Physician Fee Schedule Proposed Rule for 2027
Summary Part III: Quality Payment Program (QPP)

Medicare and Medicaid Programs; CY 2027 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-1848-P]

On July 16, 2026, the Centers for Medicare & Medicaid Services (CMS) published in the Federal Register (91 FR 43842) a proposed rule relating to the Medicare physician fee schedule (PFS) for CY 2027[1] and other revisions to Medicare Part B policies. If finalized, policies in the proposed rule generally would take effect on January 1, 2027. **The 60-day comment period ends at close of business on September 14, 2026.**

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

Part III covers the proposals for the Quality Payment Program, including the Traditional Merit-based Incentive Payment System (MIPS), MIPS Value Pathways (MVPs), and the Alternative Payment Model Incentive. Of specific note, among these proposals, CMS is proposing to sunset the traditional MIPS reporting option and fully transitioning to MVPs beginning with the 2029 performance period/2031 MIPS payment year.

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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.

IV. Quality Payment Program

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

1. Background[2]

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 2027 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.[3] 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;

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

[3] 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.[4] 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.[5] 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. Under 1833(z)(1)(A) of the Act, the APM Incentive payment will not be available for the 2027 payment year, but for the 2028 payment year QPs will receive a lump sum APM Incentive payment equal to 3.1 percent of their estimated aggregate paid amounts for covered professional services furnished in 2027. 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.

For the 2026 and 2028 payment years, QP status (based on the 2024 and 2026 QP performance periods, respectively) remains based on the thresholds of 50 percent for the payment amount method and 35 percent for the patient count method. However, the thresholds to achieve QP status in the 2027 QP performance period (2029 payment year) increase to 75 percent for the payment amount method and 50 percent for the patient count method. Overall, for the 2026 QP performance period (2028 payment year), CMS estimates between 517,800 and 530,900 eligible clinicians will become QPs and be excluded from MIPS.

2. Overview

During the 2027 payment year, MIPS payment adjustments will be applied, and APM incentive payments will be made, to eligible clinicians based on their 2025 performance data. For performance year 2027, 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 2025. As previously finalized, CMS will use 75 points as the performance score threshold through the 2028 performance periods and as the basis for adjustments during payment years 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 $332 million, and if the proposed policies were finalized, $330

[4] CMS may assign a different scoring weight to the quality or PI categories and reweight in accordance with §414.1367(d)(2).
[5] Partial QPs may elect to be subject to the MIPS reporting requirements and payment adjustment.

million, based on the budget neutrality requirement. Taking into account the proposals, CMS estimates that the overall median positive payment adjustment for 2027 is about 0.83 percent and the median negative payment adjustment is -2.62 percent. The overall proportion of clinicians receiving a positive payment adjustment is expected to be 86.57 percent in the proposed policy model (as compared to 84.58 percent in the baseline model), and 7.99 percent of clinicians in the proposed policy model (as compared to 9.90 percent in the baseline model) are expected to receive a negative adjustment.

3. Summary of Major Provisions

CMS describes its goals to align policies in MIPS and APMs within the QPP with the Making America Healthy Again (MAHA) initiative. In support of those goals, CMS is expanding the MVP portfolio to include Diabetic Disease and Hypertension MVPs and, under the Advancing Health and Wellness subcategory within the IAs performance category, is proposing new IAs that address nutrition, lifestyle approaches to disease management, and patient wellness.

CMS proposes to sunset the traditional MIPS reporting option beginning with the 2029 performance period/2031 MIPS payment year.

MVP-Specific Proposals. CMS proposes that beginning with the 2029 performance period/2031 MIPS payment year, all eligible clinicians participating in MIPS who are not reporting the APP would be required to report the measures and activities in a selected MVP. The agency also proposes including virtual groups in MVP reporting.

For MVP development and maintenance, CMS proposes:

- Three new MVPs: (i) Diabetic Disease; (ii) Hypertension; and (iii) Hospitalist.
- Several MVP maintenance updates to the MVP inventory, including aligning with the MVP development criteria.

In addition, CMS states that it updated all MVPs to include MIPS core measures and is renaming the Rehabilitative Support for Musculoskeletal Care MVP to Rehabilitative Support MVP.

APP-Specific Proposals. CMS proposes to align quality measures in the APP original quality measure set and the APP Plus quality measure set to reflect proposed changes to measures for the quality performance category.

Fast Healthcare Interoperability Resources (FHIR) Request for Information. CMS seeks input on its anticipated transition timeline, key milestones, and implementation considerations for FHIR-based quality reporting in the QPP and other CMS quality reporting programs.

Proposals Specific to MIPS Quality Performance Category. CMS proposes several policies for the quality performance category, including:

- For the 2027 performance period/2029 MIPS payment year, establishing a measure set inventory of 180 MIPS quality measures (177 of which available in traditional MIPs and 3 of which only for MVPs), including 20 measure removals, 10 additions for 2027 and

one more for 2028 (focusing on measuring patient-reported outcomes and chronic disease management), and 43 substantive changes to existing measures.

- Beginning with the 2027 performance period/2029 MIPS payment year, removing the existing data submission requirement of one outcome (or one high priority measure if no outcome measure is available) and replacing it with the requirement that eligible clinicians (other than clinicians in small practices, who would be exempt) report at least one MIPS core measure (or non-core measure if clinician attests a core measure is not available).
- Expanding collection types to include Medicare Electronic Clinical Quality Measure for Accountable Care Organizations Participating in the Medicare Shared Savings Program (Medicare eCQMs) and establishing data submission criteria and data completeness criteria for Medicare eCQMs.

Proposals Specific to MIPS Cost Performance Category. CMS proposes to update the operational list of care episodes and patient condition groups and codes to reflect coding changes identified through annual maintenance of MIPS cost measures.

Proposals Specific to MIPS IAs Performance Category. Proposals include (i) adding six new IAs into two subcategories (Care Coordination and Advancing Health and Wellness); (ii) modifying five IAs; and (v) removing eleven IAs.

Proposals Specific to MIPS PI Performance Category. Proposals include:

- Beginning with 2026 performance period/2028 MIPS payment year, removing the Office of the National Coordinator for Health Information Technology (ONC) Direct Review attestation and ONC-Authorized Certification Bodies (ONC-ACB) Surveillance attestation.
- Beginning with 2027 performance period/2029 MIPS payment year, (i) modifying the definition of certified electronic health record technology (CEHRT); (ii) modifying the electronic prior authorization measure and changing to measure to an optional measure; and (iii) removing the security risk analysis measure.
- Beginning with 2028 performance period/2030 MIPS payment year, (i) further updating the electronic prior authorization measure description to account for additional requirements and changing the measure back to being a required measure; and (ii) adding the electronic prior authorization for prescription drugs measure as a required measure under the Health Information Exchange (HIE) objective.

Proposals Specific to MIPS Scoring. CMS proposes to (i) assign zero measure achievement points for a quality measure for clinicians reporting data under traditional MIPS and MVP reporting if they do not submit a MIPS core measure or do not attest there is no available MIPS core measure; (ii) modify the publishing location of topped out measures impacted by limited measure choice and scored according to the defined topped out benchmark; (iii) apply the defined topped out benchmark for core measures that are topped out; (iv) use flat benchmarks for the proposed Medicare CQMs; and (v) modify the electronic prior authorization measure from a required measure to an optional measure worth 10 bonus points under the MIPS PI performance category for the 2027 performance period/2029 MIPS payment year.

CMS also seeks feedback on the proposed list of topped out measures and MVPs to be subject to the defined topped out measure benchmark and in a request for information (RFI) on the future direction of MVP scoring policies.

