Graphium

2026 EDITION · PART ONE

QPP Program Mechanics

How the Quality Payment Program Pays Anesthesia Practices

One of four volumes covering the Quality Payment Program (qpp.cms.gov) for anesthesia: **Program Mechanics**, **Improvement Activities**, **Quality Measures**, and **How Graphium QCDR Works**.

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75	-9%	2	4
PERFORMANCE THRESHOLD	MAXIMUM PENALTY	REPORTING PATHWAYS	PERFORMANCE CATEGORIES

What Changed for 2026

Read this page first if you are familiar with the 2025 manual.

Area	2026 Status
Performance threshold	Unchanged at **75 points**. CMS has finalized 75 through the 2028 performance year.
Category weights	Unchanged. Standard weighting is Quality 30%, Cost 30%, Promoting Interoperability 25%, Improvement Activities 15%. Most anesthesia groups are reweighted (see Section I).
Data completeness	**75%** of denominator-eligible encounters, all payers.
Payment adjustment	Negative adjustments can reach -9%; positive adjustments depend on CMS's budget-neutral calculation.
Improvement Activities	Weighting (high/medium) was **eliminated in 2025**. You now attest to **2 activities**, or **1 activity** if you hold a small practice, rural, HPSA, or non-patient-facing special status. The "Achieving Health Equity" subcategory was **retired for 2026** and replaced with "Advancing Health and Wellness." Total inventory is 104 activities.
Reporting pathways	Graphium QCDR now supports **both** Traditional MIPS and the Patient Safety and Support of Positive Experiences with Anesthesia MVP (MVP ID **G0059**). See Section II.
QID 424 Perioperative Temperature Management	**REMOVED** from MIPS and from the Anesthesia MVP, on topped-out grounds. Do not plan around it.
ABG 42 Difficult Airway	**REJECTED** by CMS for 2026 (never achieved a benchmark after 2 consecutive years in the program). Not in the 2026 set.
AQI 49 Blood Conservation	**RETIRED.** Not put forward as a QCDR measure for 2026. Not in the 2026 set.
AQI 67, AQI 72	No longer in the AQI NACOR 2026 set. Not in the 2026 set.
ABG 45 Aspiration Prevention	**NEW** for the 2026 set. Carries a 5-point scoring floor (added PY 2025, no historical benchmark; floor requires data completeness).
AQI 80 Combined Opioid Measure	**NEW** for 2026. Replaces the retired AQI 74 and AQI 75. Carries a 7-point scoring floor.
ePreop 31 Intraoperative Hypotension	Now in our licensed set. Risk-adjusted ratio measure.

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CMS sources for the 2026 performance year:

- CMS MIPS eligibility and participation
- CMS 2026 Quality Guide
- CMS 2026 Small Practices Guide
- CMS 2026 Improvement Activities Guide

I. How the Quality Payment Program Works

Overview

The Merit-based Incentive Payment System (MIPS) is one way to participate in the Quality Payment Program (QPP). The program describes how CMS reimburses MIPS eligible clinicians for Part B covered professional services and rewards them for improving the quality of patient care and outcomes.

Under MIPS, CMS evaluates your performance across multiple performance categories that lead to improved quality and value in our healthcare system.

Key points:

1. **Payment Adjustment.** For MIPS-eligible clinicians, CMS determines a payment adjustment for Medicare Part B-covered professional services associated with the NPI + TIN combination. Voluntary reporting does not produce a payment adjustment; opting in and group participation can. Negative adjustments can reach -9%; positive adjustments depend on CMS's budget-neutral calculation. The final payment adjustment is a function of the NPI's **Composite Performance Score (CPS)**.
2. **Composite Performance Score.** The CPS ranges from 0 to 100. A score of 0 results in the maximum penalty and a score of 100 results in the maximum bonus. The CPS is determined by a weighted average across **four performance categories**.
3. **Four Performance Categories.** Weighted averages of **Quality**, **Cost**, **Improvement Activities**, and **Promoting Interoperability** produce your final Composite Performance Score.

CMS designed MIPS to consolidate three earlier programs: the Medicare EHR Incentive Program for Eligible Clinicians, the Physician Quality Reporting System (PQRS), and the Value-Based Payment Modifier (VBM).

MIPS was designed to tie payments to quality and cost-efficient care, drive improvement in care processes and health outcomes, increase the use of healthcare information, and reduce the cost of care.

The **MIPS Performance Year** begins on January 1 and ends on December 31. Participants collect data on 100% of denominator-eligible cases during the calendar year and submit by March 31 of the following year. Data collected in 2026 is submitted by March 31, 2027, and drives the payment adjustment on claims filed in **2028**.

Payment Adjustment (the "Penalty" or "Bonus")

The Payment Adjustment will be negative (a penalty), positive (a bonus), or neutral (no adjustment). This percentage change is applied to Medicare claims filed by the NPI + TIN combination **two years after** the performance year.

Payment adjustments can differ across the TINs under which a clinician bills. Existing NPI + TIN combinations and new TIN affiliations are treated differently; see the employment-change examples in Section III. Do not assume an adjustment earned under one TIN can never apply to a new affiliation.

