapy Services and Section II.F, which covers the Medicare Shared Savings Program Requirements) and the Regulatory Impact Analysis.² Part II covers the Medicare Shared Savings Program Requirements.

Part III covers the updates to the Quality Payment Program, including the Traditional Merit-based Incentive Payment System (MIPS), MIPS Value Pathways (MVPs), and the Alternative Payment Model Incentive.

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¹ Henceforth in this document, a year is a calendar year unless otherwise indicated, a reference to “the Act” is a reference to the Social Security Act, and a reference to a regulatory section is a reference to that section in title 42, CFR.

² Section H: Outpatient Therapy Services was inadvertently omitted from the PFS proposed regulation and is expected to be released as part of a correction notice. HFMA will provide a revised Part I version of this summary when this section is made available.

IV. Quality Payment Program

A. Executive Summary: Background, Overview and Summary of Major Provisions

1. Background³

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula for updates to the Physician Fee Schedule (PFS), replacing the SGR with the Quality Payment Program (QPP). There are two payment tracks under the QPP: MIPS and the Advanced Alternative Payment Models (Advanced APMs).

a. MIPS Payment Track

For the MIPS payment track, MIPS eligible clinicians are subject to a MIPS payment adjustment (positive, negative, or neutral) that is applied to payment for their Medicare Part B-covered services. The adjustment is based on their performance on measures and activities in four performance categories: (i) Quality, (ii) Cost, (iii) Improvement Activities (IAs), and (iv) Promoting Interoperability (PI). Each MIPS eligible clinician's total performance is assessed during a performance period according to established performance standards with respect to the applicable measures and activities reported by the clinician in the performance categories to compute a final composite performance score. Each performance category is assigned a different weight for determining the clinician's final composite performance score. For the 2026 performance period/2028 MIPS payment year, the scoring weights are: 30 percent for the quality performance category, 30 percent for the cost performance category, 15 percent for the IAs performance category, and 25 percent for the PI performance category.⁴ Each MIPS eligible clinician's final score is compared to the performance threshold determined by CMS for the performance period to calculate the payment adjustment factor. The payment adjustment factor is determined such that a MIPS eligible clinician will receive a positive adjustment if their score is higher than the threshold, no adjustment if their score meets the threshold, and a negative adjustment if their score is below the threshold.

There are three reporting options for MIPS eligible clinicians under the MIPS payment track:

- Traditional MIPS,
- The Alternative Payment Model (APM) Performance Pathway (APP), and
- The MIPS Value Pathways (MVPs).

Under the Traditional MIPS pathway, the clinicians select quality measures and IAs from the inventories finalized from MIPS and report on them and report on the complete PI measure set. CMS collects and calculates data for the clinicians for the cost performance category. The APP is an option for MIPS eligible clinicians participating in a MIPS APM. Unlike under Traditional MIPS, performance is measured across three areas (quality, IA, and PI). The weights for the performance categories under the APP are as follows: (i) Quality, 50 percent; (ii) Cost, 0 percent;

³ More information about all aspects of the QPP is available for download at <https://qpp.cms.gov/resources/resource-library>.

⁴ These weights are subject to certain exceptions specified in section 1848(q)(5) of the Act and §414.1380.

(iii) IAs, 20 percent; and (iv) PI, 30 percent.⁵ The MVPs are the newest reporting pathway and allow clinicians to choose and report on a subset of quality measures and IAs that are specific to a specialty or medical condition. As with the other options, clinicians must report on the same complete traditional MIPS PI measure set. CMS collects and calculates data for the cost performance category.

b. Advanced APM Track

If an eligible clinician participates in an Advanced APM and is a qualifying APM participant (QP) or a partial qualifying APM participant (partial QP), the MIPS reporting requirements and payment adjustment do not apply to the clinician.⁶ For the 2026 payment year, QPs receive a lump sum APM Incentive payment equal to 1.88 percent of their estimated aggregate paid amounts for covered professional services furnished in 2025. The 2026 payment year is the last year for which there is statutory authority for the APM Incentive payment. Beginning with the 2026 payment year, there will be two separate PFS conversion factors, one for items and services furnished by a QP, and the other for items and services furnished by non-QPs (the nonqualifying APM conversion factor). Specifically, the update to the PFS CF for services that are furnished by clinicians who achieve QP status for a year will be 0.75 percent, otherwise it will be 0.25 percent.

In addition, beginning in the 2026 QP performance period/2028 payment year, the thresholds to achieve QP status will increase from 50 percent to 75 percent for the payment amount, and from 35 percent to 50 percent for the patent count. CMS estimates that for the 2026 QP performance period, between 375,000 and 482,200 eligible clinicians will become QPs and be excluded from MIPS.

2. Overview

During 2026, MIPS payment adjustments will be applied, and APM incentive payments will be made, to eligible clinicians based on their 2024 performance data. For performance year 2026, category weights will be unchanged. MIPS adjustments will range from -9 to +9 percent, applied to payments for covered Part B professional services furnished during 2026. CMS proposes 75 points as the performance score threshold for each of the 2026 through 2028 performance periods and as the basis for adjustments during payment years 2027 through 2030.

Budget neutrality is required within MIPS by statute. For a threshold score of 75 points, CMS under its baseline model projects that positive and negative payment adjustments will result in redistributing approximately \$464 million, and if the proposed policies were finalized, \$463 million, based on the budget neutrality requirement. Taking into account the proposals, CMS estimates that the median positive payment adjustment is about 1.30 percent and the median negative payment adjustment is -1.88 percent. The overall proportion of clinicians receiving a positive or neutral payment adjustment is expected to be 84.05 percent in the proposed policy model (as compared to 83.61 percent in the baseline mode), and 11.92 percent of clinicians in the

⁵ CMS may assign a different scoring weight to the quality or PI categories and reweight in accordance with §414.1367(d)(2).

⁶ Partial QPs may elect to be subject to the MIPS reporting requirements and payment adjustment.

proposed policy model (as compared to 12.33 percent in the baseline model) are expected to receive a negative adjustment.

3. Summary of Major Provisions

CMS describes its goals to create a health care system that responds to chronic diseases as well as proactively prevents such diseases. The agency is proposing (described in detail below) an Advancing Health and Wellness subcategory within the IAs performance category.

The agency is continuing its implementation of MVPs to allow clinicians to report on measures that are directly relevant to their clinical practice, engage more specialists in performance measurement, and reduce barriers to APM participation. CMS intends to move to full mandatory MVP adoption and to sunset traditional MIPS at a future date, which remains undetermined but will be established through notice and comment rulemaking. The agency is issuing several RFIs to seek feedback on the following: (1) The use of Fast Healthcare Interoperability Resources (FHIR)-based electronic clinical quality measures (eCQMs); (2) Potential Core Elements MVP reporting requirements; (3) Using Medicare procedural codes to facilitate more MVP specialty reporting; (4) Future use of well-being and nutrition measures in the QPP; (5) Potential Future modifications to the Query of Prescription Drug Monitoring Program (QPDMP) measure; (6) Potential modifications to the PI performance category's objectives and measures; and (7) Potential improvements to enhance the health information that MIPS eligible clinicians exchange across systems.

MVP-Specific Proposals. CMS proposes the following updates to two MVP subgroup policies:

- Update the MVP group registration process to add the multispecialty self-attestation requirement; and
- Maintain the MVP group reporting option for multispecialty groups with a small practice designation.

For MVP development and maintenance, CMS proposes:

- Six new MVPs: (i) Diagnostic Radiology; (ii) Interventional Radiology; (iii) Neuropsychology; (iv) Pathology; (v) Podiatry; and (vi) Vascular Surgery.
- To provide additional flexibilities to allow qualified clinical data registries (QCDRs) and qualified registries more time to fully support finalized MVPs; and
- Several MVP maintenance updates to the MVP inventory, including to align with the MVP development criteria.

In addition, CMS describes how it has updated the format of the MVP tables to stratify quality measures by clinical conditions and/or episodes of care to assist clinicians in selecting the most clinically relevant measures and identify when quality and cost measures are linked.

APP-Specific Proposals. CMS proposes updates to some quality measures in the APP to reflect proposed changes to measures for the quality performance category.

Proposals Specific to MIPS Quality Performance Category. CMS proposes several policies for the quality performance category, including (i) for the 2026 performance period/2028 MIPS payment year, establishing a measure set inventory of 190 MIPS quality measures (187 of which

available in traditional MIPS and 3 of which only for MVPs); and (ii) revising the definition of a high priority measure to remove health equity.

Proposals Specific to MIPS Cost Performance Category. Proposals include (i) modifying the total per capita cost (TPCC) measure; (ii) updating the operational list of care episodes and patient condition groups and codes to reflect coding changes identified through annual maintenance of MIPS cost measures; and (iii) adopting a 2-year informational-only feedback period for newly implemented MIPS cost measures.

Proposals Specific to MIPS IAs Performance Category. Proposals include (i) adding Advancing Health and Wellness as a new subcategory for the IAs performance category; (ii) removing the Achieving Health Equity subcategory; (iii) adding three new IAs into two existing subcategories; (iv) Modifying seven IAs; and (v) removing eight IAs.

Proposals Specific to MIPS PI Performance Category. Proposals include: (i) Modifying the Security Risk Analysis measure and the High Priority Practices Safety Assurance Factors for Electronic Health Record (EHR) Resilience (SAFER) Guide measure; and (ii) Adopting the Public Health Reporting Using the Trusted Exchange Framework and Common Agreement (TEFCA) measure as an optional bonus measure. In addition, for both the PIP performance category and the Promoting Interoperability Program (PIP), CMS proposes to adopt a measure suppression policy and to suppress the electronic case reporting measure.

Proposals Specific to MIPS Final Scoring Methodology and Payment Adjustments. For the quality performance category, CMS proposes (i) to update how it identifies measures impacted by limited measure choice to apply its criteria previously finalized for specialty measure sets also to MVPs; (ii) a list of topped out measures impacted by limited measure choice and subject to the defined topped out measure benchmark; and (iii) to modify its methodology for scoring administrative claims-based measures such that it would be based on standard deviation, median, and an achievement point value derived from the performance threshold.

CMS proposes to determine the performance threshold for the 2026 performance period/2028 MIPS payment year by continuing to use the mean of the final scores from the 2017 performance period, and to maintain the performance threshold at 75 points for the 2026 performance period/2028 MIPS payment year through the 2028 performance period/2030 payment year.

Third Party Intermediary (TPI) Proposals. CMS proposes (i) to codify two previously-finalized policies, including that CMS-approved survey vendors must submit a range of the cost of their services and that an entity is required to administer the CAHPS for MIPS survey Spanish translation to Spanish-preferring patients; (ii) to require CMS-approved survey vendors to administer the CAHPS for MIPS survey through a web-mail-phone protocol; and (iii) to sunset one of the requirements that apply for becoming a CMS-approved survey vendor.

Advanced APM-Specific Proposals. CMS proposes to (i) modify its methodology for calculating QP status; (ii) use covered professional services to identify beneficiaries to define an attribution-eligible beneficiary in its calculations for Advanced APMs; (iii) sunset the Advanced APM criterion that sets a limit on the number of clinicians belonging to an APM entity participating in

a medical home model; and (iv) align targeted review timeline for QPs with that for MIPS targeted review.