For calculating the MIPS final score, CMS proposes beginning with the 2027 performance period/2029 MIPS payment year, to use whatever data is most current and reliable to determine whether a MIPS eligible clinician is located in an area affected by an extreme and uncontrollable circumstance (EUC). Proposals also include making December 31 of the year before the relevant MIPS payment year the deadline for requesting reweighting for quality, IAs, and PI performance categories when the TPI does not submit data on time.

Third Party Intermediary (TPI) Proposals. Proposals include (i) clarifying that additional requirements for health IT vendors no longer apply beginning with 2025 performance period/2027 payment year when health IT vendors are no longer permitted to submit MIPS data as TPIs; (ii) making minor changes to the audit requirements; (iii) terminating status of TPIs that do not submit data for one year; and (iv) specifying qualified clinical data registries (QCDRs) and qualified registries must be able to submit to CMS data for at least six quality measures, including one MIPS core measure.

Public Reporting Proposals. CMS proposes to remove the prohibition on public reporting of any performance data reported through an MVP on a new IA or PI measure, objective, or activity during the first year of its inclusion in the MVP. CMS seeks feedback on the star rating assignment methodology for quality measures under the administrative claims collection type.

Advanced APM-Specific Proposals. CMS proposes to (i) modify the application of the QP and partial QP status so that only TINs participating in Advanced APMs receive the APM incentive payment and qualifying APM conversion factor; (ii) clarify when QP status is lost as a result of termination of participation in an Advanced APM; (iii) not require certain APMs to provide a participation list for QPP purposes; (iv) modify conditions by which credit for IAs are awarded; and (v) modify the QP and partial QP thresholds in accordance with the Consolidated Appropriations Act, 2026 (CAA, 2026).

B. Definitions[6]

CMS proposes to revise the definitions under §414.1305 of an APM incentive payment, collection type, high priority measure, MVP participant, and participation list. The terms and definitions are discussed in detail in the relevant sections below.

C. Transforming MIPS: MIPS Value Pathway (MVP) Strategy[7]

1. Overview and Background

CMS believes that transitioning from traditional MIPS to full MVP reporting (alongside the APP reporting) will support moving toward value-based payment. MVPs provide a cohesive set of

[6] This proposal was included as IV.A.2. in the rule.
[7] These proposals were included as IV.A.3. in the rule.

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 proposes, beginning with the 2029 performance period/2031 MIPS payment year, to sunset traditional MIPS reporting and require MIPS eligible clinicians participating in MIPS and not the APP to report the measures and activities in their selected MVP. This would mean there would be two reporting options in the QPP: MVPs and the APP. Clinicians not reporting the APP would be able to select an MVP relevant to their scope of care and further choose the quality measures and IAs within that MVP.

There are 27 existing MVPs and CMS is proposing three additional MVPs (discussed in section IV.D.1.a of this summary) for the 2027 performance period/2029 MIPS payment year, which together potentially represent coverage of 98 percent of specialties for MIPS eligible clinicians based on self-reported specialty designations and MVP topic. CMs reviews the history of the development of and timeline for full transition to the MVPs.

2. Proposal to Update Timeline for Full MVP Implementation[8]

CMS is concerned that maintaining the traditional MIPS reporting option may delay and deter adoption of MVPs. The agency proposes to maintain traditional MIPS reporting alongside the option of MVP reporting only through the 2028 performance period/2030 MIPS payment year, at which point clinicians will have had 6 years for voluntary MVP reporting, and CMS believes that period will have allowed clinicians to engage in the development of the MVP inventory, update their systems and work processes, and gain experience with MVP reporting.

CMS acknowledges that some clinicians may lack applicable measures and may not have an applicable MVP or a sufficient number of measures in an MVP. However, the agency believes it is on track to developing reporting options or exploring alternatives to address these issues by the 2029 performance period when full MVP implementation is being proposed.

Therefore, CMS believes it should move forward with full MVP implementation and proposes that beginning with the 2029 performance period/2031 MIPS payment year, all MIPS eligible clinicians (other than those reporting under the APP) must report through an MVP.

3. Proposal to Include Virtual Groups in MVP Reporting[9]

CMS proposes, beginning with the 2029 performance period/2031 MIPS payment year (same timing as for full MVP implementation) to allow virtual groups to participate in MVP reporting. CMS believes this timing would allow the agency to refine participation criteria and address potential barriers for virtual groups to participate in MVP. As part of the proposal to include virtual groups in MVP reporting, CMS would revise the definition of an MVP participant at §414.1305 to mean an individual MIPS eligible clinician, single specialty group, multispecialty

[8] This proposal is included in IV.A.3.c in the rule.
[9] This proposal is included in IV.A.3.d in the rule.

group that meets the requirements of a small practice, virtual group, subgroup, or APM entity that is assessed on an MVP in accordance with §414.1365 for all MIPS performance categories.

Since MVP participants must register during the performance period, the inclusion of virtual groups in MVP reporting would require them to register for MVP reporting (which would be in addition to the existing registration requirement to form a virtual group before the performance period). CMS notes that even with this proposal, clinicians in virtual groups would not be able to participate as subgroups because at §414.1305 a subgroup is limited to clinicians within a single TIN and virtual groups are composed of clinicians across multiple TINs.

D. QPP Reporting and Data Submissions[10]

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.[11]

1. MVP Development and Maintenance[12]

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 three new MVPs beginning for the 2027 performance period/2029 MIPS payment year. Details on these MVPs, including the specific measures included for each, are in Appendix 3: MVP Inventory, in the rule. The table below summarizes information included in the rule on the three proposed MVPs, showing for each a description of the clinician/condition focus.

MVPs Proposed for Addition		
MVP (Name)	**Focus/Applicability**	**Tables under Appendix 3 in the Proposed Rule**
Diabetic Disease	Assesses meaningful outcomes in diabetic disease care. Most applicable to clinicians who provide diabetic disease patient care, including primary care, endocrinology, ophthalmology, podiatry, and nonphysician practitioners (NPPs).	Tables under Group A.1 show measures and IAs proposed for inclusion, including 11 MIPS quality measures (4 core measures) and 2 QCDR measures, 13 IAs, and two cost measures.
Hospitalist	Assesses meaningful outcomes for patients receiving care by hospitalists. Most applicable to hospitalists, including NPPs.	Tables under Group A.2 show for proposed inclusion: 4 MIPS quality measures (3 core measures), 5 QCDR measures, 12 IAs, and one cost measure.

[10] These policies are included under section IV.A.4 of the rule.
[11] Data submission requirements are under §414.1325.
[12] These are included as section IV.A.4.a of the rule.

MVPs Proposed for Addition		
MVP (Name)	**Focus/Applicability**	**Tables under Appendix 3 in the Proposed Rule**
Hypertension	Assesses meaningful outcomes for patients receiving care for hypertension and appropriate preventive interventions for those considered high-risk. Most applicable to clinicians who treat patients at risk for hypertension and with a hypertension diagnosis, including cardiology, family medicine, geriatrics, internal medicine, nutrition and dietician, preventive medicine, and NPPs.	Tables under A.3 show for proposed inclusion: 13 MIPS quality measures (3 core measures), 11 IAs, and one cost measure.

b. MVP Maintenance Updates to Previously Finalized MVPs

There are currently 27 MVPs for the 2026 performance period/2028 MIPS payment year. CMS is proposing modifications to 23 of those MVPs by adding and removing measures and IAs based on the MVP development criteria. In addition, CMS proposes changes to all 27 MVPs to align each with the proposed implementation of MIPS core measures (discussed in section IV.A.4.d(1) of the rule). CMS also proposes to rename the Rehabilitative Support for Musculoskeletal Care MVP to instead be the Rehabilitative Support MVP.[13]

2. APM Performance Pathway (APP)[14]

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 an existing 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 one additional quality measures from the Adult Universal Foundation measure set and to which remaining Adult Universal Foundation measures are to be incrementally added by the 2028 performance period/2030 MIPS payment year.