The Payment Adjustment is determined by the CPS along a nonlinear curve. While predicting any specific adjustment is difficult, the table below gives the fixed reference points.

Payment Adjustment	Composite Performance Score	Common Name
-9%	0 to 18.75	Maximum Penalty
Linear sliding scale	18.76 to 74.99	
0%	**75**	Performance Threshold
Linear sliding scale	75.01 to 99.99	
Positive adjustment determined by CMS	100	Highest final score

Positive adjustments depend on the funds available under CMS's budget-neutral calculation. A final score of 100 does not establish a fixed bonus percentage in advance.

For 2026, CMS estimates the median final score will be roughly 89 and that about 84% of eligible clinicians will receive a positive adjustment. Solo practitioners and small practices continue to absorb a disproportionate share of penalties.

Composite Performance Score

CMS calls this the **MIPS final score**. This manual also uses the legacy shorthand CPS. The score ranges from 0 to 100 for each Performance Year, and is a weighted average across the four Performance Categories.

Standard 2026 weights (a clinician or group with no special status):

Performance Category	Weight
Quality	30%
Cost	30%
Promoting Interoperability	25%
Improvement Activities	15%

Anesthesia example without small-practice status. Many anesthesia clinicians qualify for **non-patient-facing**, **hospital-based**, or **ASC-based** status. When Promoting Interoperability is the only category reweighted to 0% and small-practice redistribution does not apply, the weights are:

Performance Category	Weight	Notes
Promoting Interoperability	0%	Automatically reweighted for non-patient-facing, hospital-based, and ASC-based clinicians. No CEHRT requirement. Verify your status at the QPP Participation Lookup rather than assuming it.

Performance Category	Weight	Notes
Cost	30%	Calculated by CMS from your Medicare claims. No data submission required. Many anesthesia groups also fall below the case minimums for every cost measure, in which case Cost is reweighted to Quality as well.
Improvement Activities	15%	Annual attestation of activities performed for 90+ consecutive days.
Quality	**55%**	The 25% from Promoting Interoperability is added to Quality's base 30%.

If Cost is *also* reweighted because no cost measure meets its case minimum, Quality reaches 85% in this example. Small practices follow different redistribution rules.

Small-practice category weights

CMS defines a small practice as 15 or fewer clinicians billing under a TIN. For small practices reporting traditional MIPS or an MVP, the standard weights with Promoting Interoperability reweighted to zero are Quality 40%, Cost 30%, and Improvement Activities 30%. If Cost is also reweighted to zero, the weights are Quality 50% and Improvement Activities 50%. Confirm your CMS small-practice designation and applicable weights in the QPP Participation Status Tool.

Small-practice reporting situation	Quality	Cost	Improvement Activities	Promoting Interoperability
Promoting Interoperability reweighted	40%	30%	30%	0%
Both Cost and Promoting Interoperability reweighted	50%	0%	50%	0%

These are CMS rules, not a separate Graphium scoring model. Qualifying Promoting Interoperability data submitted voluntarily can void that category's reweighting. Source: CMS 2026 Small Practices Guide.

Do not assume your weights. Confirm each TIN and NPI at https://qpp.cms.gov/participation-lookup. Final eligibility and special status are published by CMS in December.

The Four Performance Categories

1. Promoting Interoperability (typically 0% for anesthesia)

Most clinicians must collect data using certified electronic health record technology (CEHRT) on the required measures for a minimum continuous 180-day period. This category replaced the Medicare EHR Incentive Program,

commonly known as "Meaningful Use."

CMS automatically reweights this category to 0% for clinicians with non-patient-facing, hospital-based, ASC-based, or small practice status. Most anesthesia clinicians qualify. The redistribution depends on your reporting arrangement and small-practice status; see the category-weight examples above.

If you *are* required to report PI, note that ONC-certified health IT must be in place by **July 5, 2026** to support a valid 180-day period ending December 31. New for 2026, CMS added an optional bonus measure, **Public Health Reporting Using TEFCA**, under the Public Health and Clinical Data Exchange objective.

2. Cost (30% of CPS)

This category replaced the Value-Based Payment Modifier. CMS calculates the cost of care you provide from Medicare claims. There is no separate data submission requirement for this category. Care delivery and coordination can affect attributed costs; review the applicable cost measures and CMS feedback to understand what is being assessed.

Two 2026 changes worth knowing:

- **TPCC attribution fix.** Historically, a group where all physicians held a special status exempting them from the Total Per Capita Cost measure could still be pulled into the measure by an NP or PA who did not hold that status. CMS closed this loophole. NPs and PAs in an otherwise-exempt group are now also exempt.
- **Two-year feedback-only period for new cost measures.** New cost measures now run for two years in a feedback-only mode. Clinicians see performance without it affecting the final score, giving time to identify gaps before the measure counts.

If no cost measure meets its case minimum for your reporting arrangement, Cost is reweighted to 0%. Redistribution follows the applicable CMS rules, including the separate small-practice rules above.

3. Improvement Activities (weight varies by reporting arrangement)

This category covers activities that improve care processes, enhance patient engagement, and increase access to care.

