Quality Payment PROGRAM

Merit-based Incentive Payment System (MIPS) Quality Performance Category Fact Sheet

Purpose

To provide MIPS eligible clinicians and their representatives with an introduction to the MIPS quality performance category.

In this fact sheet, you will find:

Quality Overview

Why Is Quality Important?

Quality is a foundational component to delivering value as a part of the overall care journey. Quality includes ensuring optimal care and best outcomes for patients of all ages and backgrounds as well as across service delivery systems and settings. CMS' quality mission is for all people to receive high-quality and value-based care.

What Is the Quality Performance Category?

The quality performance category assesses the quality of care you deliver as evidenced by your performance on quality measures. Quality measures are tools that help us assess health care processes, outcomes, and patient experiences to ensure they align with our goals for health care — for services to be effective, safe, efficient, patient-centered, and timely. There are various types of measures available for quality reporting. For example:

- **Process measures** look at the actions that clinicians perform to maintain or improve health and specify generally accepted recommendations for clinical practice. For example, the percentage of patients getting preventive services (such as mammograms or immunizations).
- **Outcome measures** assess the effect, both positive and negative, of an intervention or treatment. For example, the rate of surgical site infections.

There's a complete list of quality measure types, with examples, in the Appendix.

Key Terms

Collection Type

Collection type refers to the way you collect data for a MIPS quality measure. An individual MIPS quality measure may be collected in multiple ways (i.e., may be available through multiple collection types). Each collection type has its own specification (instructions) for reporting that measure. You would follow the measure specifications that correspond with how you choose to collect your quality data. The Explore Measures & Activities tool on the QPP website includes links to the quality measure specifications for the various collection types:

- **Electronic clinical quality measures (eCQMs) –** Measure data are collected at the point of care in electronic health record technology that's been certified by the Office of the National Coordinator for Health Information Technology. Data are collected for all patients that qualify for the measure, not just Medicare patients.
- **Medicare Part B claims measures –** Measure data are reported on Medicare Part B claims when they're submitted for reimbursement. Review the 2026 Reporting MIPS Quality Measures through Medicare Part B Claims Quick Start Guide for Small Practices (PDF, 2MB) to learn more. Medicare Part B claims measures can only be reported by solo practitioners and small practices (15 or fewer clinicians). Data are only reported for Medicare patients.
- **MIPS clinical quality measures (MIPS CQMs) –** Measure data may be gathered from paper, electronic charts, or collected with the assistance of a third party intermediary. Data are collected for all patients that qualify for the measure, not just Medicare patients.
- **Qualified Clinical Data Registry (QCDR) measures –** QCDRs are CMS-approved entities with the flexibility to develop and track their own quality measures. Because many QCDRs are specialty-based, QCDR measures may be more meaningful and applicable to your practice. Data are collected in a manner specified by the QCDR for all patients that qualify for the measure, not just Medicare patients.
- **Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey measure –** This measure assesses patient experience of care and must be administered by a CMS-approved survey vendor. Advance **registration** is required, review the CAHPS for MIPS Survey Registration webpage for more details.
- **Administrative claims measures –** These quality measures are automatically evaluated by CMS based on Medicare claims and automatically scored if measure requirements are met. Data are only collected for Medicare patients.

Note that there is one additional collection type – Medicare CQMs that are available specifically to Medicare Shared Savings Program Accountable Care Organizations (ACOs) meeting the reporting requirements under the Alternate Payment Model (APM) Performance Pathway (APP) Plus.

Performance Period

Each MIPS quality measure that clinicians collect and submit to CMS has a 12-month performance period, from January 1 – December 31. Certain administrative claims measures (which are automatically collected by CMS) have a longer performance period, which can be up to 3 years.

Data Completeness

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

Your submission must identify the total eligible population/denominator for the 12-month performance period as outlined in the measure's specification.

Incomplete reporting of a measure's eligible population or otherwise misrepresenting a clinician or group's performance (only submitting favorable performance data, commonly referred to as "cherry picking"), wouldn't be considered true, accurate, or complete and may subject you to an audit.