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 D in Appendix 1 of the rule), CMS proposes to incorporate the measure

[13] Details on measures and activities (including proposed modification on measures and activities) within each of the current MVPs can be found in Group B of Appendix 3 in the rule.
[14] These proposals are included under the section IV.A.4.b of the rule.

specification changes proposed to the MIPS quality measures into the APP and APP Plus quality measure sets, specifically the proposed revisions to the Diabetes: Glycemic Status Assessment Greater Than 9% (Quality ID: 001), Preventive Care and Screening: Screening for Depression and Follow-up Plan (Quality ID: 134), and Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups (Quality ID: 479).

CMS also proposes to remove the Initiation and Engagement of Alcohol and Other Durg Dependence Treatment measure (Quality ID: 305) and Adult Immunization Status (Quality ID:493) from the APP Plus quality measure set because of operational issues impacting the development of the collection types that were finalized for the two measures.

The APP quality measure set for the APP beginning with the 2026 performance period/ 2028 MIPS payment year is shown in Table C-BC1 of the rule. The APP Plus quality measures set, as proposed beginning for the 2027 performance period/2029 MIPS payment year, is shown in Tables C-BC2 of the rule. Information from that table is provided below.

Proposed APP Plus Quality Measure Set Beginning for 2027 Performance Period/2029 MIPS Payment Year				
Qual. #	**Title**	**Collection Type**	**Submitter Type**	**Measure Type**
321	CAHPS for MIPS	CAHPs for MIPS survey	Third party intermediary (TPI)	Patient engagement/ experience
001	Diabetes: Glycemic Status Assessment Greater Than 9%	eCQM/MIPS CQM, Part B Claims (all APP reporters); Medicare CQM/ Medicare eCQMs (MSSP ACOs only)	MIPS eligible clinicians; Representative of a practice, APM entity, TPI	Intermediate Outcome
134	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	eCQM/MIPS CQM, Part B Claims (all APP reporters); Medicare CQM/ Medicare eCQMs (MSSP ACOs only)	MIPS eligible clinicians, Representative of a practice, APM entity, TPI	Process
236	Controlling High Blood Pressure	eCQM/MIPS CQM, Part B Claims (all APP reporters); Medicare CQM/ Medicare eCQMs (MSSP ACOs only)	MIPS eligible clinician, Representative of a practice, APM entity, TPI	Intermediate Outcome
479	Hospital-Wide 30-Day All-Cause Readmission Rate for MIPS eligible clinician groups	Administrative Claims	N/A	Outcome
112	Breast Cancer Screening	eCQM/MIPS CQM, Part B Claims (all APP reporters); Medicare CQM/ Medicare eCQMs (MSSP ACOs only)	MIPS eligible clinician, Representative of a practice, APM entity, TPI	Process
484	Clinician and Clinician Group Risk-Standardized Hospital	Administrative Claims	N/A	Outcome

Proposed APP Plus Quality Measure Set Beginning for 2027 Performance Period/2029 MIPS Payment Year				
Qual. #	**Title**	**Collection Type**	**Submitter Type**	**Measure Type**
	Admission Rates for Patients with Multiple Chronic Conditions			
113	Colorectal Cancer Screening	eCQM/MIPS CQM, Part B Claims (all APP reporters); Medicare CQM/ Medicare eCQMs (MSSP ACOs only)	MIPS eligible clinician, Representative of a practice, APM entity, TPI	Process

3. RFI: Fast Healthcare Interoperability Resources (FHIR)-Based Digital Quality Measurement[15]

CMS is transitioning existing quality measures and reporting process to FHIR-based digital quality reporting using digital quality measures (dQMs). The United States Core Data for Interoperability (USCDI)+ Quality Version 1 (V1) was released in 2026 and identifies a common set of quality-related data elements. The QPP and other CMS quality programs use clinical quality measures (CQMs) and electronic clinical quality measures (eCQMs). Reporting of eCQMs is supported through Quality Reporting Document Architecture (QRDA) files.

CMS seeks comment on the timeline, milestones, and implementation considerations for transitioning to FHIR-based quality reporting in the QPP and other CMS quality programs. Subject to future notice and comment rulemaking, the agency is developing a phased transition to FHIR-based digital quality reporting for applicable measures. Specifically, under this approach (using QPP as an example) there would be a two-year transition period beginning with the 2028 performance period/2030 MIPS payment year during which existing quality collection types for CQMs and eCQMs would continue to be available while FHIR-based dQM options are introduced for selected measures (both new and existing measures). After the transition period, FHIR-based reporting would be required for those applicable measures that were available as FHIR-based dQM collection types during the transition period (beginning with the 2030 performance period/2032 MIPS payment year). More specific timelines may vary by measure and program. CMS Innovation Center (CMMI) models may have separate requirements and timelines related to FHIR-based digital quality measurement and reporting.

Some of the specific areas on which CMS requests feedback include the following:

- Transition approach and design: Factors CMS should consider in determining the structure of the 2-year transition during which both FHIR-based reporting options and existing reporting options would be available; scoring implications that CMS needs to consider during the transition; ad how CMS should approach data submission criteria, completeness, and other elements.
- Factors affecting readiness for FHIR-based reporting: How readiness for adopting FHIR-based quality measurement and reporting varies across practice types, organizational

[15] This RFI is included under the section IV.A.4.c of the rule.

settings, and supporting health IT entities; the primary barriers and facilitators to adoption; how technology readiness and measure availability can be supported; approaches that would be most effective to help transition; and technical assistance and policy flexibilities that would be most helpful to solo practitioners, small practices and facilities, and those in rural or underserved areas.

- Technical Assistance: The technical assistance needed and whether support differs for entities with more complex reporting (such as multiple TIN ACOs or providers operating across multiple EHR systems.
- Any additional considerations.

MSSP ACOs are required to report the APP Plus quality measure set. As part of the RFI CMS seeks input on application of the phased transition (2-year transition period beginning with the 2028 performance period) for MSSP ACOs. Specifically, during the transition period existing quality reporting options for MSSP ACOs would continue to be available at the same time as FHIR-based dQM options are introduced for selected measures. After the transition period, FHIR-based reporting would be required for those measures that were available as FHIR-based dQM reporting options during the transition period. This means MSSP ACOs would need to be able to (by the 2030 performance period) report each applicable APP Plus measure through FHIR-based digital quality reporting if FHIR-based dQM specifications exist for the measure. Applicable existing reporting options would still be available for measures that do not have such dQM specifications until FHIR-based dQM options are adopted through future rulemaking.

E. MIPS Performance Categories, Measures, and Activities[16]

1. Quality Performance Category

a. Background

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.[17] CMS discusses the following policies related to the quality performance category.

b. Proposal to Update Definition of Collection Type

CMS proposes to amend the definition of the term "collection type" at §414.1305 to include Medicare eCQMs which are being proposed as a new collection type (i.e., set of quality measures with comparable specifications and data completeness criteria) available only to MSSP ACOs meeting the reporting requirements of the APP.

c. Proposals to Modify Quality Data Submission Criteria

Proposal to Designate MIPS Core Measures. CMS believes that the high number of quality measures from which clinicians can choose from in traditional MIPS reduces the standardization

[16] These proposals were included as section IV.A.4.d of the rule.
[17] See section 1848(q)(2)(A)(i) of the Act.

of performance data. MVPs reduce this number but still allow clinicians to choose four quality measures to report from measures included in the MVP. CMS would like to provide for more comparative clinicians' performance data.