This category changed substantially starting in 2025. Activity weighting was eliminated. There is no longer a high-weight or medium-weight distinction, and there is no longer a points-per-activity calculation. To earn full credit:

Reporting Situation	Activities Required
MVP reporting (any status)	1
Traditional MIPS, with small practice, rural, HPSA, or non-patient-facing special status	1
Traditional MIPS, all others	2

Each activity must be performed for a minimum of **90 consecutive days** during the performance year, unless the activity description states otherwise.

Because most anesthesia clinicians hold non-patient-facing status, **most of our clients need only one activity**. Attesting to more than the required number does not increase your score.

Group reporting requires that at least 50% of the clinicians in the TIN performed the same activity for a continuous 90-day period within the same performance year, unless the activity specifies otherwise. The clinicians do not have to perform the activity concurrently.

These attestations are subject to CMS audit. Documentation must be retained for six years after submission. Be diligent in your selection. Section V names the activities most applicable to anesthesia; the companion volume, *Improvement Activities*, gives the full entry for each one along with what CMS expects to see if you are audited.

4. Quality (weight varies by reporting arrangement)

This category covers the quality of care you deliver, measured against national benchmarks.

Traditional MIPS requirements: - Report **6 measures**, at least one of which must be an **outcome measure**, or a **high priority measure** if no applicable outcome measure exists. - Alternatively, report a complete specialty measure set. The CMS-recommended Anesthesiology Measure Set for 2026 contains QID 404, 430, 463, and 477. - Collect data for the **full calendar year**, on **100% of denominator-eligible encounters, across all payers**, not just Medicare. - Meet the **75% data completeness threshold**: you must submit performance or exclusion/exception data for at least 75% of denominator-eligible encounters.

MVP requirements: Report **4 measures** from the MVP's defined list. See Section II.

NOTE: Graphium QCDR will report quality data for all measures you collect, but under Traditional MIPS CMS counts only your **top 6**. Leaving a single question blank will not necessarily harm your Payment Adjustment, *provided there are another 6 applicable measures being captured well*. Under the MVP, with only 4 measures counted from a smaller pool, that cushion is thinner and each measure matters more.

How Quality Measures Are Scored

This section is worth reading closely. Measure selection, not just measure performance, drives the Quality score.

Category Maximum Points

Under Traditional MIPS, each of your top 6 measures is worth a maximum of 10 points, giving the category a maximum of 60 points. If you earn 25 points across your top 6 measures, you have earned 41.7% (25/60) of the Quality category.

In an example where Quality has a 55% weight, that 41.7% contributes 22.9 points to the MIPS final score. The contribution differs when category weights change, including for small practices.

Points per Measure

Each measure is scored from 0 to 10 based on how your performance rate compares to that measure's **national benchmark**. CMS divides the national distribution of performance rates into deciles. Points can vary within a decile and are subject to data completeness, case minimums, applicable floors and caps, and other CMS scoring rules.

Historical benchmarks are the norm. They are built from data submitted two years before the performance year, so the 2026 benchmarks published by CMS were calculated from **2024** submissions. This means the benchmark is known before the performance year begins, which is what makes measure selection a planning exercise rather than a guess.

Worked example using the real 2026 benchmark for **QID 430 (Prevention of PONV, Combination Therapy)**:

Decile 1	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
84.00 to 85.99	86.00 to 87.99	88.00 to 89.99	90.00 to 91.99	92.00 to 93.99	94.00 to 95.99	96.00 to 97.99	98.00 to 98.99	99.00 to 99.99	100.00

A performance rate of 98.6% falls in Decile 8. A rate of 92.5% falls in Decile 5. Note how tight this benchmark is: the entire scoring range spans only 16 percentage points, because nearly everyone performs well on this measure.

This is the single most important thing to understand about MIPS scoring: a performance rate of 69% on Measure A may be worth more CPS points than a 98% rate on Measure B. Points are a function of **both** your rate **and** the national distribution. Chasing a high raw percentage on a topped-out measure is often a worse use of effort than a moderate percentage on a measure with a wide benchmark.

Topped Out Measures and the 7-Point Cap

A measure is **topped out** when the national distribution is so compressed at the high end that the measure no longer meaningfully discriminates between clinicians. CMS flags these.

A topped-out measure that has been flagged for multiple consecutive years becomes subject to a **7-point cap**: no matter how well you perform, the measure cannot earn more than 7 of the 10 available points.

For 2026, **QID 430, QID 463, and QID 477 are all flagged as topped out but are NOT yet 7-point capped**. They can still earn a full 10 points this year. Plan for the cap to arrive in a future year and diversify accordingly. CMS also continues a policy introduced in 2025 that allows a selection of topped-out, point-capped measures drawn from certain specialty sets to still reach 10 points.

Scoring Floors for New Measures

First- and second-year measures have **scoring floors** when data completeness is met. These floors can apply even when a benchmark is unavailable or the case minimum is not met:

- Measures added in **PY 2025** carry a **5-point floor**.
- Measures added in **PY 2026** carry a **7-point floor**.