B. Definitions⁷

CMS proposes to revise the definitions under §414.1305 of a high priority measure, attribution-eligible beneficiary, multispecialty group, MVP participant, and single specialty group. The terms and definitions are discussed in detail in the relevant sections below.

C. Transforming the Quality Payment Program (QPP)⁸

1. Vision and Strategy Overview

CMS describes its goal of transitioning from traditional MIPS to full MIPS Value Pathway (MVP) reporting. MVPs provide a cohesive set of measures and activities focused on care relevant to a specialty or clinical condition. They are intended to align the MIPS performance categories, simplify MIPS, and encourage clinicians to report on measures that are relevant to their practice. Voluntary reporting of MVPs began in the 2023 performance period/2025 MIPS payment year. CMS continues to incrementally develop MVPs to support its intended full transition to MVPs. In support of that goal, the agency is proposing policies to (i) enable groups to self-identify their specialty composition and submit MVP data that reflects the range of services provided by the group and (ii) continue the voluntary subgroup participation option for multispecialty group practices that qualify as small practices. CMS also issues RFIs on developing a subset of measures within MVPs to improve comparison of clinician performance and on identifying Medicare part B procedural billing codes that align with each MVP and potentially requiring specialists to report the relevant MVP based on their use of those codes.

CMS notes that in the 2025 PFS proposed rule the agency discussed its anticipated readiness to fully transition to MVPs by the 2029 performance period/2031 MIPS payment year.⁹

2. Subgroup Reporting

Background. Clinicians choosing to report an MVP currently have an option to report as a subgroup. Beginning with the 2026 performance period/2028 MIPS payment year, multispecialty groups choosing to report as an MVP participant will be required to form subgroups to report an MVP (referred to as the mandatory subgroup reporting requirement for multispecialty groups). Under the subgroup reporting policies, a group places clinicians providing a similar scope of care into one or more subgroups for reporting an MVP; remaining clinicians under the group TIN who are not part of a subgroup could participate as individuals for reporting an MVP or traditional MIPS. Alternatively, the entire TIN (including those that are part of the subgroup) could submit data as a group in traditional MIPS.

⁷ This proposal was included as IV.A.2. in the rule.

⁸ These proposals were included as IV.A.3. in the rule.

⁹ 89 FR 62012.

An MVP participant is defined under §414.1305 as an individual MIPS eligible clinician, multispecialty group, single-specialty group, subgroup, or APM entity that is assessed on an MVP for all MIPS performance categories. As previously finalized, beginning with the 2026 performance period/2029 MIPS payment year, “multispecialty group” will be excluded from that definition and replaced with “subgroup” consistent with the mandatory subgroup reporting requirement beginning for the 2026 performance period. This means that if a multispecialty group would like to report MVP, MIPS eligible clinicians in that group must report the MVP as subgroups or individuals, or alternatively the MIPS eligible clinicians in the multispecialty group could participate in traditional MIPS reporting.

Proposal to Maintain MVP Group Reporting Option for Small Practices. A small practice is defined at §414.1305 as a TIN consisting of 15 or fewer eligible clinicians during the MIPS determination period. CMS does not believe that there are benefits to requiring a small practice to further divide into smaller subgroups. The agency believes that such a requirement may result in the small practice subgroups not being able to meet the established case minimums for quality measures in the MVP, resulting in lower scores for the small group practice and potentially resulting in fewer small group practices choosing to participate in MVP reporting.

CMS proposes to change the definition of an MVP participant to provide that, beginning for the 2026 performance period/2028 MIPS payment year, multispecialty groups that are small practices may be MVP participants and thus allow small practice multispecialty groups (unlike other multispecialty groups) to report an MVP as a single group (and not be required to divide and report as subgroups).

Proposal to Modify MVP Group Registration Process. To implement the mandatory subgroup reporting requirement beginning with the 2026 performance period, CMS describes that it will need to determine the specialty composition of a group as a single specialty or multispecialty group. A single specialty group is a group that consists of one specialty type, as determined by CMS using Medicare Part B claims. A multispecialty group is a group that consists of two or more specialty types, as determined by CMS using such claims. Currently under the QPP, CMS assigns specialty type for MIPS eligible clinicians at the individual (TIN-NPI) level and not collectively at the group (TIN) level. A single specialty group and a multispecialty group are both defined under §414.1305. CMS reviews several concerns with using claims data to accurately identify the specialty composition of a group for determining if it is a single specialty group (not subject to the subgroup division requirement) or multispecialty group (subject to the subgroup division requirement), including examples of when a group practice consists of multiple specialty types but provides care in a single area or when the overall composition of a group changes such as due to clinician turnover or consolidation of practices.

Therefore, CMS proposes that it would not use claims data for designating a group as either a single specialty or multispecialty group. Instead, in order for a single-specialty group or a multispecialty group that is a small practice to report an MVP as a single group, the group would be required to self-identify as (and attest to being) a single specialty group or multispecialty group that is a small practice. Beginning with the 2026 performance period/2028 MIPS payment year, a group practice registering for MVP reporting that intends to participate as a single group would need to make this self-attestation during MVP registration. This self-attestation

requirement is not being proposed for subgroups because subgroup registration is an additional step in the MVP registration process for multispecialty groups choosing to report an MVP.¹⁰

CMS also proposes conforming changes to the regulatory definitions under §414.1305 for a single specialty group and multispecialty group to remove the requirement that CMS uses Medicare Part B claims for such a designation.

3. Core Elements RFI

CMS expresses concern about whether MVP reporting will achieve its goal to produce sufficient comparative performance data on standardized measures to support patient choice of care – primarily because of the volume of measures (ranging from 8 to 24 quality measures) from which MVP participants may select. The agency is considering policies to ensure more direct comparability of performance, specifically a policy to require an MVP participant to select one quality measure from a subset of quality measures in each MVP (referred to as core elements), which could be outcome measures. This one core element would be in addition to three other quality measures selected by the MVP participant and the participant would still have to meet existing MVP reporting requirements. The core elements for an MVP are to reflect the critical care elements for the MVP’s relevant specialty, medical condition, or episode of care. CMS notes that since there are measure gaps for certain specialists and subspecialists there may be clinicians for whom there would not be an applicable core element. The agency is considering proposing the core elements policy in the 2027 PFS proposed rule and considering proposing implementation before the sunset of traditional MIPS.

CMS requests feedback on several RFI questions, some of which ask about the following:

- Are there ways (other than the core elements) to ensure MVP reporting results provide comparative performance data for patients on critical measures?
- What is the ideal number or percentage of core elements in MVPs? Core elements are to be selected based on clinical relevance, but for consistency across MVPs, CMS is considering a set number of core elements for all MVPs, such as by setting the number of core elements in an MVP based on a percentage of the total number of quality measures in an MVP.
- CMS expresses concern that core elements for a few collection types (such as eQMs or QCDR measures) could limit clinician choice or force them to report via intermediaries. CMS mentions including core elements with different collection types as a solution and asks for other flexibilities or options that could address the concern.
- What are ways to include measures that are applicable for many clinicians (such as cross-cutting measures) and ways to avoid disadvantaging clinicians without an applicable core element?
- What are specific measures that should or should not be considered for as core elements?
- Would the core elements policy impact decision to report on MVP while traditional MIPS remains an option?

¹⁰ See §414.1365(b) for the subgroup registration process.

4. Medicare Procedural Codes RFI

CMS is considering using Medicare procedural codes to appropriately identify MVPs relevant to a clinician specialty type to increase MVP specialty reporting and to potentially require specialists to report an applicable MVP. MVP participants are currently able to select any MVP to report. CMS recognizes that assigning clinicians to a specific MVP would eliminate that choice and limit the measures which they could select to report, but believes it is important that clinicians report on an MVP relevant to their specialty or scope of care to ensure clinically relevant performance measurement and to allow for meaningful comparison of data. Specifically, CMS is considering identifying relevant procedural codes for each MVP and identifying clinicians to report that MVP based on their billing of those codes.

In addition, CMS is considering requiring clinicians to report a *specific* MVP based on procedural codes they bill and potentially requiring specialists to report *specific* measures within that MVP. CMS refers to the Ambulatory Specialty Model (ASM) being proposed under section III.D. That model would identify specialists to participate in the model by using specialty codes on Medicare part B claims data to identify specialty type combined with a minimum volume of episodes trigger mechanism for the relevant condition-specific episode-based cost measure. CMS lists several questions, some of which cover the following areas:

- Other ways to encourage specialty reporting of relevant MVPs based on scope of care provided.
- Data sources that should be used to assign clinicians to an MVP.
- Whether it is appropriate to use procedural billing codes from the MIPS determination period (which is used to determine MIPS eligibility); i.e., from 2 years before the performance year in which the clinician would report the MVP.
- What an appropriate volume threshold of procedural billing codes would be to be assigned to an MVP.
- Timeframe needed for clinicians to prepare for these policies.

5. Well-being and Nutrition Measures RFI

CMS seeks feedback on well-being and nutrition measures for future years in the QPP, specifically on tools and measures that assess overall health, happiness, and satisfaction in life, as well as that assess for the integration of health, skill building, and self-care.

D. QPP Reporting and Data Submissions¹¹

MIPS eligible clinicians, groups, virtual groups, subgroups, and APM entities must submit data on measures and activities for the quality, Improvement Activities (IAs), and Promoting Interoperability (PI) performance categories. There are no data submission requirements for the cost performance category or administrative claims-based quality measures.¹²

¹¹ These policies are included under section IV.A.4 of the rule.

¹² Data submission requirements are under §414.1325.

1. MVP Development and Maintenance¹³

CMS introduced the concept of MVPs during the 2020 PFS rulemaking cycle as “the future state of MIPS” and has continued their development through subsequent cycles. Each MVP contains quality and cost measures and improvement activities with a definable focus (e.g., a disease, a specialty, an episode of care) that are superimposed on a population health measure(s) (e.g., all-cause readmission for patients with chronic conditions). All MIPS Promoting Interoperability performance category requirements are incorporated into each MVP.

a. Development of New MVPs

CMS proposes six new MVPs. Details on these MVPs, including the specific measures included for each, are in Group A of Appendix 3: MVP Inventory, in the rule. The table below summarizes information included in the rule on the six proposed MVPs, showing for each a description of the clinician/condition focus.

MVPs Proposed for Addition

MVP (Name)	Focus/Applicability	Tables under Appendix A in the Proposed Rule
Diagnostic Radiology	Assesses meaningful outcomes in diagnostic radiology. Most applicable to clinicians who treat patients within the practice of diagnostic radiology.	Tables under A.1 show measures and IAs proposed for inclusion, including 6 MIPS quality measures and 3 QCDR measures, 11 IAs, and one cost measure.
Interventional Radiology	Focuses on the clinical theme of Assesses meaningful outcomes in interventional radiology. Most applicable to clinicians who treat patients within the practice of interventional radiology.	Tables under A.2 show for proposed inclusion: 6 MIPS quality measures, 4 QCDR measures, 19 IAs, and 3 cost measure.
Neuropsychology	Focuses on the clinical specialty of providing treatment and management of neuropsychological care. Most applicable to clinicians who treat patients within the practice of neuropsychology, including NPPs such as NPs and PAs.	Tables under A.3 show for proposed inclusion: 6 MIPS quality measures, 3 QCDR measures, 10 IAs, and 2 cost measures.
Pathology	Focuses on assessing meaningful outcomes in pathology. Most applicable to pathology clinicians.	Tables under A.4 show for proposed inclusion: 7 MIPS quality measures, 7 QCDRs, 13 IAs, and one cost measure.
Podiatry	Focuses assessing meaningful outcomes in foot and ankle care for patients with chronic conditions, wound/ulcers, and general care for the podiatry patient. Most applicable to podiatry clinicians, including NPPs such as NPs and PAs.	Tables under A.5 show for proposed inclusion: 7 MIPS quality measures, 10 QCDR measures, 10 IAs, and one cost measure.
Vascular Surgery	Focuses on clinical specialty of surgery. Most applicable to clinicians who treat patients within the surgical settings of vascular surgery, including NPPs such as NPs and PAs.	Tables under A.6 show for proposed inclusion: 13 MIPS quality measures, 4 QCDR measures, 16 IAs, and 3 cost measures.