Case Minimum

Each MIPS quality measure that clinicians collect and submit to CMS has a case minimum of 20 denominator-eligible instances. Administrative claims measures (which are automatically collected by CMS) have different case minimums, which are outlined in their measure specifications.

Reporting Requirements

The quality performance category is 1 of 4 performance categories that make up your MIPS final score. The specific weight of each performance category may change from year to year based on finalized policies in a future Medicare Physician Fee Schedule Final Rule.

Each of the 3 MIPS reporting options has a different set of measure reporting requirements for the quality performance category while data completeness and case minimum criteria are the same for all 3 reporting options. Note that these reporting requirements are subject to change each year through rulemaking.

Traditional MIPS The original MIPS reporting option.	**Alternative Payment Model (APM) Performance Pathway (APP)** A streamlined reporting option for MIPS APM participants.	**MIPS Value Pathways (MVPs)** This reporting option offers clinicians a more meaningful and reduced grouping of measures and activities relevant to a specialty or medical condition.
• Select 6 quality measures. • We'll evaluate you on any applicable administrative claims-based measures based on data we collect. ○ You'll be scored on every one of these measures for which you meet the measure requirements.	• Collect data for a pre-determined set of quality measures. There are 2 quality measure sets available (APP and APP Plus) • Administer the CAHPS for MIPS Survey measure. • We'll evaluate you on administrative claims-based measures based on data we collect.	• Select 4 quality measures within your selected MVP. • We'll evaluate the population health measures using data collected through administrative claims.

Where Can You Go for Help?

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

People who are deaf or hard of hearing can dial 711 to be connected to a Telecommunications Relay Services (TRS) Communications Assistant.

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

Appendix

There are 6 types of quality measures available to assess your performance in the quality performance category. This table provides a definition and an example for each measure type.

Types of Quality Measures		
Measure Type	**Definition**	**Example**
Process Measures	A process measure is a measure that focuses on steps that should be followed to provide good care. There should be a scientific basis for believing that the process, when executed well, will increase the probability of achieving a desired outcome.	The percentage of patients receiving age-appropriate preventive and wellness services.
Outcome Measures	An outcome measure is a measure that focuses on the health status of a patient (or change in health status) resulting from health care—desirable or adverse.	The rate of surgical complications, such as surgical site infections.
Intermediate Outcome Measures	An intermediate outcome measure is a measure that assesses the change produced by a health care intervention that leads to a long-term outcome.	The percentage of patients diagnosed with hypertension whose blood pressure was adequately controlled during the measurement period. (Reducing a patient's blood pressure in the short-term decreases the risk of longer-term outcomes such as cardiac infarction or stroke.)

Types of Quality Measures		
Measure Type	**Definition**	**Example**
Patient-Reported Outcome-Based Performance Measures	A patient-reported outcome-based performance measure (PRO-PM) is a performance measure that is based on patient-reported outcome measure (PROM) data aggregated for an accountable health care entity. The data are collected directly from the patient using the PROM tool, which can be an instrument, scale, or single-item measure.	The percentage of patients who had cataract surgery and had improvement in visual function achieved within 90 days following the cataract surgery, based on completing a pre-operative and post-operative visual function survey.
Patient Engagement/Experience Measures	Patient engagement/experience measures use direct feedback from patients and their caregivers about the experience of receiving care. The information is usually collected through surveys.	Administering the CAHPS for MIPS Clinician/Group Survey measure.
Efficiency Measures	An efficiency measure is the cost of care (inputs to the health system in the form of expenditures and other resources) associated with a specified level of health outcome.	The percentage of emergency department visits for patients aged 2 through 17 years who presented with a minor blunt head trauma and were classified as low risk for traumatic brain injury and who had a head CT for trauma ordered by an emergency care provider. (i.e., Measuring the overuse of diagnostic imaging in a specific patient population, such as patients with minor blunt head trauma who have no indication for a head CT.)