For 2026, **AQI 80, AQI 81, and AQI 82 have 7-point floors; ABG 45 and AQI 79 have 5-point floors**, subject to data completeness. Higher scores may be available when CMS can score performance against a benchmark. These measure-level floors do not guarantee a final MIPS score or payment adjustment.

Measures with No Benchmark and No Floor

A missing historical benchmark does not settle the final score. CMS attempts to establish a performance-period benchmark from that year's submissions. **AQI 18, AQI 71, and ePreop 31** lack historical benchmarks for 2026. If no performance-period benchmark can be established, CMS applies the applicable scoring rules, including small-practice exceptions. Choose clinically relevant measures and review CMS's final benchmark and scoring guidance rather than assuming these measures will score poorly.

Source: CMS 2026 Quality Benchmarks User Guide.

How Graphium handles this. We report Performance Met percentage per measure and stop there. We do not project deciles or estimate a final Composite Performance Score, for the reasons set out in the companion volume, *How Graphium QCDR Works*. The benchmark tables reproduced throughout *Quality Measures* are provided so you can interpret your own rates against the published distribution. They are reference material, not a scoring engine.

Performance Rate Calculation

For each measure, every anesthesia case in the reporting period is evaluated against the measure's criteria and assigned one of the following states:

Performance Met: The case is eligible (meets denominator criteria) and the numerator criteria were satisfied.

Performance Not Met: The case is eligible but the numerator criteria were not satisfied.

Data Completeness Not Met: The case is eligible but is missing data required to evaluate the numerator.

Ineligible: The case does not meet denominator criteria, or falls under a **Denominator Exclusion**. Exclusions are defined per measure. Your Performance Met rate is unaffected by these cases.

Denominator Exception: The case was eligible but was removed because it met additional criteria defined by the measure. Your Performance Met rate is unaffected by these cases, but they *do* count toward data completeness.

Performance Rate = Performance Met ÷ (Performance Met + Performance Not Met)

Data Completeness Rate = (Performance Met + Performance Not Met + Denominator Exceptions) ÷ (Performance Met + Performance Not Met + Denominator Exceptions + Data Completeness Not Met)

For 2026, a measure below 75% data completeness generally earns **0 points**. Small practices receive **3 points** for a submitted measure that does not meet the data completeness requirement. Missing documentation affects completeness; it is not the same as documenting that performance was not met. See the CMS 2026 Quality Guide.

Reporting Thresholds, Participation Status, and Reporting Options

Low-Volume Threshold

CMS reviews Medicare Part B claims and PECOS data twice for each Performance Year. Each review is called a determination segment. Data from the two segments is reconciled and released as the final eligibility determination. See https://qpp.cms.gov/mips/how-eligibility-is-determined.

You must participate in MIPS, unless otherwise exempt, if in **both** 12-month segments of the MIPS Determination Period you:

- Bill more than **$90,000** for Part B covered professional services, **and**
- See more than **200** Part B patients, **and**
- Provide more than **200** covered professional services to Part B patients.

You must exceed all three in both segments, unless another exclusion applies. Clinicians or groups meeting CMS's other eligibility conditions and exceeding one or two, but not all three, elements can elect to **opt in**. Opting in creates exposure to positive, neutral, or negative payment adjustments. It is distinct from voluntary reporting.

Participation Status

Eligibility is determined at the **TIN/NPI level**. A clinician who works across multiple practices can be required to report at one and exempt at another. Status can also change mid-year, and CMS finalizes eligibility in December.

Voluntary reporting of traditional MIPS does not produce a MIPS payment adjustment. Opting in is different: clinicians or groups that are opt-in eligible and elect to opt in can receive a positive, neutral, or negative adjustment. Group participation can also affect clinicians who are below the individual low-volume threshold. Check participation status for each TIN/NPI combination before deciding how to report.

Voluntary reporters receive limited performance feedback, rather than a payment adjustment based on their submission. Source: CMS MIPS eligibility and participation.

Check any EC's status at https://qpp.cms.gov/participation-lookup.

Reporting as a Group vs. an Individual

Each TIN may report as a Group, as Individuals, or both. Exempt status is evaluated for each NPI on both an individual and a group basis: the criteria are applied at the NPI level (all cases for an NPI) and at the TIN level (all cases for a TIN).

Report as an Individual. The NPI's measures and activities for the given TIN are reported. The CPS is based on that individual's performance.

Report as a Group. All NPIs' measures and activities for the TIN are reported. Performance across all four categories is evaluated in aggregate for the TIN, and every EC in the group receives the same CPS.

If reporting as a Group, you must report quality data for ALL NPIs within the TIN. A single high-volume clinician who is not being captured will drag the entire group's rates. For a complete list of NPIs within your TIN, check your CMS portal at https://portal.cms.gov.

Subgroup reporting. Beginning in 2026, multispecialty groups intending to report MVPs must report as subgroups. A subgroup is a subset of a group identified by the combination of the group TIN, a subgroup identifier, and each clinician's NPI. Anesthesiologists inside a multispecialty group may be able to report the Anesthesia MVP through subgroup reporting. See Section II.