¹³ These are included as section IV.A.4.a of the rule, beginning on page 927 of the display copy.

b. MVP Maintenance Updates to Previously Finalized MVPs

There are currently 21 MVPs for the 2025 performance period/2027 MIPS payment year. CMS is proposing modifications to all 21 MVPs by adding and removing measures and IAs based on the MVP development criteria. In addition, CMS has updated the format of the MVP tables to stratify quality measure by clinical conditions and/or episodes of care for each MVP.¹⁴

c. Third Party Intermediaries (TPIs) Support of MVPs

TPIs are required to submit data on behalf of MIPS eligible clinicians for certain MIPS performance categories. Under §414.1400(b)(1)(ii), QCDRs and qualified registries are required to support MVPs that are applicable to the MVP participants on whose behalf they submit data – but the regulatory provision does not address by when QCDRs and qualified registries must do so.

CMS proposes that, beginning with the 2026 performance period/2028 MIPS payment year, QCDRs and qualified registries would be required to support MVPs that are applicable to the MVP participants on whose behalf they submit MIPS data no later than one year after finalization of the MVP. CMS explains this would provide QCDRs and qualified registries with one year post the effective date of the final rule for preparation for MVP reporting.¹⁵

2. APM Performance Pathway (APP)¹⁶

a. Overview

The APP is established at §414.1367 as a MIPS reporting option. Accountable Care Organizations (ACOs) under the Medicare Shared Savings Program (MSSP) are required to report quality data through the APP. The Medicare CQMs collection type is a temporary collection type option in the APP measure set, which is available to only ACOs participating in the MSSP. Under the Medicare CQM option, ACOs report on only their Medicare FFS beneficiaries, in contrast to having to report on their all payer/all patient population under the eCQM/MIPS CQM option. In the 2025 PFS final rule, CMS established a second, optional quality measure set within the APP (the APP Plus quality measure set), which beginning for the 2026 performance period includes the current APP quality measures and two additional quality measures from the Adult Universal Foundation measure set and to which the remaining Adult Universal Foundation measures are to be incrementally added by the 2028 performance period/2030 MIPS payment year.

¹⁴ Details on measures and activities (including proposed modification on measures and activities) within each of the current MVPs for the 2025 performance period/2027 MIPS payment year can be found in Group B of Appendix 3 in the rule.

¹⁵ The reference in the preamble to one year after the effective date of the final rule does not specify what final rule, but could mean one year from the effective date of the final rule establishing the applicable MVP. It is unclear if the one-year period has any application to the current MVPs, or only new MVPs going forward.

¹⁶ These proposals are included under the section IV.A.4.b on page 932 of the display copy of the rule.

b. Updates to Quality Measure in the APP and APP Plus Quality Measure Sets

The quality measures used within the APP and APP Plus quality measure sets are MIPS measures so any updates CMS applies to MIPS measures are also incorporated into the APP and APP Plus measure sets. To conform with changes to the MIPS quality measure inventory (shown in Table Group DD and Table Group C of the rule), CMS proposes to incorporate the updated versions of the MIPS quality measures into the APP quality measure set, specifically the proposed revisions to the Preventive Care and Screening: Screening for Depression and Follow-up Plan measure (Quality ID: 134 and Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (Quality ID: 484). Similarly, CMS is proposing changes to the following APP Plus quality measures to reflect the proposed updated measures in the MIPS measure set: Breast Cancer Screening, Colorectal Cancer Screening, Preventive Care and Screening: Screening for Depression and Follow-up Plan, Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions, and Screening for SDOH.

The APP quality measure set for the quality performance category for the APP, reflecting the proposed changes, is shown in Table 54 of the rule. The APP Plus measures sets for the 2026 performance period/2028 MIPS payment year through 2028 performance period/2030 MIPS payment are shown in Tables 55 through 57 of the rule, respectively. Information from Tables 55 through 57 is consolidated and included below.

APP Plus Quality Measure Set Beginning for 2026 Performance Period/2028 MIPS Payment Year

Qual. #	Title	Collection Type[^]	Submitter Type	Meaningful Measure 2.0 Area	Measure Type	Included in APP Plus Beginning with Performance Year
321	CAHPS for MIPS	CAHPs for MIPS survey	Third party intermediary (TPI)	Person-centered care	Patient engagement/experience	2025
001	Diabetes: Hemoglobin A1c Poor Control	eCQM/MIPS CQM, Part B Claims (all APP reporters)/Medicare CQM (MSSP ACOs only)	MIPS eligible clinicians; Representative of a practice, APM entity, TPI	Chronic conditions	Intermediate Outcome	2025
134	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	eCQM/MIPS CQM, Part B Claims (all APP reporters)/Medicare CQM (MSSP ACOs only)	MIPS eligible clinicians; Representative of a practice, APM entity, TPI	Behavioral health	Process	2025
236	Controlling High Blood Pressure	eCQM/MIPS CQM, Part B Claims (all APP reporters)/Medicare	MIPS eligible clinician; Representative of a practice,	Chronic conditions	Intermediate Outcome	2025

Qual. #	Title	Collection Type^	Submitter Type	Meaningful Measure 2.0 Area	Measure Type	Included in APP Plus Beginning with Performance Year
		are CQM (MSSP ACOs only)	APM entity, TPI			
479	Hospital-Wide 30-Day All-Cause Readmission Rate	Administrative Claims	N/A	Affordability and Efficiency	Outcome	2025
112	Breast Cancer Screening	eCQM/MIPS CQM, Part B Claims (all APP reporters)/Medicare CQM (MSSP ACOs only)	MIPS eligible clinician Representative of a practice, APM entity, TPI	Wellness and Prevention	Process	2025
484	Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	Administrative Claims	N/A	Affordability and Efficiency	Outcome	2026
113	Colorectal Cancer Screening	eCQM/MIPS CQM, Part B Claims (all APP reporters)/Medicare CQM (MSSP ACOs only)	MIPS eligible clinician Representative of a practice, APM entity, TPI	Wellness and Prevention	Process	2026
305	Initiation and Engagement of Substance Use Disorder Treatment	eCQM (all APP reporters)/Medicare CQM (MSSP ACOs only)	MIPS eligible clinician Representative of a practice, APM entity, TPI	Behavioral Health	Process	2027
487	Screening for SDOH	eCQM (all APP reporters)/Medicare CQM (MSSP ACOs only)	MIPS eligible clinician Representative of a practice, APM entity, TPI	Equity	Process	2028*
493	Adult Immunization Status	eCQM (all APP reporters)/Medicare CQM (MSSP ACOs only)	MIPS eligible clinician Representative of a practice, APM entity, TPI	Wellness and Prevention	Process	2028*

* Indicates this measure will be incorporated into the APP Plus quality measure set in the CY 2028 performance

period/2030 MIPS payment year, or the performance period that is one year after the eCQM specification becomes available, whichever is later.

^MIPS CQM collection type is sunset beginning with the 2027 performance period/2029 MIPS payment year.

3. Toward Digital Quality Measurement RFI

CMS solicits comments on its anticipated approach to using Health Level Seven® (HL7) Fast Healthcare Interoperability Resources® (FHIR) in eCQM reporting in the Medicare Shared Savings Program (MSSP) and QPP. Similar RFIs were included in the 2026 IPSS/LTCH PPS proposed rule to solicit comments on FHIR-based eCQM activities in the Hospital Inpatient Quality Reporting (HIQR) program, the Hospital Outpatient Quality Reporting (HOQR) program, and the Medicare Promoting Interoperability Program.

CMS aims to transition fully to digital quality measures (dQMs) and describes how it is collaborating with federal agencies, including the Assistance Secretary for Technology Policy (AST) and the Office of the National Coordinator for Health Information Technology (ONC) (collectively ASTP/ONC) to support data standardization and alignment of requirements for developing and reporting on dQMs. For example, it is collaborating with ASTP on future versions of the United States Core Data for Interoperability (USCDI), a baseline set of data elements referenced in health information exchange certification criteria under the ONC Health IT Certification Program.

CMS requests feedback on the following five components of the dQM transition related to FHIR-based eCQMs for the MSSP and MIPS quality performance category, as discussed below:

FHIR-based eCQM conversion progress. CMS believes it is important that eCQMs (which currently use structured data defined by the Quality Data Model (QDM) are specified using the FHIR standard and that they be calculated consistently using standardized data represented in FHIR. The agency is considering a requirement that all quality measures proposed for addition to CMS programs be specified in FHIR and to include FHIR-based specifications for QCQR measures. **CMS seeks feedback** on (i) Specific eCQMs or components of existing eCQMs that may present particular challenges in specifying FHIR; (ii) Gaps in QI-Core IG that are likely to impact the agency's ability to specify current CMS eCQMs in FHIR; and (iii) Supplementary activities that would encourage additional engagement in FHIR testing.

Data standardization for quality measurement and reporting. CMS and ONC are assessing standards to use as the basis for new health IT certification criteria supporting FHIR-based quality measurement and reporting, including by reviewing the QI-Core IG, which is used to represent data elements necessary to support current eCQMs and builds on the HL7 FHIR US Core IG (US Core IG) which is currently referenced under the ONC Health IT certification program. The agency reviews several standards it is considering, including the USCDI+Quality, Data Exchange for Quality Measures (DEQM) IG, and HL& FHIR Bulk Data. **CMS seeks feedback** on (i) Experiences or challenges reviewing, implementing, or testing the QI-Core, DEQM, or Bulk FHIR standards; (ii) Any deficiencies in the DEQM IG that must be addressed before use for reporting on eCQMs using FHIR APIs; (iii) Additional baseline requirements that need to be considered before FHIR-based eCQMs could be reported using Bulk FHIR; and (iv) Additional supports that CMS should consider for QI Core, DEQM, or Bulk FHIR IGs.

Timeline under consideration for FHIR-based eCQM reporting. CMS is considering a transition period (referred to as a reporting options period), which would be at least two years, for MIPS and other programs that use the eCQM collection type during which providers that choose to satisfy the applicable quality reporting requirements through reporting eCQMs could choose to submit either QDM-based or FHIR-based eCQMs. **CMS requests feedback** on (i) Whether a minimum of 2 years provide sufficient time; (ii) Resources that CMS could provide to assist with the transition to submission of FHIR-based eCQM data; (iii) Challenges anticipated with the reporting timeline of FHIR-based eCQMs; and (iv) Support the agency could provide to encourage early adoption and reporting of FHIR-based eCQMs.