CMS proposes, beginning with the 2027 performance period/2029 MIPS payment year, that clinicians reporting an MVP be required to select and report one quality measure from a subset of "core" quality measures in the MVP, which would count as one of the four required quality measures. For each MVP, CMS proposes to select a minimum of three core measures from the list of MIPS quality measures assigned to that MVP that are reflective of care that is unique to the MVP's specialty or medical condition.

CMS proposes the MIPS core measures would be selected based on the following factors:

- Whether the measure is outcome-based.
- Measure collection type availability and clinicians' ability to meet reporting requirements to the extent practicable. QCDR measures were not considered for core measure selection.
- Measure adoption and current and historic performance rates.
- Whether the measure is most reflective of care central to the clinical focus of the MVP, represents best practices, or addresses important areas for improving care.

Appendix 3: MVP Inventory in the rule shows the proposed MIPS core measures for each previously finalized MVP as well as for the proposed MVPs.

CMS further proposes that core measure designation would apply to quality measures in traditional MIPS as well as MVPs. Clinicians reporting through traditional MIPS would select from the complete inventory of available MIPS core measures for the performance period. The proposed MIPS core measure inventory includes over 70 quality measures and overlaps with the measures currently designated as high priority measures (and, as discussed below, CMS is proposing removal of that designation).

Appendix 1: MIPS Quality Measures of the rule includes details on the proposed core measures inventory for the 2027 performance period/2029 MIPS payment year.

Proposal to Remove High Priority Measure Designation and High Priority Quality Measure Retention Consideration. 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.

Given the agency's proposal for MIPS core measures, CMS is also proposing to remove the high priority designation from the MIPS quality measure inventory and MVP inventory. High priority designation is provided to quality measures that reflect agency-wide priorities, whereas the proposed MIPS core measure designations represent quality measures that reflect relevance to a specifical clinical specialty, medical condition, or episode of care. CMS believes since there is great overlap between the proposed core measures and high priority measures, agency-wide priorities would still be captured by the core measures selection alone.

In alignment with that proposal, CMS would no longer include the use of a high priority measure designation as a consideration for retaining a MIPS quality measure.

Proposal to Implement Data Submission Requirement for MIPS Core Measures. Currently, MIPS eligible clinicians reporting under traditional MIPS must report at least six quality measures, including at least one outcome measure (or, if an outcome measure is not available, one high priority measure) and an MVP participant (other than certain small practices) must report, if applicable, four quality measures, including one outcome measure (or, ig an outcome measure is not available, one high priority measure) included in the MVP, excluding the required population health measure.

CMS proposes, beginning with the 2027 performance period/2029 MIPS payment year, along with the MIPS core measures proposal, to also (i) remove the existing requirement under traditional MIPS and MVPs for submission of one outcome measure (or, if an outcome measure is not available, one high priority measure), and (ii) replace that requirement with a MIPS core measure data submission requirement. Specifically:

- If reporting under traditional MIPS, must submit data on at least six measures, including at least one MIPS core measure from the full inventory of available MIPS core measures for the performance period.
    - If reporting a specialty measure set in traditional MIPS, would need to report at least six measure and choose an applicable MIPS core measure, if available, within that specialty measure set; if the set has fewer than six measures (or fewer than six apply) then must report on each measure that is applicable; if the set does not have a MIPS core measure then must still report on at least six measures (or if there are fewer than six, on each applicable measure within the set).
- If reporting an MVP, must select and report, if applicable, four quality measures, including at least one MIPS core measure from those available in the MVP, excluding the required population health measure.

CMS proposes a MIPS core measure self-attestation process under which a clinician that does not have an available and applicable MIPS core measure that meets the numerator and denominator criteria would be required during the data submission period to attest to that lack of availability of such a core measure to report. The clinician would be required to choose a measure to report instead of the MIPS core measure (which could be any measure in the MIPS quality measure inventory for traditional MIPS reporting or in the MVP if reporting an MVP). If circumstances change in which a core measure becomes available after attestation, the clinician could then (after submission of the attestation) report on that MIPS core measure. CMS notes that in future years it may conduct random reviews to verify that there were no available and applicable MIPS core measures for reporting.

In both traditional MIPS and MVP reporting, CMS proposes that small practices be exempt from the MIPS core measure data submission requirement. Clinicians in small practices[18] would

[18] Small practices are defined under §414.1305.

continue to report six quality measures for traditional MIPS or four quality measures for MVPs (though small practices would be allowed to voluntarily report core measures if they chose).

Proposal to Modify Data Submission Criteria for Medicare CQMs. CMS proposes to amend the data submission criteria for the Medicare CQMs in §414.1335(a)(4) by specifying that a clinician could satisfy that submission criteria by reporting on the Medicare CQMs within the APP measure set or APP Plus measure set and administering the CAHPS for MIPS Survey. Currently, that section references the APP measure set but not also the APP Plus measure set.

Proposal to Implement Data Submission Criteria for Medicare eCQMs. For the proposed Medicare eCQMs collection type, CMS proposes to specify that a MIPS eligible clinician, group, and APM Entity reporting on the Medicare eCQMs (reporting quality data on beneficiaries eligible for Medicare eCQMs as defined at §425.20) within the APP Plus measure set (as applicable) and administering the CAHPS for MIPS Survey as required under the APP would meet the data submission criteria.

d. Proposal to Modify Data Completeness Criteria

Medicare CQMs. Under section III.G.3.c of the rule (which is discussed in the HFMA PFS proposed rule summary part II), CMS proposes extending the availability of the Medicare CQMs collection type and anticipating sunsetting the collection type starting with the 2030 performance period/2032 MIPS payment year when FHIR-based reporting would become mandatory. CMS proposes amendments to the language at §414.1340(d) for the data completeness criteria threshold for the Medicare CQMs to conform with that extension.

Medicare eCQMs. Under section III.G of the rule (which is discussed in the HFMA PFS proposed rule summary part II), CMS proposes the Medicare eCQM collection type as a new reporting option for MSSP ACOs, which would apply measures specifications to an ACO's assigned Medicare beneficiaries rather than all-payer. For the data completeness criteria for the proposed Medicare eCQMs, CMS proposes that an MSSP ACO be required to submit data on at least 75 percent of the APM entity's applicable beneficiaries eligible for the Medicare eCQM who meet the measure's denominator criteria.

e. 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

[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.

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 2027 performance period were included on the 2025 MUC list.[20]

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 be 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.

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 2027 performance period, CMS proposes an inventory of 10 MIPS quality measures.

- Table Group A of Appendix 1 shows the ten new MIPS quality measures being proposed, including measures focused on patient-reported outcomes and chronic disease management.
- Table Group B of Appendix 1 shows proposed modifications to existing specialty sets, including new measures and modified measures.
- Table Group C of Appendix 1 includes a list of 20 MIPS quality measures proposed for removal and the applicable rationale for each removal (two are extremely topped out, four have reached the end of the topped-out lifecycle, three are no longer maintained by the measure steward, eight are duplicative of new or current measure, one has no benchmark, one is a low bar process measure, and one lacks robustness).
- Tables Group D and Group DD of Appendix 1 show the 43 MIPS quality measures for which substantive changes are being proposed.