The Reporting Year Timeline

Date	Milestone
January 1, 2026	Performance year opens. Quality data collection begins on 100% of eligible cases, all payers.
April 1, 2026	MVP registration window opens.
July 5, 2026	Latest date to have ONC-certified health IT in place if you must report Promoting Interoperability.
Any continuous 90 days	Improvement Activity performance period. Must be completed within the calendar year.

Date	Milestone
November 30, 2026	MVP registration window closes. Registration is required, and it cannot be done retroactively.
December 2026	CMS publishes final eligibility and special status determinations.
December 31, 2026	Performance year closes.
January to March 2027	Submission window. Attestations and quality data finalized.
March 31, 2027	Submission deadline.
Mid-2027	CMS performance feedback and targeted review window.
January 1, 2028	Payment adjustment applied to claims.

II. Reporting Pathways: Traditional MIPS vs. MVP

Graphium QCDR now supports both reporting pathways. This section explains the difference and how to choose.

What Is an MVP?

MIPS Value Pathways are a streamlined reporting option within MIPS. Instead of picking six measures from an inventory of several hundred that span every specialty in medicine, an MVP presents a curated set of measures and activities aligned around a specialty or clinical focus area. You pick from that smaller, more relevant set.

CMS finalized **27 MVPs** for the 2026 performance year, including six new ones. The one relevant to us is:

> **Patient Safety and Support of Positive Experiences with Anesthesia MVP ID: G0059**

CMS has been explicit that MVPs are the future of the program and that Traditional MIPS will eventually sunset. The timeline has slipped repeatedly and no sunset date is currently in force, but the direction is settled. Groups that move early build familiarity before it becomes mandatory.

Side-by-Side Comparison

Quality measures required	**6**, including at least one outcome or high priority measure	**4**, chosen from the MVP's defined list
Measure pool	The full MIPS and QCDR inventory	A curated anesthesia-specific list of 7 measures
Improvement Activities required	**2**, or **1** with a special status	**1**, regardless of special status
Promoting Interoperability	Same requirements, subject to automatic reweighting	Same requirements, subject to automatic reweighting
Cost	Assigned by CMS from claims	Assigned by CMS from claims, drawn from cost measures aligned to the MVP
Registration required	No	**Yes.** April 1 to November 30 of the performance year
Subgroup reporting	Not applicable	Required for multispecialty groups reporting an MVP as of 2026
Population health measure	Not applicable	A foundational population health measure applies

The MVP Quality Measure List

Under the Anesthesia MVP you select **4** measures from the following:

Measure	Type	High Priority	2026 Benchmark Status
QID 404 Anesthesiology Smoking Abstinence	Intermediate Outcome	Yes	Historical, wide benchmark, not topped out
QID 430 Prevention of PONV, Combination Therapy	Process	Yes	Historical, topped out
QID 463 Prevention of POV, Combination Therapy (Pediatrics)	Process	Yes	Historical, topped out
QID 477 Multimodal Pain Management	Process	Yes	Historical, topped out
AQI 48 Patient-Reported Experience with Anesthesia	PRO-PM	Yes	Historical, not topped out
ABG 44 Low Flow Inhalational General Anesthesia	Process / Efficiency	Yes	Historical, not topped out
ePreop 31 Intraoperative Hypotension	Intermediate Outcome	Yes	No historical benchmark

Note that QID 424 was removed from the MVP for 2026, alongside its removal from Traditional MIPS. ASA formally opposed this removal in its CY 2026 comments on the grounds that topped-out measures reflecting a central focus of a specialty should not be stripped out, but CMS finalized the removal.

Three of the seven MVP measures are QCDR measures (AQI 48, ABG 44, ePreop 31), which can only be reported through a QCDR that licenses them. A Qualified Registry can only report the national measures, meaning the four QID measures. This matters: a group reporting the MVP through a Qualified Registry has exactly four eligible measures and no room to drop a poor performer. **Reporting through Graphium QCDR gives you seven to choose four from.**

MVP Improvement Activities

MVP participants attest to **one** activity from the MVP's approved list. Examples include:

- Regularly assess patient experience of care and follow up on findings (**IA_BE_6**)
- Improved practices that engage patients pre-visit (**IA_BE_22**)
- PSH Care Coordination (**IA_CC_15**)
- Tracking of clinician's relationship to and responsibility for a patient by reporting MACRA patient relationship codes (**IA_CC_19**)
- Practice-Wide Quality Improvement in MIPS Value Pathways (**IA_MVP**)
- Participation in an AHRQ-listed patient safety organization (**IA_PSPA_1**)

- Use of QCDR data for ongoing practice assessment and improvements (**IA_PSPA_7**)
- Use of decision support and standardized treatment protocols (**IA_PSPA_16**)
- Electronic submission of Patient Centered Medical Home accreditation (**IA_PCMH**)

Note that **IA_PSPA_7 (Use of QCDR data)** appears in both this list and our Traditional MIPS recommendations. Graphium QCDR data can support this activity when your team performs and documents the required ongoing assessment and improvement work.