Measure development and reporting tools. CMS describes its goal to develop and implement a single point of data receipt for quality reporting programs through a unified CMS FHIR receiving system. The agency has decided not to advance a FHIR-based measure calculation tool (MCT). **CMS seeks feedback** on (i) Capabilities that would be most useful for CMS to support in a FHIR-based eCQM reporting model; and (ii) Any additional concerns that CMS should consider when developing FHIR-based reporting requirements for systems receiving quality data.

FHIR reporting and data aggregation for ACOs. CMS describes reporting incentives it has provided to encourage the adoption of eCQMs and MIPS CQMs. The agency is interested in how a transition to FHIR-based reporting could help mitigate burden on ACOs related to aggregating quality data from multiple practices and multiple EHR systems. CMS seeks feedback on several questions, some of which include (i) Types of technical support that would be beneficial to ACOs in implementing FHIR-based eCQMs; (ii) Changed need to health IT functionality to better support efforts to aggregate data to enable ACOs to report eCQMs using FHIR; (iii) estimated costs and timelessness for implementing capabilities necessary to perform data aggregation from multiple settings and health IT systems; and (iv) ACO experience using DEQM IG, Bulk FHIR, or QI Core IG.

In addition to the preceding five categories of questions, **CMS seeks feedback** on (i) Any additional factors that may help reduce reporting burden specific to FHIR-based quality reporting, including beyond eCQMs or potential dQMs; (ii) Whether the ability to reuse or repurpose technology, standards, data elements, or specifications reduce burden; and (iii) How the Trusted Exchange Framework and Common Agreement (TEFCA) could support exchange of FHIR-based quality measures or enable the use of data for secondary uses such as treatment and research.

E. MIPS Performance Categories, Measures, and Activities¹⁷

1. Quality Performance Category

a. Background

¹⁷ These proposals were included as section IV.A.4.f. of the rule on page 958 of the display copy.

Each MIPS eligible clinician’s final total performance score is required by statute to take into account the quality performance category, based on performance on the applicable quality measures included in such category.¹⁸ CMS discusses the following policies related to the quality performance category.

b. High Priority Measure Definition

The term “high priority measure” is defined at §414.1305 as an outcome (including intermediate-outcome and patient-reported outcome), appropriate use, patient safety, efficiency, patient experience, care coordination, or opioid-related quality measure as well as a quality measure pertaining to health equity. CMS states that including measures pertaining to health equity in the definition was a way to address health disparities exacerbated by the COVID-19 PHE and believes that since the PHE has ended, such disparities are best addressed through other mechanisms. Therefore, CMS proposes that, beginning with the 2026 performance period/2028 MIPS payment year, the reference to quality measurement pertaining to health equity would be removed from the definition for the term high priority measure.

c. Selection of Quality Measures

New measures. Before proposing a new MIPS quality measure in a proposed rule, CMS receives public input through a pre-rulemaking process (the pre-rulemaking measure review (PRMR)) established in accordance with section 1890A of the Act.¹⁹ This process begins with the agency’s publication of measures under consideration for use in Medicare (the MUC list). Measures on the MUC list are reviewed by one of several committees convened by a consensus-based entity (CBE), providing multistakeholder input to the Secretary. The final vote of the multistakeholder committee may result in the measure being (i) recommended, (ii) recommended with conditions, (iii) not recommended, or (iv) no consensus.

Quality measures that are considered for potential implementation in MIPS starting with the 2026 performance period were included on the 2024 MUC list.²⁰ The MIPS quality measures being proposed in the rule are described in Table Group A of Appendix 1 of the rule.

Measure Removals. CMS reviews its policies regarding the removal of quality measures. Its policies on criteria for the removal of MIPS quality measures from the MIPS quality measure inventory are under §414.1330(c). Such criteria include measures determined by the Secretary to no longer meaningful, measures that are topped out, measures for which the measure steward is no longer able to maintain the measure, measures that are duplicative, not maintained or updated to reflect current clinical guidelines, low-bar standard of care process measures, and measures that do not meet case minimum and reporting volumes required for benchmarking after being in the program for two consecutive performance periods.

¹⁸ See section 1848(q)(2)(A)(i) of the Act.

¹⁹ Section 1848(q)(2)(D)(v) of the Act provides that the 1890A process is not required for the selection of MIPS quality measures, but CMS finds the process provides a comprehensive review of the measures. Section 1848(q)(2)(D)(v) of the Act allows the Secretary to propose a measure that is not endorsed by a CBE as long as the measure is evidence-based.

²⁰ The MUC list is available at <https://mmshub.cms.gov/sites/default/files/2024-MUC-List.xlsx>.

Quality Measure Inventory. CMS proposes changes to the MIPS quality measure inventory, which are shown in Appendix 1 of the rule, including the addition of new measures, updates to specialty sets, removal of existing measures, and substantive changes to existing measures.

For the 2026 performance period, CMS proposes an inventory of 190 MIPS quality measures (187 of which would be available in traditional MIPS and MVPs, and three of which would be available only in MVPs).

- Table Group A of Appendix 1 shows the five new MIPS quality measures being proposed, including 3 high priority measures, of which one is also a patient-reported outcome measure.
- Table Group B of Appendix 1 shows proposed modifications to existing specialty sets.
- Table Group C of Appendix 1 includes a list of 10 MIPS quality measures proposed for removal and the applicable rationale for each removal (one is not aligned with current clinical guidelines, four are extremely topped out, one has reached the topped-out lifecycle, one is no longer able to be maintained by the measure steward, and three are process measures).
- Table Group D of Appendix 1 shows the 42 MIPS quality measures for which substantive changes are being proposed.

2. Cost Performance Category²¹

a. *Overview*

Beginning with the 2026 performance period/2028 MIPS payment year, for the cost performance category CMS proposes to:

- Modify measures in the MIPS cost measure inventory (shown in Appendix X of the rule).
- Update the operational list of care episode and patient condition groups and codes to reflect changes identified through annual maintenance of measures.
- Adopt a 2-year informational-only feedback period for new cost measures.

In selecting new cost measures, CMS refers to the goals to support the transition from traditional MIPS to MVPs as well as to move closer to the statutory goal of covering 50 percent of expenditures under parts A and B.²²

b. *Cost Measure Inventory*

For the 2025 performance period/2027 MIPS payment year, there are currently 35 cost measures in the cost performance category, including 33 episode-based measures and 2 population-based measures. CMS is not proposing to adopt any new cost measures for the 2026 performance period/2028 MIPS payment year and is not proposing to remove any for such period/year. Beginning for the 2026 performance period/2028 MIPS payment year, CMS proposes substantive changes to the Total Per Capital Cost (TPCC) measure (which is one of the two population-based measures). Changes are shown in Table Group A of Appendix X of the rule.

²¹ Policies for the cost performance category are codified under §414.1350.

²² See section 1848(r)(2)(i)(I) of the Act.

c. Proposed Revisions to the Operational List of Care Episode and Patient Condition Groups and Codes

Section 1848(r)(2) of the Act requires the development of care episode and patient coding groups (and classification codes for such groups).²³ The operational list of such care episodes, groups, and codes is required to be annually updated.

CMS is proposing to revise the operational list to reflect coding changes due to annual measure maintenance of implemented cost measures. Specifically, there are several non-substantive changes to service and diagnosis codes that were identified to be reflected in the operational list care episode and patient conditions groups to better align the operational list with measure specifications.

d. Proposed Adoption of Two-Year Informational-Only Feedback Period

Background. A MIPS eligible clinician's performance is assessed on any measure CMS has specified for the MIPS cost category for a performance period that is attributed to that clinician. To determine a MIPS eligible clinician's score for the cost measure, the clinician's attributed costs for a measure are compared to benchmark ranges based on the median cost of all MIPS eligible clinicians attributed the same cost measure. CMS explains that while clinicians have access to information about new cost measures on which they may be assessed before the start of the performance period, they do not receive a score or performance feedback on any new cost measure until partially through the second performance period in which the measure is in use. The agency has received feedback from multiple interested parties requesting CMS to make performance feedback available sooner, including to inform clinicians sooner on which cost measures they will be assessed, which episodes and patients will be attributed to them, and for what costs outside of their practice they are being held accountable. Many commenters to the 2025 PFS proposed rule suggested an informational-only feedback period to apply to new cost measures. CMS agrees that such a period would allow clinicians to improve their cost performance and better predict how they will perform on a new measure before the new measure affects payment.

Proposal. CMS proposes to implement and codify under §414.1380(b)(2)(vi) an informational-only feedback period of two years for new costs measures finalized for use in MIPS beginning with the 2026 performance period/2028 MIPS payment year (this policy would not apply to any cost measures already in the measure inventory). A new cost measure would be defined as a measure that CMS has newly specified for the MIPS cost performance category for a performance period beginning with the 2026 performance period for the 2028 payment year, and would exclude any cost measure that CMS has specified for the cost performance category for any payment year before the 2028 payment year.

CMS would score all new cost measures for informational-only purposes for the first 2 years after the measure is initially included and would not incorporate any informational-only score

²³ The current operational list and prior operational lists are available <https://www.cms.gov/medicare/quality/value-based-programs/cost-measures/about>.

into the cost performance category score or MIPS final score of a MIPS eligible clinician. During the informational-only feedback period, CMS would confidentially provide the score and MIPS performance feedback to the clinician on an annual basis. The new cost measures' scores would be incorporated into the MIPS eligible clinicians' cost performance category and final scores beginning with the measure's third year in MIPS (i.e., after the 2-year informational-only feedback period), at which time performance on those measures would affect MIPS payment adjustments.

Cost measures within an informational-only feedback period would be able to be included in an MVP if clinically relevant to that MVP. An MVP participant that selects and reports on that MVP would receive performance feedback on that measure on an annual basis during that informational-only feedback and informational-only scores on those cost measures would not be incorporated into the MVP participant's cost performance category score of MIPS final score.

CMS would not publicly report performance on a cost measure while the measure is within the informational-only feedback period.

3. Improvement Activities (IA) Performance Category

a. Background

IAs are activities identified as improving clinical practice or delivery that CMS determines are likely to result in improved outcomes. The Secretary is required by statute to specify subcategories of IAs, including the following 6 subcategories: (i) expanded practice access, (ii) population management, (iii) care coordination, (iv) beneficiary engagement, (v) patient safety and assessment, and (vi) participation in an alternative payment model.²⁴

b. IA Inventory

Annual Call for Activities. CMS describes the formal annual call for activities process used for adding possible new IAs and possible modifications to IAs in the inventory.²⁵ CMS establishes IAs through rulemaking.²⁶

Changes to the IA Inventory. Beginning with the 2026 performance period/2028 MIPS payment year, CMS proposes each of the following changes to the IA inventory.

Removal of AHE Subcategory. CMS proposes to remove the AHE subcategory, consistent with its strategic shift to emphasize new priorities, including wellness and prevention.

Addition of Advancing Health and Wellness (AHW) Subcategory. CMS proposes to add the AHW subcategory to replace the AHE subcategory. The subcategory is to address gaps in MIPS eligible clinicians' involvement in preventive care and health promotion, including mental health

²⁴ See section 1848(q)(2)(B)(iii) of the Act.

²⁵ A nomination form available at www.qpp.cms.gov must be submitted during the Annual Call to submit a request for a new activity or modification.

²⁶ A complete list of current IAs may be found at [Explore Measures & Activities \(cms.gov\)](https://www.cms.gov/medicare/quality/initiatives/qpp/ia).

and chronic disease management. CMS also proposes to reassign the Chronic Care and Preventative Care Management for Empaneled Patients improvement activity (IA_PM_13) to the AHW subcategory.