2. Cost Performance Category[21]

a. Overview

Beginning with the 2027 performance period/2029 MIPS payment year, for the cost performance category CMS proposes to update the operational list of care episode and patient condition groups and codes to reflect changes identified through annual maintenance of measures.

[20] The MUC list is available at *https://mmshub.cms.gov/sites/default/files/2025-MUC-List.xlsx*.
[21] Policies for the cost performance category are codified under §414.1350.

CMS refers to the goals of selecting cost measures 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 2026 performance period/2028 MIPS payment year, there are currently 35 cost measures in the cost performance category, including 33 episode-based measures and 2 population-based measures. For the 2027 performance period/2029 MIPS payment year, CMS is not proposing to adopt any new cost measures, remove any cost measures, nor make any substantive changes to any existing cost measures.

c. Proposed Update 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 episodes 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.

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 2027 performance period/2029 MIPS payment year, CMS proposes each of the following changes to the IA inventory.

[22] See section 1848(r)(2)(i)(I) of the Act.
[23] The current operational list and prior operational lists are available https://www.cms.gov/medicare/quality/value-based-programs/cost-measures/about.
[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).

New IAs. CMS proposes to adopt six new IAs:[27]

- Two for the Care Coordination subcategory: The Use of Data to Improve Practice Workflows and Understand and Improve Diagnostic Performance.
- Four for Advancing Health and Wellness subcategory: (i) Systematic Screening and Intervention for Nutrition and other Health-Impacting, Non-Clinical Issues, (ii) Advance Care Planning Conversations to Support Patient Wellness and Care Preferences, (iii) Clinician Use of Artificial Intelligence (AI) to Improve Patient Care, and (iv) Lifestyle Approaches to Diabetes Remediation.

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

- Combining each of the following IAs with elements of similar IAs in the inventory: IA_BMH_4 "Depression screening", IA_CC_8 "Implementation of documentation improvements for practice/process improvements", IA_CC_9 "Implementation of practices/processes for developing regular individual care plans", and IA_PM_4 "Glycemic management services".
- Modifying IA_PSPA_16 ("Use decision support—ideally platform-agnostic, interoperable clinical decision support (CDS) tools, including AI-enabled predictive decision-support interventions—and standardized treatment protocols to manage workflow on the care team to meet patient needs") to incorporate AI-enabled decision support and strengthen oversight requirements.

Removals. CMS proposes to remove eleven IAs under removal factor 1 or 7 – removal based on a determination that the IA is duplicative of another activity or obsolete.[28] The eleven IAs are: IA_BMH_5, IA_CC_10, IA_CC_11, IA_CC_12, IA_PSPA_2, IA_CC_16, IA_BE_15, IA_PM_19, IA_PM_20, IA_EPA_4, and IA_PM_2.[29]

4. Promoting Interoperability (PI) Performance Category

a. Background

The PI performance 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

Background. 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. CMS also reviews the HTI-5 proposed rule,[31] which proposed many updates to the ONC Health IT Certification Program, including deregulatory actions that would remove 34 certification criteria and revise 7 certification criteria. Table C-G1 in the 2027 PFS proposed rule describes the potential impacts the removals and revisions proposed in HTI-5 may have on MIPS eligible clinicians reporting the MIPS PI performance category and describes how the criteria subject to the HTI-5 proposals are incorporated into the definition of CEHRT.

The HTI-5 proposed changes would affect ONC health IT certification criteria included in the CEHRT definition, including in the following ways:

- Several proposals revise or remove specific ONC Health IT Certification Program certification criteria included within the base EHR definition, which is incorporated in the definition of CEHRT. Mening these proposed changes would remove the requirement that a MIPS eligible clinician must use CEHRT that includes health IT certified to the criteria that would be removed under the HTI-5 proposals.
- ONC proposed to remove 5 ONC health IT certification criteria specified in the text of the definition of CEHRT ((i) family health history, (ii) patient health information capture, (iii) automated numerator recording, (iv) automated measure calculation, and (v) clinical quality measures – filter).
- Several proposals remove or revise other certification criteria that directly support certain MIPS PI performance category measures.
- ONC proposed to remove a series of criteria related to privacy and security functionality, most of which are included in the Health IT Module certification requirements.

Proposal. CMS proposes to amend the definition of CEHRT in §414.1305 to align the definition with applicable ONC proposals to remove and revise certain ONC health IT certification criteria, as proposed in the HTI-5 proposed rule. Specifically, CMS proposes to remove references to the following five certification criteria beginning for the 2027 performance period/2029 MIPS payment year: (i) family health history, (ii) patient health information capture, (iii) automated numerator recording, (iv) automated measure calculation, and (v) clinical quality measures – filter. This proposal would not be contingent upon the final actions that ONC makes regarding their proposals in the HTI-5 proposed rule. Meaning, a MIPS eligible clinician's EHR technology would no longer be required to meet the first four named certification criteria and the fifth named criterion would no longer be included as optional.

c. Proposal to Remove ONC Direct Review and ONC-Authorized Certification Bodies (ACB) Surveillance Attestations

Currently, the ONC Direct Review attestation is a required element of the PI performance category. A MIPS eligible clinician must attest that, if requested, they cooperated in good faith

[31] Health Data, Technology, and Interoperability: ASTP/ONC Deregulatory Actions to Unleash Prosperity proposed rule (90 FR 60970).

with ONC direct review of their health IT certified under the ONC Health IT Certification Program as authorized by 45 CFR part 170, subpart E, to the extent that such technology meets (or can be used to meet) the definition of CEHRT. In addition, there is an optional attestation (ONC-ACB Surveillance attestation) that acknowledges the option to cooperate in good faith with ONC-ACB surveillance of health IT certified under the ONC Health IT Certification Program if a request to assist in ONC-ACB surveillance is received.

CMS proposes to remove the required ONC Direct Review attestation and the optional ONC-ACB Surveillance attestation beginning with the 2026 performance period/2028 MIPS payment year. The agency believes that the administrative burden associated with these attestations outweighs their value compared to when the attestations were originally adopted.

d. Proposal to Remove Security Risk Analysis Measure

Background. The HIPAA Security Rule[32] 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" to both of the following (i) whether they have conducted or reviewed a security risk analysis in compliance with the HIPAA Security Rule, and (ii) to having implemented security measures sufficient to reduce risks and vulnerabilities to a reasonable and appropriate level as required by the HIPAA Security Rule implementation specification for risk management. If a "no" is submitted for either, 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 to remove the Security Risk Analysis measure beginning with the 2027 performance period/2029 MIPS payment year to reduce reporting burden. CMS believes that since MIPS eligible clinicians are covered entities under the HIPAA Security Rule, removal of the measure will not weaken any cybersecurity requirements for MIPS eligible clinicians.

e. Proposal to Adopt New Electronic Prior Authorization for Prescription Drugs Measure

The 2026 CMS Interoperability Standards and Prior Authorization for Drugs proposed rule includes proposals that would require impacted payers[33] to support electronic prior authorization (PA) for all drugs that require PA.[34] The 2024 CMS Interoperability and Prior Authorization

[32] 45 CFR part 160 and subparts A and C of part 164.
[33] Impacted payers include Medicare Advantage organizations, state Medicaid and CHIP FFS programs, Medicaid managed care plans, CHIP managed care entities, and Qualified Health Plans offered on the Federally-facilitated Exchanges.
[34] 91 FR 19890.

final rule finalized adoption of the electronic prior authorization measure into MIPS.[35] That measure assesses MIPS eligible clinicians on the use of a PA application programming interface (API) to request PA for medical items and services (but not prescription drugs). CMS believes standards-based electronic PA would improve timeliness and transparency of medication access and therefore believes that including electronic PA for prescription drugs is an appropriate aspect of demonstrating meaningful use of CEHRT.