Advantages of the MVP for Anesthesia Groups

1. Materially less reporting burden. Four measures instead of six, one improvement activity instead of two. For a group that struggles to find six applicable measures, this is not a marginal convenience. It is the difference between reporting a full set and taking a scoring hit on measures that barely apply.

2. It eliminates the "six applicable measures" problem. Anesthesia has historically had a thin measure inventory. Groups routinely end up reporting a measure with tiny denominators or one that maps poorly to their case mix, simply to reach six. The MVP removes that pressure. Every measure in the pool was selected because it is relevant to anesthesia.

3. Better measure-to-practice fit. The pathway groups measures around anesthesia care. Selecting an MVP does not itself create a separate anesthesia-only benchmark for a measure.

4. Cost measures are aligned to the MVP. Rather than being assessed against general cost measures that may have nothing to do with your scope of practice, MVP cost assessment draws from measures aligned to the pathway.

5. It builds readiness before MVPs become mandatory. CMS continues to expand MVP adoption. Learning the registration mechanics, the subgroup rules, and the measure set now is cheaper than learning them under a deadline.

6. Subgroup reporting unlocks the pathway inside multispecialty groups. Anesthesiologists employed by a multispecialty group have historically been scored on a blended TIN performance that reflects other specialties' measures. Subgroup reporting lets the anesthesia subset report the Anesthesia MVP on its own.

Disadvantages and Cautions

1. Registration is mandatory and cannot be done retroactively. The window is April 1 to November 30 of the performance year. Missing it means you cannot report the MVP for that year, full stop.

2. Less room to drop a bad measure. With six measures under Traditional MIPS and more than six being collected, a single weak measure can be excluded from scoring. With four required from a pool of seven, one badly performing measure has a larger effect on your Quality score.

3. Benchmark status still matters. ePreop 31 lacks a historical benchmark, and three of the four QID measures are topped out. Review the applicable CMS scoring rules; these labels alone do not determine the final points earned.

4. Subgroup reporting adds administrative complexity for multispecialty groups: subgroup identifiers, clinician rosters, and separate submissions.

Choosing a Pathway

You can register for an MVP and still report Traditional MIPS or the APM Performance Pathway. **CMS takes the highest score.** Registering for the MVP therefore costs you nothing but the registration step and preserves optionality through the year.

The practical decision rules:

- **If your group can comfortably report six or more measures with strong performance and reasonable denominators, Traditional MIPS remains viable.** The contribution to the final score depends on the applicable category weights and CMS scoring rules.
- **If your group struggles to reach six applicable measures, the MVP is likely the better pathway.** This describes most small and mid-sized anesthesia groups.
- **If you are inside a multispecialty group and your MIPS score is currently being dragged by other specialties' performance, investigate subgroup reporting under the MVP.** This is the single largest potential swing available to affected anesthesiologists.
- **Register for the MVP regardless.** Registration is free, reversible in effect (you can still submit Traditional MIPS), and CMS scores whichever is higher.

2026 MVP Key Dates

Date	Milestone
April 1, 2026	MVP registration opens
November 30, 2026	MVP registration closes. Hard deadline.
January 1 to December 31, 2026	Performance year
Announced by CMS	Data submission period

Verify eligibility and special status at https://qpp.cms.gov/participation-lookup and subgroup eligibility at https://qpp.cms.gov/eligibility-participation/ways-to-participate/individual-or-groups.

III. Interpreting Payment Adjustments with New or Multiple TIN/NPI Combinations

Payment adjustments follow the NPI, but they are calculated per TIN/NPI combination. The table below covers the common scenarios, using a 2026 performance year and its 2028 payment year.

Scenario	Payment Adjustment
Clinician has a 2026 Final Score under TIN A. Clinician continues to bill under TIN A in the 2028 payment year.	Clinician receives a payment adjustment for covered professional services billed in 2028 under their TIN A/NPI combination, based on the 2026 Final Score attributed to that TIN A/NPI combination.
Clinician has a single 2026 Final Score, received at TIN A. Clinician bills under TIN B in the 2028 payment year.	Clinician receives a payment adjustment for covered professional services billed in 2028 under their TIN B/NPI combination, based on the 2026 Final Score attributed to their TIN A/NPI combination.
Clinician has a 2026 Final Score under TIN A and a 2026 Final Score under TIN B. Clinician bills under TIN C in the 2028 payment year.	Clinician receives a payment adjustment for covered professional services billed in 2028 under their TIN C/NPI combination, based on their **higher** 2026 Final Score, either the one attributed to TIN A/NPI or the one attributed to TIN B/NPI.
Clinician has a 2026 Final Score under TIN A and a 2026 Final Score under TIN B. Clinician bills under both TIN A and TIN B in the 2028 payment year.	Clinician receives a payment adjustment under TIN A/NPI based on the 2026 Final Score attributed to TIN A/NPI, and a separate payment adjustment under TIN B/NPI based on the 2026 Final Score attributed to TIN B/NPI.

The practical takeaway for a clinician joining a new practice: your adjustment follows you from wherever you last earned a score, and if you earned several, the highest one travels with you.