New IAs. CMS proposes to adopt three new IAs:²⁷

- Two for the Population Management subcategory: The Improvement Detection of Cognitive Impairment in Primary Care and Integrating Oral Health Care in Primary Care.
- One for the Patient Safety and Practice Assessment subcategory: Patient Safety in Use of Artificial Intelligence (AI).

Modifications. CMS proposes modifications to seven IAs. The modifications are shown in Table F-B2 of Appendix 2 of the proposed rule. Modifications include:

- Reassigning five IAs currently in the Achieving Health Equity (AHE) subcategory to other subcategories (specifically: IA_AHE_1, IA_AHE_3, IA_AHE_6, IA_AHE_7, and IA_AHE_10).
- Reassigning IA_PM_13 to the proposed AHW subcategory.
- Modifying IA_BMH_1 (Diabetes Screening) to expand the scope of the activity. Currently the activity is focused on screening only diabetic patients taking antipsychotic medications. The modifications would broaden the patient population by requiring physical health screening on all patients taking such medications, as well as then rename it to Antipsychotic-Medication-Associated Physical Health Condition Assessment and Monitoring.

Removals. CMS proposes to remove 8 IAs under removal factor 7 – removal based on a determination that the IA is obsolete.²⁸ The 8 IAs are IA_AHE_5, IA_AHE_8, IA_AHE_9, IA_AHE_11, IA_AHE_12, IA_PM_6, IA_PM_26, and IA_ERP_3.²⁹ CMS believes these IAs are obsolete since they do not reflect the agency’s current prioritization of best clinical practices and have been suspended for 2025. CMS states that removal of IA-ERP_3 would align with recent FDA and CDC guidance regarding updating vaccination recommendations.

4. Promoting Interoperability (PI) Performance Category

a. Background

This category measures the meaningful use of certified electronic health record technology (CEHRT). A MIPS eligible clinician must meet three meaningful use of CEHRT requirements during a performance period: (i) demonstrate use of CEHRT in a meaningful manner, (ii) demonstrate that their CEHRT is connected in a manner that provides for electronic exchange of health information to improve the quality of care and that they are not knowingly and willfully limiting the interoperability of CEHRT, and (iii) use CEHRT to submit information on clinical quality measures and other measures selected by the Secretary.³⁰

²⁷ Table F-B1 in Appendix 2 of the rule includes information on each of the proposed IAs.

²⁸ The IAs removal policy is under §414.1355(d).

²⁹ Table F-B3 in Appendix 2 of the rule contains information on the proposed removals.

³⁰ See sections 1848(q)(2)(B)(iv) and 1848(o)(2) of the Act; §§ 414.1375 and 414.1380(b)(4).

b. Definition of CEHRT

CMS reviews the definition of meaningful EHR user and CEHRT under §414.1305, the importance of those definitions for purposes of earning a score for the MIPS PI performance category, and recent updates to the ONC Health IT Certification Program’s certification criteria, including updates in the HT-1 final rule (89 FR 1192).

c. Proposal to Modify Security Risk Analysis Measure

Background. The HIPAA Security Rule³¹ includes requirements for administrative safeguards, including standard and implementation specifications, that covered entities and business associates must implement. As part of such requirements, covered entities and business associates must conduct an accurate and thorough assessment of potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information (ePHI) and to implement security measures sufficient to reduce risks and vulnerabilities to a reasonable and appropriate level.

A MIPS eligible clinician must, for the Security Risk Analysis measure, attest “yes” as to whether they have conducted or reviewed a security risk analysis in compliance with the HIPAA Security Rule to be considered a meaningful EHR user. If a “no” is submitted, the clinician earns a zero for the entire PI category score. The Security Risk Analysis measure does not require a MIPS eligible clinician to manage their security risk or attest to having implemented measures to manage that risk.

Proposal. CMS proposes beginning with the 2026 performance period/2028 MIPS payment year, to modify the Security Risk Analysis measure to add a second attestation requiring a MIPS eligible clinician to also attest “yes” to having implemented security measures sufficient to reduce risks and vulnerabilities to a reasonable and appropriate level such that they are compliant with 45 CFR 164.306(a) as required by the HIPAA Security Rule implementation specification for risk management. To meet the requirements of the modified measure, the clinician would need to separately attest “yes” to both components of the measure. The MIPS eligible clinician would be able to attest “yes” regarding completion of actions included in the measure as long as they are completed any time during the year in which the performance period occurs (which is consistent with the current time requirements of the measure). CMS is not proposing any changes to the scoring approach for measure – To meet the requirements of the PI performance category, MIPS eligible clinicians would need to attest “yes” to both components of the measure; if not, then the score for the entire PI performance category would be zero.

d. Proposal to Modify High Priority Practices Safety Assurance Factors for EHR Resilience (SAFER) Guide Measure

Background. The SAFER Guides were developed by ONC to help organizations conduct self-assessments to maximize the safety and use of EHRs. CMS adopted the SAFER Guides measure under the Protect Patient Health Information objective beginning with the 2022 performance period/2024 MIPS payment year. The measure requires attestation to whether an annual self-

³¹ 45 CFR part 160 and subparts A and C of part 164.

assessment using the High Priority Practices SAFER Guide was conducted. Failure to attest to the measure results in a score of zero for the PI performance category, though the score did not depend on the answer to the attestation or the level of implementation of any of the practices. Beginning with the 2024 performance period, the measure was modified so that clinicians are required to attest to “yes” to having completed the assessment. An updated set of SAFER Guides was published in January 2025.³²

Proposal. CMS proposes to modify the High Priority Practices SAFER Guide measure to specify that MIPS eligible clinicians, beginning with the 2026 performance period/2028 MIPS payment year, use the 2025 version of the SAFER Guides.

e. Public Health and Clinical Data Exchange Objective: Proposal to Adopt the Public Health Reporting Using TEFCA Measure as Optional Bonus Measure

Background. There are currently 5 measures under the PI Public Health and Clinical Data Exchange objective: 2 that are required (Immunization Registry Reporting and Electronic Case Reporting) and 3 that are optional bonus measures (Syndromic Surveillance Reporting, Public Health Registry Reporting, and Clinical Data Registry Reporting). Up to 5 bonus points are possible for reporting on one or more of the optional measures. CMS describes that a difficulty with electronic exchange of health information for public health purposes is that exchanges between public health agencies (PHAs) and MIPS eligible clinicians require different processes for each measure under the Public Health and Clinical Data Exchange objective. The Trusted Exchange Framework and Common Agreement (TEFCA) establishes a common governance and technical framework for nationwide health information exchange and CMS believes that participation in TEFCA could address this difficulty.

Proposal. CMS proposes to adopt the Public Health Reporting Using TEFCA measure as an optional bonus measure under the Public Health and Clinical Data Exchange objective, which would apply beginning with the 2026 performance period/2028 MIPS payment year. To attest “yes” to the measure, the MIPS eligible clinician (i) participates as a signatory to a TEFCA Framework Agreement,³³ (ii) is not suspended from participating in the agreement, (iii) submits health information using TEFCA to a PHSA consistent with one or more of the measures under the Public Health and Clinical Data Exchange objective, (iv) is in active engagement Option 2 (Validated Data Production) with a PHA to transfer health information for one or more of such measures, and (v) uses the functions of CEHRT to exchange with the PHA.

MIPS eligible clinicians are required to report their level of active engagement as either Option 1 (Pre-production and Validation) or Option 2 (Validated Data Production), and may only spend one performance period at Option 1 level of active engagement before advancing to Option 2 to fulfill measure requirements. The proposed bonus measure would only be available where the MIPS eligible clinician is in active engagement Option 2 with a PHA to transfer health

³² The 2025 updated SAFER Guides can be found at <https://www.healthit.gov/topic/safety/safer-guides>. Table 58 in the rule provides the titles of and chapters within the guides.

³³ Framework Agreement is defined by the Common Agreement for Nationwide Health Information Interoperability as published in the **Federal Register** (89 FR 93309) and at https://www.healthit.gov/sites/default/files/2024-11/Common_Agreement_2.1.pdf.

information for one or more of the measures under the Public Health and Clinical Data Exchange objective. The MIPS eligible clinician would be able to earn five bonus points under the objective if they attest they are in active engagement Option 2 with a PHA to submit electronic production data for at least one measure under the objective using TEFCA. As an optional measure under the objective, it would be one of four optional measures and a MIPS eligible clinician would continue to be able to receive a total of five bonus points regardless of how many of those measures the clinician attests “yes”.

CMS explains that when it codified its previously finalized scoring policy, its regulatory text at §414.1380(b)(4)(ii)(C) did not accurately reflect the intent of the allocation of bonus points for optional measures finalized policy in the 2022 PFS final rule (86 FR 65474 and 65475). The regulatory text inadvertently referred to five bonus points for performance of each optional measure, whereas the 2022 finalized policy intended the maximum total of five bonus points. CMS proposes to amend the regulatory text to reflect its previously finalized scoring policy to provide that, beginning with the 2026 performance period/2028 MIPS payment year, the total number of bonus points available, regardless of number of bonus measures reported, is five bonus points.

f. Proposed Measure Suppression Policy

CMS explains that there are circumstances in which it needs flexibility to determine whether to use a measure to calculate scores or otherwise determine whether MIPS eligible clinicians meet the meaningful EHR user definition in the PI performance category and whether eligible hospitals and critical access hospitals (CAHs) meet the definition for the Promoting Interoperability Program (PIP). Specifically, a measure suppression policy could provide this flexibility to account for the impact of changing conditions beyond the control of the MIPS eligible clinicians, eligible hospitals, and CAHs.

Therefore, CMS proposes, beginning with the 2026 performance period/MIPS payment year for MIPS eligible clinicians (for the MIPS PI performance category) and beginning with the EHR reporting period in 2026 for eligible hospitals and CAHs (for the PIP), to adopt a measure suppression policy that would allow CMS to exclude a measure from scoring and from the determination of meaningful EHR user due to circumstances that impede the effective measurement of the measure within the applicable objective. Similar policies have been finalized for the quality and cost performance categories.³⁴

Under the proposed policy, CMS would determine whether certain circumstances exist to warrant the measure suppression within either the PI performance category or PIP, based on consideration of one or more of the following: (i) The nature, breadth, and duration of the circumstances effect on the ability to fulfill the measure requirement, (ii) The availability of certified health IT modules to fulfill the measure, (iii) Whether the circumstances affect the measure such that calculating the score would lead to misleading or inaccurate results (which may include performance or compliance), (iv) Whether there are out-of-date or conflicting

³⁴ See §414.1380(b)(1)(vii)(A) for the quality performance category and §414.1380(b)(2)(v)(A) for the cost performance category.

technical standards, (v) The technical or operational capacity of required partners, or (vi) Other factors determined by CMS.