CMS therefore proposes to adopt the electronic prior authorization for prescription drugs measure for the PI performance category (within the HIE objective) beginning with the 2028 performance period/2030 MIPS payment year. The proposed specifications for the measure include the following:

- Measure Description: For at least one prescription drug (for which PA is required) ordered by the MIPS eligible clinicians during the performance period, the PA is requested electronically using CEHRT.
- Reporting Requirement: To successfully report the measure (i.e., in order to earn a score for the PI performance category), the clinician must submit a "Yes" response or (if applicable) claim an exclusion. Submission of "no" response or failure to submit an attestation (without claiming an applicable exclusion) would result in score of zero for the PI performance category and not being considered a meaningful EHR user.
- Exclusions: MIPS eligible clinicians who do not prescribe drugs that require PA, only prescribe drugs requiring PA where the payer does not support the specified electronic PA standard, or prescribe fewer than 100 permissible prescription drugs (any, not only those requiring PA) during the performance period.
- Application: The measure would apply to prescription drugs covered under a pharmacy benefit, defined by whether PA can be authorized using the NCPDP SCRIPT standard. Drugs covered under a medical benefit (i.e., generally using FHIR-based electronic PA processes) are not in scope of the proposed measure.

Adoption of the proposed electronic prior authorization for prescription drugs measure is not contingent upon finalization of the proposals in the 2026 CMS Interoperability Standards and Prior Authorization for Drugs proposed rule.

f. Proposals to Modify Electronic Prior Authorization Measure

Beginning with the 2027 performance period/2029 MIPS payment year, MIPS eligible clinicians (under existing policy) are required to attest to the electronic prior authorization measure, and once the measure becomes effective as a required measure in the PI performance category MIPS eligible clinicians will be required to satisfactorily report on the measure. The previously finalized measure specifications and related policies are as follows:

- Measure Description: For at least one medical item or service (excluding drugs) ordered by the MIPS eligible clinician during the performance period, the PA is requested electronically from a PA API using data from CEHRT.
- Exclusions: MIPS eligible clinicians who do not order any medical items or services (excluding drugs) requiring PA during the performance period or only order medical

[35] 89 FR 8909 through 8927.

items or services (excluding drugs) requiring PA from a payer that does not offer an API that meets CMS' PA API requirements.

- Reporting and Scoring: Not scored (i.e., not assigned points for successful completion) for 2027 performance period/2029 MIPS payment year. Satisfactory performance demonstrated by submitting a "yes" response or claiming an applicable exclusion. If submit "no" response or fail to submit any attestation response (and do not claim applicable exclusion) receive a score of zero for PI performance category and not considered meaningful EHR user.

CMS proposes to modify the measure description for the electronic prior authorization measure for the 2027 performance period/2029 payment year so that it would instead specify that (i.e., provider could submit "yes" response if) for at least one medical item or service (excluding drugs) ordered by the MIPS eligible clinician during the performance period, the PA is requested electronically through a PA API using CEHRT. The difference from the current description is that instead of "using data from CEHRT" it would say "using CEHRT" to clarify that certified Health IT modules must be used to complete the action specified in the measure.

CMS further proposes, beginning with the 2028 performance period/2030 MIPS payment year, to include in the measure description a complete set of actions necessary to support PA and require use of Health IT modules certified to the ONC health IT certification criteria at paragraphs (31), (32), and (33) of 45 CFR 170.315(g). Specifically, the measure description would specify that (i.e., provider could submit "yes" response if) for at least one medical item or service (excluding drugs) ordered by the MIPS eligible clinician during the performance period, the MIPS eligible clinician uses CEHRT to electronically request *and receive coverage requirements, request and populate prior authorization documentation using templates and rules, submit the prior authorization request, and receive the payer response through a provider PA API.*[36] This would mean that the following actions would be required within the same PA request to meet the measure requirement: (i) electronically request and receive coverage requirements, (ii) request and populate PA documentation using template and rules, (iii) submit PA request, and (iv) receive the payer response.

If the proposal is finalized to require an electronic PA to be requested using CEHRT in order to meet the electronic prior authorization measure, then CMS would require the following:

- For the 2027 performance period/2029 MIPS payment year, such CEHRT used for those requests must include utilization of one or more Health IT Modules certified to the ONC health IT certification criterion under paragraph (31), (32), or (33) of 45 CFR 170.315(g). CMS provides examples of how a clinician could successfully report on the measure using CEHRT that includes a Health IT Modules certified to only one criterion or different combinations of criteria.
- For the 2028 performance period/2030 MIPS payment year, such CEHRT used for those requests must include utilization of all three Health IT Modules certified to the criterion under all three of those paragraphs. The three criteria under those paragraphs are based on the HL7 Da Vinci CRD, DTR, and PAS IGs, and address different parts of the electronic prior authorization workflow (i) enabling a provider to request information

[36] Substantive (but not conforming) proposed changes for the 2028 performance period compared to the proposed description for the 2027 performance period are marked in italics.

from payers about coverage requirements; (ii) providing mechanism for providers to assemble documentation needed to support a PA request according to payer's requirements, and (iii) enabling submission of PA requests from health IT systems and checking status of previous request).

In addition, CMS proposes that for the 2027 performance period/2029 MIPS payment year (the first year of the measure's inclusion), reporting the measure would be optional (instead of required, as previously finalized). For that performance period/payment year, submitting a "yes" response for the proposed revised measure would make the clinician eligible for 10 bonus points. For that performance period/payment year, submitting a "no" response would not have an effect on the score for the PI performance category.

CMS proposes to push back inclusion of the measure as a required measure by one year. This means that beginning with the 2028 performance period/2030 MIPS payment year, a MIPS eligible clinician must submit a "yes" response or claim an applicable exclusion to satisfy the measure. Consistent with the reporting requirements previously finalized, the measure would not affect the total score for the PI performance category, but if the clinician (i) submits a "no" response or (ii) fails to submit any attestation without claiming an applicable exclusion, the clinician would receive a score of zero for the performance category and would not be considered a meaningful EHR user.

Finally, CMS issues an **RFI for future potential performance-based measures of electronic prior authorization**. CMS seeks comments on potential future updates to the electronic prior authorization measures to encourage MIPS eligible clinicians to use CEHRT for electronic PA for a more substantial set of electronic PA requests, including on barriers and challenges that clinicians in small, rural, or under-resourced practices may face as well as alternative approaches to support the use of electronic PA.

g. Proposals to Modify Requirements and Scoring Policies for PI Performance Category

To show the requirements that would be required for the PI performance category for the 2027 performance period/2029 MIPS payment year and subsequent performance periods/MIPS payment years, including reflecting its proposals, CMS provides several tables spanning multiple pages, including the following. The tables specifically reflect changes (including modifications to scoring) resulting from the following proposals discussed above: (i) Beginning with 2026 performance period, removal of ONC Direct Review and ONC-ACB Surveillance attestations; (ii) For 2027 performance period, removal of Security Risk Analysis and making electronic prior authorization optional; and (iii) Beginning with 2028 performance period, making electronic prior authorization required and adopting new electronic prior authorization for prescription drugs measure.