IV. The 2026 Quality Measures at a Glance

Graphium QCDR supports twelve quality measures for 2026. This section is the short version: what each one asks, and how each is likely to score. **Full specifications - denominators, numerators, registry codes, benchmarks, rationale and references - are in the companion volume, *QPP for Anesthesiology: Quality Measures*.**

You do not need to read that volume to report well. You need it when you are building capture workflow, auditing a rate you do not believe, or answering a clinician who wants to know exactly what a measure counts.

Every measure there ends with its complete denominator CPT code list. If the question is "which measures does this case fall into," start from the procedure code: the same code lists drive the lookup on the Graphium QCDR site, where entering a CPT code returns the measures it can trigger. Bear in mind throughout that a matching code makes a case *eligible for consideration* - age, elective status, diagnosis and anesthetic type still decide whether it actually counts.

What Each Measure Asks

Measure	What it asks of the anesthesia team
ABG 44 Low Flow Inhalational General Anesthesia	On an elective inhalational general anesthetic running 30 minutes or longer, was total fresh gas flow held at or below 1 L/min through maintenance - 2 L/min for sevoflurane?
ABG 45 Aspiration Prevention in Gastric Distension	For a patient with GI obstruction, ileus, incarcerated hernia, gastroparesis, or a recent GLP-1 agonist dose, was one of four aspiration mitigation strategies applied before the procedure?
AQI 18 CABG Prolonged Intubation	After an isolated CABG, did the patient still require intubation beyond 24 hours? **Inverse measure - a lower rate is better.**
AQI 48 Patient-Reported Experience with Anesthesia	Surveyed after the fact, did the patient report a positive experience of their anesthesia care?
AQI 65 Avoidance of Cerebral Hyperthermia	During cardiopulmonary bypass, did the patient avoid a documented temperature at or above 37.0 °C?
AQI 71 Ambulatory Glucose Management	A four-part composite for diabetic patients in ambulatory surgery: was glucose tested, was hyperglycemia treated, was it re-checked after insulin, and was the patient educated?
AQI 80 Buprenorphine or Methadone Continuation	Was a patient already on buprenorphine or methadone continued on it through the perioperative period rather than having it stopped?
ePreop 31 Intraoperative Hypotension	Did mean arterial pressure sit below 65 mmHg for a cumulative 15 minutes or more? **Inverse and risk-adjusted**, and derived entirely from the record - it asks the clinician nothing.
QID 404 Anesthesiology Smoking Abstinence	Did a current smoker abstain from cigarettes before anesthesia on the day of an elective procedure?

Measure	What it asks of the anesthesia team
QID 430 Prevention of PONV, Combination Therapy	For an adult with three or more PONV risk factors under inhalational general anesthesia, were at least two prophylactic antiemetics of different classes given?
QID 463 Prevention of POV, Combination Therapy (Pediatrics)	Same question for a child aged 3 to 17 with two or more risk factors for post-operative vomiting.
QID 477 Multimodal Pain Management	For selected surgical procedures, was pain managed with more than one modality rather than opioids alone?

How Each Measure Is Likely to Score

Read this table with *How Quality Measures Are Scored* in Section I. Historical benchmark status is a planning input, not a final score. Performance-period benchmarks, completeness, case minimums, applicable floors and caps, and special scoring rules can affect the result.

Measure	Steward	Type	High Priority	2026 Benchmark Status	Scoring Considerations
ABG 44	ABG QCDR	Efficiency	Yes	Historical benchmark, not topped out	Up to 10, subject to CMS rules
ABG 45	ABG QCDR	Process	Yes	No historical benchmark; **5-point floor**	Floor requires data completeness
AQI 18	ASA/AQI	Outcome (inverse)	Yes	No historical benchmark	Performance-period benchmark may be established
AQI 48	ASA/AQI	PRO-PM	Yes	Historical benchmark, not topped out	Up to 10, subject to CMS rules
AQI 65	ASA/AQI	Outcome	Yes	Historical benchmark, not topped out	Up to 10, subject to CMS rules
AQI 71	ASA/AQI	Composite	Yes	No historical benchmark	Performance-period benchmark may be established
AQI 80	ASA/AQI	Process	Yes	No historical benchmark; **7-point floor**	Floor requires data completeness

Measure	Steward	Type	High Priority	2026 Benchmark Status	Scoring Considerations
ePreop 31	Provation / Cleveland Clinic	Intermediate Outcome (inverse)	Yes	No historical benchmark	Performance-period benchmark may be established
QID 404	CMS	Intermediate Outcome	Yes	Historical benchmark, not topped out	Up to 10, subject to CMS rules
QID 430	CMS	Process	Yes	Historical benchmark, **topped out** (not yet capped)	Up to 10, subject to CMS rules
QID 463	CMS	Process	Yes	Historical benchmark, **topped out** (not yet capped)	Up to 10, subject to CMS rules
QID 477	CMS	Process	Yes	Historical benchmark, **topped out** (not yet capped)	Up to 10, subject to CMS rules

The practical instruction is the same either way: report every measure you are eligible for and document it completely. Under Traditional MIPS, CMS selects your best six. You do not have to predict which ones will score well, and trying to game the selection reliably does worse than reporting broadly.