If CMS suppresses a measure under this policy, the measure would still need to be reported, but regardless of what is reported the measure would not affect the score for the applicable objective or determination of a meaningful EHR user (as long as the measure is reported). CMS would be able to identify measures for suppression outside of rulemaking to timely address the situation. The agency would notify MIPS eligible clinicians, eligible hospitals, and CAHs through existing communication channels.

g. Proposal to Suppress the Electronic Case Reporting Measure

Background. CMS describes the Public Health and Clinical Data Exchange objective of the PI performance category and the PIP as an important mechanism for encouraging health care data exchange for public health purposes. As discussed above, for the MIPS PI performance category there are currently two required and three optional measures in this objective (and the Public Health Reporting Using TEFCA measure is being proposed as another optional measure). For the PIP, there are eight measures under the objective (two of which are optional). In the 2026 IPPS/LTCH PPS proposed rule, CMS proposed the Using TEFCA measure as a ninth measure (which would be optional) to be added to the objective under the PIP.³⁵

The Electronic Case Reporting measure is a required measure under the objective under both the PI performance category and the PIP. The measure requires that the MIPS eligible clinician, eligible hospital, or CAH be in active engagement with a PHA to submit electronic case reporting of reportable conditions. The level of active engagement must be reported as either Option 1 (Pre-production and Validation) or Option 2 (Validated Data Production). In the 2023 PFS final rule, CMS finalized that beginning with the CY 2024 performance period/2026 MIPS payment system and the EHR reporting period in CY 2024, MIPS eligible clinicians, eligible hospitals, and CAHs may spend only one performance period at the Option 1 (Pre-production and Validation) level of active engagement for measures specified for the objective, and must progress to the Option 2 (Validated Data Production) level of active engagement in the next EHR reporting period. This means that beginning with the 2025 performance period and EHR reporting period in 2025, many MIPS eligible clinicians, eligible hospitals, and CAHs may need to submit case files (production data) using CEHRT to the PHA to report progress to Option 2 level of active engagement for the Electronic Case Reporting measure.

The CDC has temporarily paused electronic case reporting registration and onboarding of new health care organizations (HCOs) to establish an automated process. Because of this pause, some MIPS eligible clinicians, eligible hospitals, and CAHs may not meet the electronic case reporting registration and onboarding requirements by the end of the 2025 performance period/EHR reporting period in 2025.

Proposal. CMS proposes to suppress the Electronic Case Reporting measure; specifically, the agency would exclude the measure from scoring under the MIPS PI performance category for the 2025 performance period and the PIP for the EHR reporting period in 2025. MIPS eligible

³⁵ 90 FR 18360.

clinicians, eligible hospitals, and CAHs would need to report on the measure, but their score would not be affected regardless of the responses reported. If the proposal is finalized, the 25 points attributed to the objective under the PI performance category as well as under the PIP would apply to the other required measures in the objective that are not suppressed.

h. Requirements for PI Performance Category for 2026 Performance Period/2028 MIPS Payment Year

To show the requirements that would be required for the PI performance category for the 2026 performance period/2028 MIPS payment year, including reflecting its proposals, CMS provides several tables spanning multiple pages, including the following:

- Table 59: Proposed Objectives and Measures for the PI Performance Category for the 2026 Performance Period. For each measure, this table shows the objective, numerator and denominator (if measure is not Y/N), and any exclusions.
- Table 60: Proposed Scoring Methodology for the 2026 Performance Period. For each measure, this table shows the objective, maximum points, and whether the measure is optional or required.
- Table 61: Proposed Exclusion Redistribution for the 2026 Performance Period. For each measure, this table shows the objective and the redistribution policy if an exclusion is claimed. If a MIPS eligible clinician believes an exclusion for a measure (shown in Table 59) applies to them, they may claim it when they submit their data. The maximum points available in Table 60 do not include the points that will be redistributed based on an exclusion claimed. Table 61 shows how points will be redistributed.
- Table 62: Promoting Interoperability Performance Category Objectives and Measures and ONC Health IT Certification Criteria. For each measure, this table shows the objective and the associated ONC health IT certification criteria under 45 CFR 170.315, which is currently applicable.

Information from Table 60 is shown below.

Table 60: Proposed Scoring Methodology for the 2026 Performance Period/2028 MIPS Payment Year

Objective	Measure	Maximum Points	Required/Optional
Electronic Prescribing	e-Prescribing	10 points	Required
	Query of PDMP	10 points	Required
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	15 points	Required (MIPS eligible clinician's choice of one of the three reporting options)
	Support Electronic Referral Loops by Receiving and Reconciling Health Information	15 points	
	-OR-		
	Health Information Exchange Bi-Directional Exchange	30 points	
	-OR-		
	Enabling Exchange under TEFCA	30 points	
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	25 points	Required

Objective	Measure	Maximum Points	Required/Optional
Public Health and Clinical Data Exchange	Report the following two measures: <ul style="list-style-type: none"> Immunization Registry Reporting Electronic Case Reporting**** 	25 points	Required
	Report one of the following measures: <ul style="list-style-type: none"> Public Health Registry Reporting Clinical Data Registry Reporting Syndromic Surveillance Reporting Public Health Reporting Using TEFC*A* 	5 points (<i>bonus</i>)	Optional
Protect Patient Health Information	Security Risk Analysis*	Not Scored**	Required
	High Priority Practices SAFER Guide*	Not Scored**	Required
No Associated Objective: Attestation Requirements ***	ONC Direct Review Attestation	Not Scored	Required
	Actions to Limit or Restrict the Compatibility of CEHRT	Not Scored	Required
	ONC-ACB Surveillance Attestation	Not Scored	Optional

* The proposed optional bonus measure, Public Health Reporting Using TEFC*A, and the proposed modifications to the High Priority Practices SAFER Guide measure would be effective beginning with the 2026 performance period.

**MIPS eligible clinicians must submit an affirmative attestation regarding the Security Risk Analysis measure and High Priority Practices SAFER Guide measure. Failure to submit a “yes” attestation to fulfill requirements will result in a zero score for the PI performance category.

***Attestation requirements: Must submit an attestation regarding the ONC Direct Review and that did not knowingly and willfully take action to limit or restrict the compatibility or interoperability of CEHRT, as required by § 414.1375(b)(3). Failure to submit an attestation or an affirmative (“Yes”) attestation to fulfill such requirements will result in a zero score for the Promoting Interoperability performance category.

****The proposal pertaining to the suppression of this measure excludes the measure from scoring for the CY 2025 performance period/2028 MIPS payment year. The proposed suppression of this measure does not include the CY 2026 performance period/2028 MIPS payment year.

i. RFI Regarding Query of Prescription Drug Monitoring Program (PDMP) Measure

Background. PDMPs are electronic databases that monitor use of controlled substances. The agency discusses how integration of PDMP data into health IT systems (such as EHRs, pharmacy dispensing software (PDS) systems, and health information exchanges (HIEs)) helps to reduce barriers to and burden of PDMP review. CMS reviews the agency’s continued work, including with Federal partners and stakeholders, to further common standards for information exchange between PDMPs, EHRs, PDS systems, HIEs, and exchange networks. The Health Data, Technology, and Interoperability: Patient Engagement, Information Sharing, and Public Health Interoperability (HTI-2) proposed rule³⁶ included a proposal for a PDMP certification criterion that would enable the query of prescription drug monitoring systems and the receipt, validation, parsing, and filtering of medication information from PDMPs, but ONC has not finalized the proposal. Also, CMS describes the Query of PDMP measure, which is included under the e-prescribing objective of the PI performance category.

³⁶ 89 FR 63498.

CMS seeks feedback through the two RFIs below to potentially inform future rulemaking for the Query of PDMP measure.

RFI: Changing the Query of PDMP measure from an attestation-based to a performance-based measure. The measure was initially finalized in the 2019 PFS final rule³⁷ as a performance-based measure as follows:

- Numerator: Number of Schedule II opioid prescription in the denominator for which data from CEHRT is used to conduct a PDMP query for prescription drug history, except where prohibited. Numerator of at least one required to fulfill the measure
- Denominator: Number of Schedule II opioids electronically prescribed using CEHRT by the MIPS eligible clinician during the performance period.

Based on concerns that it was premature to require a score based on performance, CMS finalized in the 2023 PFS final rule that the measure would instead require a “yes” or “no” attestation beginning with the 2023 performance period.³⁸

CMS describes that since the 2023 PFS final rule, PDMPs have become widely available and PDMP integration with HIEs, EHRs, and PDSs has increased. **The agency seeks comment** on potentially changing the Query of PDMP to be a performance-based measure and specifically asks for feedback on the following: (i) How the numerator and denominator should be defined, (ii) Potential barriers for meeting the measure if it’s performance-based, (iii) How CMS should account for varying levels of readiness and capacity, particularly for rural providers, (iv) Specific exclusions that should be considered, (v) Timeframe for implementing a performance-based measure, (vi) Whether adoption and use of Health IT Modules meeting the certification criterion proposed in the HTI-2 rule help to mitigate burden associated with implementing a performance-based Query of PDMP measure, and (vii) How the adoption of use of Health IT Modules certified to the certification criterion proposed in HTI-2 impact the potential measure.

CMS also asks several questions related to a broader set of performance-based measure concepts that the agency could consider, specifically related to overdose prevention.

RFI: Modification of Query of PDMP Measure to Include All Schedule II Drugs. PDMPs are operated at the state level and requirements for reporting and use differ by state. Almost every state collects data on Schedules II, III, and IV drugs that are prescribed. The Query of PDMP measure includes Schedule II opioids as well as Schedule III and IV drugs. CMS is considering proposing in future rulemaking to expand the measure to also include all Schedule II drugs.³⁹ **CMS invites feedback** on such an expansion, including on the following: (i) Any challenges that exist around such expansion; (ii) Potential benefits and risks; (iii) Whether the expansion create barriers for patients appropriate prescribed Schedule II non-opioid drugs; (iv) How CMS should account for varying levels of readiness and capacity to meet expanded scope of measure; and (v) Any exclusions that should be considered.

³⁷ 83 FR 59800-598045.

³⁸ 87 FR 70062-70067.

³⁹ Table 65 in the rule provides examples of schedule II opioid drugs and other schedule II drugs.

j. RFI: Performance-Based Measures

The measures under the Public Health and Clinical Data Exchange objective have historically been attestation measures. CMS is exploring whether performance-based measures could encourage improvements in the quality and consistency of reporting to public health agencies (PHAs) and seeks feedback on new measure concepts for public health reporting. CMS asks many specific questions. Some of the areas in which **the agency seeks feedback** include: (i) Aspects of data quality and usability that are most appropriate and valuable to measure in the context of the Public Health and Clinical Data Exchange objective; (ii) How data completeness could be defined (examples are provided); and (iii) Any other available metrics that should be considered that more directly relate to actions and outcomes that public health reporting is intended to enable (such as overdose prevention).

CMS is also considering revising the scoring approach to measures under the objective. Currently, 25 points can be earned for reporting on two required measures, with an additional 5 bonus points available for reporting any of the optional bonus measures. **CMS seeks comment** on:

- A potential revised scoring approach of 10 points for each required measure and 5 points for each bonus measure (with a maximum of 10 bonus points) for a total of 30 points for the objective.
- Any other scoring approaches that should be considered.
- Should all public health measures for which a numerator and denominator are finalized be scored based on performance – or should only a subset of measure be scored based on performance.