- Table C-G2: Proposed Objectives and Measures for the PI Performance Category for the 2027 Performance Period, 2028 Performance Period, and Subsequent Periods. For each measure, this table shows the objective, numerator and denominator (if measure is not Y/N), and any exclusions.

- Tables C-G3, C-G1020, and C-G1021: Proposed Scoring Methodology for the 2026 Performance Period, 2027 performance period, and 2028 and subsequent performance periods, respectively. For each measure and performance period, these tables show the objective, maximum points, and whether the measure is optional or required.
- Table C-G6: Summary of Proposed Requirements for PI Performance Category for Performance Periods 2026, 2027, and 2028 and Subsequent Periods: Summarizes the required measures and attestations for each of the performance periods.
- Table C-G7: Proposed Exclusion Redistribution for the 2027 Performance Period. For each measure, this table shows the objective and the redistribution policy (i.e., how points would be redistributed) if an exclusion is claimed. If a MIPS eligible clinician believes an exclusion for a measure (shown in Table C-G2) applies to them, they may claim it when they submit their data. The maximum points available in Table C-G7 do not include the points that will be redistributed based on an exclusion claimed.
- Table C-G8: 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, and changes to such criteria if HTI-5 proposals are finalized.

Information from Table C-G6 is shown below.

Summary of Proposed Requirements for PI Performance Category for the 2026 Performance Period (PP) and Performance Periods

Objective	Measure	2026 PP	2027 PP	2028 and Subsequent PPs
Electronic Prescribing	e-Prescribing	Required (10 pts)	Required (10 pts)	Required (10 pts)
	Query of PDMP	Required (10 pts)	Required (10 pts)	Required (10 pts)
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	Required (30 pts for selected option)	Required (30 pts for selected option)	Required (30 pts for selected option)
	Support Electronic Referral Loops by Receiving and Reconciling Health Information			
	-OR-			
	Health Information Exchange Bi-Directional Exchange			
	-OR-			
	Enable Exchange under TEFCA			
	Electronic Prior Authorization	--------	Optional (10 bonus pts)	Required (not scored)*
	Electronic Prior Authorization for Prescription Drugs	--------	--------	Required (not scored)*
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	Required (25 pts)	Required (25 pts)	Required (25 pts)
Public Health and Clinical Data Exchange	Report the following two measures: • Immunization Registry Reporting • Electronic Case Reporting	Required (25 pts)	Required (25 pts)	Required (25 pts)
	Report one of the following measures: • Public Health Registry Reporting • Clinical Data Registry Reporting	Optional (5 bonus pts)	Optional (5 bonus pts)	Optional (5 bonus pts)

Summary of Proposed Requirements for PI Performance Category for the 2026 Performance Period (PP) and Performance Periods				
Objective	**Measure**	**2026 PP**	**2027 PP**	**2028 and Subsequent PPs**
	• Syndromic Surveillance Reporting • Public Health Reporting Using TEFCA			
Protect Patient Health Information	Security Risk Analysis	Required (not scored)*	--------	--------
	High Priority Practices SAFER Guide	Required (not scored)*	Required (not scored)*	Required (not scored)*
No Associated Objective: Attestation Requirements	Actions to Limit or Restrict the Comparability of CEHRT	Required (not scored)*	Required (not scored)*	Required (not scored)*
* Measures/attestations that are required but not scored do not have associated points, but failure to fulfill the requirement will result in a zero score for the PI performance category.				

F. MIPS Final Score Methodology[37]

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 2026 performance period/2028 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.

2. Scoring the MIPS Quality Performance Category

Proposal for Scoring MIPS Core Measures. As part of its MIPS core measure proposal (discussed above), CMS proposes the following changes to its quality performance scoring policy.

Beginning for the 2027 performance period/2029 MIPS payment year, for scoring the quality performance category for clinicians not part of a small practice, the MIPS core measure would be included as one of the six measures required for traditional MIPS or one of the four measures required for MVP reporting. Clinicians attesting to not having an applicable and available core measure would need to report enough measures to meet the required number of six (for traditional MIPS) or four (for MVPs).

CMS would use the highest scoring six or four measures, respectively, to determine the quality performance category score. If an attestation of no available/applicable core measure is submitted during data submission and a MIPS core measure (later becoming available) is also

[37] These policies were included as section IV.B in the rule.

reported, CMS would score the core measure as one of the required measures. If data for more than one core measure is reported, CMS would use the highest scoring core measure as one of the six or four (as applicable) required measures and the remaining scored measures used would consist of the next five highest or three highest (as applicable) scoring measures. If a MIPS eligible clinician (except clinicians in a small practice) reporting traditional MIPS or MVP does not submit a MIPS core measure and does not attest during data submission to not having an available and applicable core measure, CMS proposes to assign zero measure achievement points for one quality measure (consistent with existing policy under §414.1380(b)(1)(i).

Clinicians in small practices would be exempt from the core measurement requirement. If a small practice chooses to submit data for a core measure, CMS would include the measure in the quality performance score only if the measure is one of the six highest scoring measures in traditional MIPS or one of the four highest for MVPs.

Scoring for Topped Out Measures in Specialty Measure Sets and MVPs 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.[38] 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.

As previously finalized, measures in specialty measure sets and MVPs impacted by limited measure choice are not subject to the 7 measure achievement point cap.[39] CMS identifies and publishes in the Federal Register on an annual basis the measures for which a defined topped out measure benchmark will apply. To identify the list of measures impacted by limited measure choice and subject to topped out measure benchmarks, CMS reviews each specialty measure set and MVP 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. CMS makes this determination by analyzing the ability of clinicians reporting the specialty measure sets and MVPs to reasonably achieve 75 percent of available quality achievement points based upon the measures available to them and program requirements.

Proposed Measures Impacted by Limited Measure Choice to be Subject to Defined Topped Out Benchmark. Table C-H1 in the rule shows the list of 17 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 2027 performance period/2029 MIPS payment year. The list includes measure IDs 127, 144, 145, 249, 250, 351, 360, 364, 395, 396, 397, 405, 406, 430, 440, 463, and 477.

[38] Topped out measures are defined in §414.1305 differently for process versus non-process measures.
[39] 89 FR 98429 through 98435.

Proposal to Score Topped Out MIPS Core Measures According to Defined Topped Out Benchmark. There are 19 proposed MIPS core measures (see Appendix 1) that are topped out and subject to the 7-point topped out measure scoring cap for the 2026 performance period/2028 MIPS payment year. CMS is concerned that the combination of limited measures choice and the 7-point cap to topped out MIPS core measures would penalize clinicians for complying with the proposed reporting requirements. Therefore, CMS proposes that MIPS core measures in their second or more consecutive year of being topped out would not be subject to the 7-point topped out measure scoring cap and instead the measure would be scored from 1 to 10 measure achievement points according to the existing defined topped out benchmark calculation (i.e., defined topped out benchmarks are 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).

Clarification on Scoring Non-Topped Out Measures. CMS clarifies that if a measure previously finalized for removing the 7-point cap is no longer topped out (for instance, based on updated benchmark data for that performance period), it would be scored using its historical benchmark instead of the topped-out measure benchmark.

Proposal to Modify Location for Publishing List of Measures Subject to Defined Topped Out Benchmark. Currently, the list of topped out measures impacted by limited measure choice is annually published in the Federal Register. CMS is concerned that publication before the benchmark information for the performance period is available can lead to confusion with outdated data. CMS therefore proposes, beginning for the 2027 performance period/2029 MIPS payment year, to instead publish the list annually on the QPP website at www.https//qpp.cms.gov not later than the publication of the proposed rule for the performance period/MIPS payment year. This way CMS could update the list, once the benchmark information for the performance period becomes available, to remove measures that are no longer topped out based on the most current benchmarks published in the performance period. Once the list is finalized during rulemaking, the only changes to the list would be such removals.