V. The 2026 Improvement Activities at a Glance

Seventeen activities in the 2026 inventory map cleanly onto anesthesia practice. This section names them and says what each asks. **The full entries - CMS's activity description, what Graphium clients can typically use as evidence, and the validation documentation CMS expects at audit - are in the companion volume, *QPP for Anesthesiology: Improvement Activities*.**

Attest to **two** activities, or **one** for MVP, small-practice, rural, HPSA, or non-patient-facing status. Each requires **at least 90 consecutive days**, unless specified otherwise. For group attestation, **at least 50%** of clinicians in the TIN must perform the same activity. Their periods **do not have to coincide**, but must fall within the same performance year. Extra activities earn no extra credit. CMS guidance, page 19.

Activities marked **(Graphium Recommended)** are ones our clients can typically document from work they are already doing.

Activity	Subcategory	What it asks of the practice
IA_PSPA_7 Use of QCDR data for ongoing practice assessment and improvements ***(Graphium Recommended)***	Patient Safety	Participate in a QCDR and actually use what comes back - feedback reports, comparative analysis, corrective steps. If you are a Graphium client you are already doing the hard part.
IA_BE_6 Regularly Assess Patient Experience of Care and Follow Up on Findings ***(Graphium Recommended)***	Beneficiary Engagement	Collect patient experience data **and** follow up on it with a written improvement plan. The follow-up, not the survey, is the part CMS audits.
IA_PSPA_2 Participation in MOC Part IV ***(Graphium Recommended)***	Patient Safety	Complete Maintenance of Certification Part IV, which already requires reviewing outcomes, fixing what you find, and evaluating the result.
IA_PSPA_19 Implementation of formal quality improvement methods, practice changes, or other practice improvement processes ***(Graphium Recommended)***	Patient Safety	Adopt a named QI model and involve staff and leadership in running it. Your complications review and provider-variation work both count.
IA_CC_15 PSH Care Coordination	Care Coordination	Participate in a Perioperative Surgical Home coordinating care from pre-procedure assessment through post-acute recovery.
IA_PSPA_16 Use of decision support and standardized treatment protocols	Patient Safety	Manage workflow with decision support and standardized protocols. ERAS pathways and surgical risk calculators qualify.
IA_PSPA_1 Participation in an AHRQ-listed patient safety organization	Patient Safety	Belong to an AHRQ-listed PSO. Documentation is a welcome letter or equivalent written confirmation.

Activity	Subcategory	What it asks of the practice
IA_CC_8 Implementation of documentation improvements for practice or process improvements	Care Coordination	Document care coordination activity across the team. CMS's own example describes an anesthesia preoperative workflow almost exactly.
IA_CC_19 Tracking of clinician's relationship to and responsibility for a patient by reporting MACRA patient relationship codes	Care Coordination	Report patient relationship codes via HCPCS modifiers on at least half your Medicare claims for 90 continuous days.
IA_BE_22 Improved Practices that Engage Patients Pre-Visit	Beneficiary Engagement	Change workflow to engage patients before the visit - a shared agenda, or targeted pre-visit testing available for discussion.
IA_PSPA_13 Participation in Joint Commission Evaluation Initiative	Patient Safety	Participate in the Joint Commission's Ongoing Professional Practice Evaluation.
IA_PSPA_3 Participate in IHI Training or Forum Event, National Academy of Medicine, AHRQ TeamSTEPPS, or Other Similar Activity	Patient Safety	For clinicians not doing MOC Part IV, attend a recognized quality or safety training.
IA_PSPA_12 Participation in private payer clinical practice improvement activities	Patient Safety	Take part in a designated private payer improvement program.
IA_PSPA_28 Completion of an Accredited Safety or Quality Improvement Program	Patient Safety	Complete an accredited performance-improvement CME program that targets a documented gap, sets measurable aims, intervenes, and measures the result.
IA_BMH_12 Promoting Clinician Well-Being	Behavioral and Mental Health	Stand up a real program for clinician well-being and resilience - relationship-building, leadership development, or a standing internal team.
IA_ERP_2 Participation in a 60-day or greater effort to support domestic or international humanitarian needs	Emergency Response	Sixty continuous days or more of humanitarian volunteer work. Registering alone does not count.
IA_PSPA_34 Patient Safety in the Use of Artificial Intelligence ***(NEW for 2026)***	Patient Safety	Govern the AI tools in clinical or documentation use: an inventory, validation before deployment, monitoring, a human-in-the-loop path, and an incident record.

Documentation must be retained for six years after submission, and these attestations are audited. Several activities that earlier editions of this manual recommended no longer exist. The companion volume opens with the list of what was removed or renumbered; check it before re-attesting to anything you used last year.

VI. Disclaimer and Copyright

Disclaimer

Participation in Graphium QCDR does not guarantee satisfactory participation in the CMS Merit-based Incentive Payment System. Successful submission to CMS is contingent upon each individual eligible clinician and/or group meeting the MIPS program requirements and the timeliness, quality, and accuracy of the data they provide for reporting.

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