CMS describes how the agency, ASP/ONC, and CDC plan to continue to explore ways to leverage FHIR-based capabilities within certified health IT to support public health reporting. **CMS seeks comment** on how future updates could impact potential measure strategies discussed. Specifically: (i) What are the most promising uses of FHIR approaches to public health reporting requirements under the PI performance category; (ii) How FHIR approaches to public health data exchange might impact measurement of MIPS eligible clinician performance; and (iii) Whether CMS should consider streamlining the number of measures in the PI performance category if approaches to public health reporting using FHIR are implemented in certified health IT.

k. RFI: Data Quality

CMS emphasizes the importance of high-quality data and believes that poor data quality poses direct threats to patient safety and that deficits in data quality can negatively affect clinical innovation and health-related decision-making. For purposes of the RFI, data quality is defined as the degree to which health information is accurate, complete, timely, consistent, and reliable. **CMS seeks comment** on the following: (i) Data quality challenges experienced, efforts to address those challenges, and what challenges persist across patient populations; (ii) The primary barriers to collecting high-quality data and resources that could help; (iii) Solutions that have been found to be the most effective to address data quality; and (iv) Steps CMS should consider to further improvement in the quality and usability of health information exchanged.

F. MIPS Final Score Methodology⁴⁰

1. Performance Category Scores: Background

To calculate the MIPS final score for a MIPS eligible clinician, CMS applies different weights for the four performance categories, as required under section 1848(q)(5) of the Act. Unless an exception is applied, the scoring weights for the 2025 performance period/2027 MIPS payment year are: (i) 30 percent for the quality performance category; (ii) 30 percent for the cost performance category; (iii) 15 percent for the IA performance category; and (iv) 25 percent for the PI performance category.

CMS proposes the following for the 2026 performance period/2028 MIPS payment year:

- To apply to MVPs the approach currently applied to specialty measure sets for identifying measures impacted by limited measure choice and subject to topped out measure benchmarks.
- A list of identified impacted by limited measure choice to be subject to topped out measure benchmarks.
- To modify the benchmarking methodology for scoring administrative claims-based measures in the quality performance category.

No changes are proposed to scoring policies for the cost, IAs, or PI categories.

2. Scoring the Quality Performance Category

Scoring for Topped Out Measures in Specialty Measure Sets with Limited Measure Choice.

Topped out measures are measures on which performance is considered so high and unvarying that meaningful distinctions and improvements are no longer possible.⁴¹ Under the topped-out measure lifecycle, scoring is capped for topped out measures at 7 points in the second consecutive year that it is identified as topped out, resulting in some clinicians having limited measure choice and limited scoring chances. If a measure is identified as topped out for three consecutive years after being identified through the benchmarks, the measure may then be proposed for removal through notice and comment rulemaking. Clinicians in some specialties have limited measure choice with an overrepresentation of topped out measures.

In the 2025 PFS final rule, CMS finalized that beginning for the 2025 performance period/2027 MIPS payment year, measures impacted by limited measure choice will not be subject to the 7 measure achievement point cap.⁴² As finalized, CMS identifies and publishes in the Federal Register on an annual basis the measures for which a defined topped out measure benchmark will apply. Measures on the list are scored from 1 to 10 achievement points according to defined topped out measure benchmarks calculated from performance data in the baseline period in which a performance rate of 97 percent corresponds to 10 percent of the performance threshold for the corresponding performance year. To identify the list of measures impacted by limited measure choice and subject to topped out measure benchmarks, CMS reviews each specialty

⁴⁰ These policies were included as section IV.B.1 in the rule.

⁴¹ Topped out measures are defined in §414.1305 differently for process versus non-process measures.

⁴² 89 FR 98429 through 98435.

measure set by collection type and identifies if the prevalence of topped out measures within the set hinders the ability of clinicians in the specialty to successfully participate.

Proposed Measures to be Subject to Defined Topped Out Measure. CMS proposes that, beginning with the 2026 performance period/2028 MIPS payment year, to identify measures impacted by limited measure choice, the agency would apply its previously finalized analysis and criteria to MVPs in addition to specialty measure sets. CMS proposes to continue to use an analysis threshold of 75 percent of available quality achievement points for the 2026 performance period/2028 MIPS payment year.

CMS believes that, like specialty measure sets, MVPs contain a limited set of quality measures and could face similar challenges where there is high presence of topped out measures. Therefore, it is proposing to apply to MVPs the same analysis applicable to topped out measures within specialty measure sets. Specifically, CMS would conduct an analysis of each MVP to identify the prevalence of topped out measure within such MVP hinders clinicians' ability to successfully participate in the quality performance category.

- Each MVP would be reviewed by collection type and CMS would identify if the prevalence of topped out measures within the MVP hinders the ability of clinicians to successfully participate (that is, looking at clinicians' ability to reasonably achieve 75 percent of the available quality achievement points based on measures available to them in the MVP).
- At the collection type level, each quality measure in the MVP would be assigned points: new measures receive 7 or 5 points based on the year in the program, measures with benchmarks are given points based upon the highest decile achievable with a less than perfect score (less than 100 percent or greater than 0 percent for inverse measures), and measures with no available historic benchmark are given 0 points.
- All points would be summed to get an output of scoring potential; the Medicare Part B claims collection type measure sets have an additional 6 points added to the output to account for the small practice bonus.
- The sum of quality achievement points for each MVP would be compared to the analysis threshold, which is currently 75 percent of available quality achievement points, based upon the number of available measures. Any MVPs that are not able to meet or exceed the threshold would be flagged as 'at-risk.'

Table 66 in the rule shows the list of measures that meet the criteria for topped out measures impacted by limited measure choice in specialty measure sets and MVPs and for which CMS is proposing to apply the defined topped out measure benchmark for the 2026 performance period/2028 MIPS payment year.

Benchmark Methodology on Scoring Administrative Claims Measures. There is no data submission requirement for cost measures or administrative claims measures in the quality performance category since those measures are calculated on behalf of participants by CMS using administrative claims data. CMS scores administrative claims measures using performance period benchmarks. CMS uses a decile-based approach to create benchmarks by dividing measure performance rates into deciles and having each decile contain a range of performance rates. Measure achievement points are assigned based on the benchmark decile range the

measure performance rate falls between. The four administrative claims-based quality measures are all inverse measures – the lower the measure performance rate, the higher the measure achievement points, meaning lower benchmark deciles are associated with higher performance rates.

CMS has observed, based on quality measure scores for the 2022 performance period, lower scores for administrative claims-based quality measures than the other quality measures, and discusses several factors that could account for this finding, including that administrative claims-based measures are scored against a performance period benchmark, rather than a benchmark determined based on historical data (which provides performance targets in advance of the performance period) and that the benchmark methodology uses a decile range.

The agency reviews how in the 2025 PFS final rule, CMS modified the cost performance category scoring methodology.⁴³ Under that methodology, CMS assigns an achievement point value equal to 10 percent of the performance threshold to a MIPS eligible clinician whose average costs attributed under a cost measure is equal to the median cost for all MIPS eligible clinicians that had the measure attributed to them. For each cost measure, the benchmark ranges are calculated based on standard deviations, expressed in dollars, from the median. Table 68 provides an example of the cost scoring methodology for a cost measure when the performance threshold is 75 points.

CMS is now proposing a similar scoring methodology for administrative claims-based quality measures beginning with the 2025 performance period/2027 MIPS payment year. The methodology would be based on standard deviation, median, and an achievement point value that is derived from the performance threshold. An achievement point value equal to 10 percent of the performance threshold would be assigned to a MIPS eligible clinician with a performance rate or an administrative claims-based measure that is equal to the median performance rate for all who are scored on that measure. Cut-offs for benchmark ranges for each such measure would be calculated based on standard deviations from the median.

To determine the benchmark ranges, CMS would use the following principles:

- Center the majority of performance rates around the performance threshold-derived point value.
- Determine benchmark ranges according to the statistical distribution curve of the performance rate.
- Distribution of achievement points for administrative claims-based quality measures would be reflective of overall program performance.

Table 69 in the rule provides an example applying the modified methodology.

CMS would continue to apply its current formula to assign partial achievement points. That formula is:

⁴³ 89 FR 98439-98446; 89 FR 98563. §414.1380(b)(2).

Benchmark Range # + [(performance rate – bottom of benchmark range) / (top of benchmark range – bottom of benchmark range)] = Administrative claims-based quality measures achievement points.

The proposed modification is to align the assignment of achievement points for the administrative claims-based quality measures such that clinicians with performance rates near the measure’s median would not receive a disproportionately low score. Using data from the 2024 performance period, CMS’s analyses show that the proposed methodology would (i) increase the mean quality performance category score from 76.75 out of 100 to 80.42 out of 100, (ii) increase the means for each such measure score from 1.46 to 1.96 points, and (iii) increase the mean final score by 1.63 points for MIPS eligible clinicians assessed on at least one administrative claims-based quality measure and receiving a quality performance category score.

G. MIPS Payment Adjustments⁴⁴

1. Background

The MIPS payment adjustment factor is a percentage determined by comparing the MIPS eligible clinician’s final score for the year to the performance threshold established for that year. The threshold is computed as the mean or median (as selected by the Secretary) of the final scores for all MIPS eligible clinicians with respect to a prior period specified by the Secretary. The threshold methodology, mean or median, may be reassessed by the Secretary every 3 years. The mean is the methodology that has been selected for determining the performance threshold for the 2025 performance period/2027 MIPS payment year through the 2027 performance period/2029 MIPS payment year. Adjustment factors specified for a year must result in differential payments such that clinicians with final scores above the threshold receive a positive adjustments factor, at the threshold receive a neutral adjustment factor, and below the threshold receive a negative adjustment factor.

2. Performance Threshold

To provide stability for MIPS eligible clinicians, CMS proposes to continue using the mean of the final scores for all MIPS eligible clinicians from the 2017 performance period/2019 MIPS payment year to compute the performance threshold as 75 points for the 2026 performance period/2028 MIPS payment year through the 2028 performance period/2030 MIPS payment year. CMS recognizes that it is establishing the performance threshold for years beyond the period (i.e., through 2030) for which it has established the mean methodology as the methodology to determine the performance threshold (i.e., through 2029) but the agency states that the statute requires that it reassess the methodology every three years (which it plans to do) but does not prevent it from setting the methodology for a longer period.

The table below is based on Table 70 in the rule and shows the performance thresholds established for performance periods 2017 through 2025/ MIPS payment years 2019 through 2027.

⁴⁴ These policies are included in section IV.B.2 of the rule appearing on page 1078 of the display copy.

Performance Thresholds for the 2017 through 2025 Performance Periods (PP)								
2017 PP	2018 PP	2019 PP	2020 PP	2021 PP	2022 PP	2023 PP	2024 PP	2025 PP
3 points	15 points	30 points	45 points	60 points	75 points	75 points	75 points	75 points

3. RFI: Future MIPS Performance Thresholds

CMS seeks feedback on establishing the performance threshold for single versus multiple years and on increasing the performance threshold based on data from a prior period which would provide larger positive MIPS payment adjustments for MIPS eligible clinicians with MIPS final scores higher than the threshold.

4. Example of Adjustment Factors

The adjustment factor is determined on a linear sliding scale from 0 to 100, with 0 being the lowest possible score and resulting in the lowest payment adjustment, and 100 being the highest possible score and resulting in the highest payment adjustment.⁴⁵ CMS notes the following 2 deviations from that sliding scale, required per statute: (1) payments are also adjusted such that all clinicians whose final scores fall between zero and one-fourth of the threshold (which would be between 0 and 18.75 points based on a threshold of 75, as proposed) receive the lowest possible MIPS payment adjustment of -9 percent; and (2) a scaling factor greater than 0 but no higher than 3 is applied as needed to render MIPS payments budget neutral (i.e., positive payment adjustment amounts in aggregate must equal negative adjustment amounts). Figure 5 from the rule illustrates payment adjustment factors for MIPS payment year 2028 (performance period 2026), that would reflect the statutory requirements described above along with the proposed MIPS threshold score of 75 points.

Shown below is information from Table 72 in the rule, which links the final score points to the payment adjustments, taking into account the proposed policies.

Relationship of MIPS Final Performance Score to Proposed MIPS Payment Adjustment for 2026 Performance Period/ 2028 MIPS Payment Year (from Table 72 of the rule)	
Final Score Points	MIPS Adjustment
0.0 – 18.75	Negative 9%
18.76 – 74.99	Negative MIPS payment adjustment > negative 9% and < 0% on a linear sliding scale
75.0	0% adjustment
75.01 – 100	Positive MIPS payment adjustment > 0% on a linear sliding scale; the sliding scale ranges from 0 to 9% for scores from 75.00 to 100.00. This sliding scale is multiplied by a scaling factor greater than 0 but not exceeding 3.0 to preserve budget neutrality.

⁴⁵ See section 1848(q)(6) of the Act.

H. Review and Correction of MIPS Final Score⁴⁶

CMS is statutorily required to provide MIPS eligible clinicians with timely confidential feedback on their performance on the quality and cost performance categories and may provide such feedback on the IA and PI categories.⁴⁷ CMS provides such reports for the quality and costs categories annually, and for the IA and PI categories if technically feasible. Feedback for the 2023 payment period/2025 MIPS payment year was made available on August 12, 2024, and the agency states it aims to provide feedback for the 2024 performance period/2026 MIPS payment year around July 1, 2025.

I. Third Party Intermediaries General Requirements⁴⁸

1. Requirements for CMS-approved Survey Vendors

Codification of certain policies. Section 414.1305 defines a CMS-approved survey vendor to mean a survey vendor approved by CMS for a particular performance period to administer the CAHPS for MIPS survey and to transmit survey measure data to the agency. These vendors must submit a survey vendor application to CMS for each MIPS performance period for which they seek to transmit that data.

In the 2025 PFS final rule, CMS finalized a policy to require an entity seeking to become a CMS-approved survey vendor to include on its application the range of costs of their third-party intermediary services. CMS is now proposing to codify that policy at §414.1400(d)(9), with a technical modification specifying the requirement begins on January 1, 2026 (rather than with the 2026 performance period/2028 MIPS payment year).

In the 2024 PFS final rule, CMS finalized a policy to require organizations to contract with a CMS-approved survey vendor that would administer the CAHPS for MIPS survey in Spanish to Spanish-preferring patients using procedures detailed in the CAHPS for MIPS Quality Assurance Guidelines. CMS now proposes to codify that policy at §414.1400(d)(3)(iv)(A), with technical modifications to refer more broadly to procedures detailed in sub-regulatory guidance (rather than specifically to procedures detailed in the CAHPS for MIPS Quality Assurance Guidelines).

Proposal to Require Web-Mail-Phone Protocol to Administer CAHPS for MIPS Survey. CMS proposes to require that, beginning with the 2027 performance period/2029 MIPS payment year, CMS-approved survey vendors would have to administer the CAHPS for MIPS survey via a web-mail-phone protocol (instead of the current mail-phone protocol). Beginning January 1, 2027, an entity applying to become a CMS-approved survey vendor would be required to be capable of administering a web-mail-phone protocol before CMS approval.

Proposal to Sunset Application Requirement. To become a CMS-approved survey vendor, §414.1400(d)(8) requires the entity to submit an interim survey data file to CMS that shows its

⁴⁶ Note that this policy is included under section IV.B.3 of the rule, on page 1090 of the display copy.

⁴⁷ Section 1848(q)(12)(A)(i) of the Act.

⁴⁸ Note that this policy is included under section IV.B.4 of the rule, on page 1092 of the display copy.

ability to accurately report CAHPS data. CMS notes this is not feasible to implement because an entity cannot collect data before it is approved by CMS and the requirement therefore has not been used for approval. CMS proposes to sunset the requirement at §414.1400(d)(8) beginning with January 1, 2026.

J. Advanced APMS⁴⁹

1. Qualifying APM Participant (QP) Determinations

Background. For making QP determinations, an eligible clinician must be on the Participation List of an APM entity in an Advanced APM on one of the snapshot dates (March 31, June 30, or August 31) for the QP performance period.⁵⁰ If an eligible clinician is included on such a list on any such snapshot date, the clinician is included in the APM entity group. CMS makes a QP determination at the individual level in two cases: (i) If an eligible clinician appears on a Participation List for more than one APM entity but does not achieve QP status based on any APM entity-level determination; or (ii) If an eligible clinician appears on an Affiliated Practitioner list for an Advanced APM. QP determinations are not made at the individual level for eligible clinicians in a single APM entity.

Thresholds scores for QP determinations are calculated by the payment amount method and patient count method. The payment amount method is based on payments for Medicare Part B covered professional services while the patient count method is based on numbers of patients. Both methods use the ratio of “Attributed beneficiaries” to “Attribution-eligible beneficiaries.” If the Threshold Score (using either method) meets or exceeds the relevant QP threshold described in §414.1430(a), the individual eligible clinician (or all those on the APM entity’s Participation List) achieves QP status for the year.

Attributed beneficiaries are those attributed to the APM Entity under the terms of the Advanced APM as indicated on the most recent available list of attributed beneficiaries at the time of a QP determination.

Individual QP determination. CMS has observed that its policy of making most QP determinations at the APM entity level has created conflicting incentives for an APM entity – a goal for its eligible clinicians to achieve QP status under the QPP versus the goal of the Advanced APM in which the APM entity participates. Recently CMS has also observed that clinicians in condition-specific or episode-of-care focused models are particularly disadvantaged when their APM entity fails to achieve QP status.

Therefore, CMS proposes, beginning with the 2026 QP performance period, to add a QP determination at the individual level for all Advanced APM participants. This would not affect the current policies for APM entity level determinations under §414.1425(b)(1) or determinations for Affiliated Practitioners under §414.1425(b)(2). In addition to the current determinations, CMS would add a calculation of Threshold Scores for QP determinations at the individual level for each unique NPI associated with an eligible clinician participating in an Advanced APM based on services furnished across all TINs to which the eligible clinician has reassigned their billing rights. Calculations at the APM entity level and the individual level would be made at each of the snapshot dates throughout the QP performance period. An eligible

⁴⁹ Note that these policies are included under section IV.B.5 of the rule, on page 1098 of the display copy.

⁵⁰ The QP determination policy is under §414.1425.

clinician would be a QP for a year under the Medicare option if they met or exceeded the corresponding QP payment amount threshold or QP patient count threshold for the QP performance period at the APM entity level or as an individual eligible clinician. Conforming changes would be made to add the same policy with respect to partial QP determinations as well beginning with the 2026 performance period.

Attribution-eligible definition. Attribution-eligible beneficiaries generally are those who, during the QP Performance Period, could be eligible for the Advanced APM by meeting the following six criteria (§414.1305):

- Is not enrolled in an MA or a Medicare cost plan;
- Does not have Medicare as a secondary payer;
- Is enrolled in both Medicare Parts A and B;
- Is at least 18 years of age;
- Is a United States resident; and
- Has a minimum of one claim for evaluation and management (E/M) (office visit) services furnished by an eligible clinician who is in the APM Entity for any period during the QP Performance Period.

The sixth criterion also has an alternative—for an Advanced APM that does *not* base attribution on E/M services (and for which attributed beneficiaries are not a subset of the attribution-eligible beneficiary population based on the requirement to have at least one claim for E/M services furnished by an eligible clinician who is in the APM Entity), the attribution basis determined by CMS uses the Advanced APM's attribution methodology, which may include a combination of E/M and/or other services. This alternative applies to four Advanced APMs:

- Bundled Payments for Care Improvement Advanced Model,
- Comprehensive Care for Joint Replacement Payment Model (CEHRT Track),
- Comprehensive ESRD Care Model (LDO⁵¹ arrangement and Non-LDO Two-Sided Risk Arrangement), and
- Maryland Total Cost of Care Model (Care Redesign Program).

Regarding the sixth criterion, CMS discusses that by having a more narrowly defined default approach to beneficiary attribution (relying on E/M services), the agency frequently needed to exercise the flexibility to determine an appropriate attribution methodology for an Advanced APM that falls into the exception, which meant identifying several individually tailored ways of performing the attribution methodology for each specific Advanced APM. In the 2025 PFS proposed rule, CMS proposed to change the sixth criterion by expanding the scope of services used to all covered professional services. The proposal was not finalized and CMS indicated it anticipated to propose in future rulemaking a comprehensive approach to QP determination.

CMS continues to believe that application of its current regulations may result in increased complexity over time, particularly as Advanced APMs continue to evolve and use novel approaches to value-based care that emphasize a broader range of covered professional services. In addition, primary care practitioners generally furnish a higher proportion of E/M services than

⁵¹ Large Dialysis Organization.

specialists, so that the emphasis on E/M services in the beneficiary attribution policy may have inadvertently encouraged APM Entities to exclude specialists from their Participation Lists.

CMS notes that the QP thresholds have increased under statute relative to previous years.⁵² Effective with the 2025 QP performance period, according to statute, the thresholds are at 75 percent for the payment amount and 50 percent for the patient count. This will reduce the number of QPs relative to the previous lower thresholds.⁵³

The agency is now re-proposing to modify the sixth criterion to include any beneficiary who has received a covered professional service furnished by the eligible clinician, beginning with the 2026 QP performance period. The proposal would standardize the attribution methodology for QP determinations by making covered professional services the basis for attribution across all Advanced APMs. This, along with the additional individual-level of QP determination discussed above, would allow for an overall expansion of QP determination.

2. Medical Home Model 50 Eligible Clinician Limit

Under the Medical Home Model nominal financial risk criterion, CMS set a limit of 50 eligible clinicians in an Advanced APM participating in such a model. If the limit is exceeded, then certain requirements under §414.1415(c)(1) and (c)(3) apply (instead of the Medical Home Model standards). The same limitations are applied under the Aligned Other Payer Medical Home Model as well as the Medicaid Medical Home Model. CMS expects that these policies could prove to be a barrier to participation in models that meet the Medical Home Model definition.

CMS proposes, beginning with the 2026 QP performance period, to sunset the Medical Home Model 50 eligible clinician limit as well as sunset the same limit under the Aligned Other Payer Medical Home Model and Medicaid Medical Home Model.

3. Targeted Review of QP Determinations

CMS modified the targeted review period for both MIPS and QPs so that it could apply the differentially higher QP conversion factor beginning on January 1 of each payment year, beginning with 2026. However, when it made the update, the agency did not make changes to the QP targeted review regulation at §414.1455 to correspond to the changes it made to the MIPS targeted review at §§414.1385(a)(2) and 414.1385(a)(5). The agency is now proposing to make the corresponding regulatory changes to the QP targeted review section.

⁵² Section 1833(z)(2) of the Act specifies the thresholds for the level of participation in Advanced APMs required for an eligible clinician to become a QP for a year.

⁵³ Note that beginning with payment year 2026, by statute, there is a differentially higher conversion factor applied for services furnished by QPs (0.75) as compared to services furnished by non-QPs (0.25).