3. Scoring the Quality Performance Category for Medicare Shared Savings Program (MSSP) ACOs

Proposal to Use Flat Benchmarks to Score MSSP ACOs Reporting Medicare CQMs. As previously finalized, beginning in the 2025 performance period, measures of the Medicare CQM collection type are scored using flat benchmarks for their first two performance periods in MIPS. As described in section III.G.3.c of the rule (discussed in the HFMA PFS proposed rule summary part II), CMS proposes to extend the use of flat benchmarks to score all Medicare CQMs (not just those in their first two years of MIPS) for the 2026 performance period and subsequent performance periods. This proposal involves retroactively applying flat benchmarks to Quality IDs 001, 134, and 236 if reported via the Medicare CQMs collection type for the 2026 performance period. CMS proposes conforming changes to the MIPS regulations at §414.1380(b)(1)(ii)(F).

Proposal to Use Flat Benchmarks to Score MSSP ACOs Reporting Medicare eCQMs. As described in section III.G.3.d(3) of the rule (discussed in the HFMA PFS proposed rule summary part II), CMS proposes flat benchmarks for measures within the proposed Medicare eCQMs collection type reported by MSSP ACOs, beginning with the 2027 performance period. CMS proposes conforming changes to the MIPS regulations by adding a new §414.1380(b)(1)(ii)(G).

4. Scoring the PI Performance Category

Currently, when reporting any number of optional measures, the total number of possible bonus points that can be earned is five bonus points. The optional measures available for reporting are not identified by objective, but all of the current ones are under the Public Health and Clinical Data Exchange objective.

To account for the allocation of the proposed bonus points specific to the electronic prior authorization measure for the 2027 performance period/2029 MIPS payment year, CMS proposes changes to the scoring methodology for optional measures to reflect the following:

- Beginning for the 2026 performance period/2028 MIPS payment year, an allocation of five bonus points when reporting one, more than one, or all optional measures available under the Public Health and Clinical Data Exchange objective bonus (Syndromic Surveillance Reporting, Public Health Registry Reporting, Clinical Data Registry Reporting, and Public Health Reporting Using TEFCA); and
- In addition, for the 2027 performance period/2029 MIPS payment year only, an allocation of a total of 10 bonus points when reporting the optional electronic prior authorization measure available under the HIE objective, but only for the 2027 performance period/2029 MIPS payment year.

5. MVP Scoring RFI

CMS seeks feedback on a number of areas of inquiry and questions regarding the future of MVP scoring, some of which include the following:

- A scoring methodology that would help to ensure appropriate comparisons between clinicians participating in different MVPs; questions include if CMS should consider normalizing score prior to MIPS payment adjustment determination and if so, various questions on how such normalization could be applied and impacts.
- Any additional scoring methodologies or approaches to ensure fairness within and across MVPs.
- Consideration of providing larger positive payment adjustments for high performing clinicians under MVP reporting, including impacts on those receiving negative payment adjustments because of budget-neutrality requirement.
- Ways to better support scoring transparency and predictability.

G. Third Party Intermediaries (TPI) General Requirements[40]

1. Proposed Clarification that Health IT Vendors Can Not Submit Data and Preexisting Requirements No Longer Apply

In the 2024 PFS final rule, CMS eliminated health IT vendors from the category of TPI in the QPP beginning with the 2025 performance period. Consequently, if an organization that was under the health IT vendor category as a TPI would like to continue serving as a TPI for the QPP, they must meet requirements to become a qualified registry or QCDR. Additional requirements for health IT vendors submitting data for the MIPS performance category, however, were left under §414.1400(c)(1) and has caused confusion. To address confusion and provide clarification, CMS proposes to amend the regulatory text to clarify that those additional requirements for health IT vendors only apply through the 2024 performance period, when health IT vendors were a separate type of TPI, and to add that beginning with the 2025 performance period, health IT vendors cannot submit MIPS data unless they meet the requirements for a qualified registry or QCDR.

2. Conditions for Approval

a. Proposal to Provide Performance Feedback Reports at Level of Data Submitted

CMS proposes to add at §414.1400(b)(3)(iii) that QCDRs or qualified registries must provide required performance feed at the level at which the data had been or will be submitted (e.g., individual, group, virtual group, subgroup, APM entity). This would codify requirements that were previously established but not codified in the 2017 QPP final rule QCDRs and qualified registries to provide feedback at the level at which data are submitted.[41]

b. Proposal to Update Sampling Methodology for Data Validation

Current QCDR and qualified registry data validation audit sampling methodology requirements at §414.1400(b)(2)(v)(E) require the following:

- Intermediary must submit a sample size of at least 3 percent of a combination of the individual MIPS eligible clinicians, groups, virtual groups, subgroups and APM entities for which the QCDR or qualified registry will submit data to CMS, except the sample size has to be a combination of at least 10 and not more than 50.
- Intermediary must use a sample that includes at least 25 percent of patients of each individual clinician, group, virtual group, subgroup, or APM entity in the sample, except the sample for each must include at least 5 patients and need not include more than 50 patients.

CMS proposes to update those requirements by specifying:

- If the intermediary submits MIPS data to CMS for fewer than 10 QPP participants, the data validation audit sample must include all QPP participants. If the intermediary

[40] These policies are included as section IV.H in the rule.
[41] 81 FR 77367-77374 and 77383-77387.

submits data for 10 or more QPP participants, the current requirement (described in the first bullet point above) would apply.

- If there are fewer than 5 patient records from a QPP participant, the patient record audit sample must include all patient records. If there are 5 or more patient records, the current requirement (described in the second bullet point above) would apply.

c. Proposal to Require Submission of Self-Nomination Plan for TPIs that Do Not Submit Data for One Year

CMS continues to be concerned about QCDRs and qualified registries that do not submit data but are still being listed on the qualified posting. Currently, an approved QCDR or qualified registry must submit a participation plan (for CMS approval) if they do not submit data for either 2 years preceding the applicable self-nomination period. CMS proposes, beginning with the 2027 performance period/2029 MIPS payment year, to require an approved QCDR or qualified registry to instead submit a participation plan (for CMS approval) if they do not submit data for the year preceding the applicable self-nomination period.

d. Proposal to Update Qualified Posting

CMS annually publishes on the CMS website a qualified posting containing a list of all CMS-approved TPIs that have self-nominated to submit data on behalf of MIPS eligible clinicians for the performance period. CMS has become aware that certain TPIs are making changes to information provided for their qualified posting after receiving CMS approval of the posting. Therefore, CMS proposes to require that changes to information on the qualified posting must be included and finalized during the qualified posting review period and not after the qualified posting is publicly posted on the QPP Resource Library page.

e. Proposal to Update CMS Data Submission Requirements for TPIs

To align TPI requirements with the agency's proposals for MIPS core measure and removal of high priority designation of quality measures, CMS proposes that beginning with the 2027 performance period/2029 MIPS payment year, a QCDR or qualified registry must be able to submit to CMS data for at least six quality measures including at least one MIPS core measure.

3. Remedial Action and Termination of TPIs[42]

In order to shorten the timeline of when CMS becomes aware that a TPI does not submit any data and when CMS consequently terminate the TPI's status, the agency proposes it would request, before the end of the calendar year for a given MIPS performance period, documentation that the TPI has contracted with QPP's participants who will submit MIPS data for the given MIPS performance period. If the documentation cannot be provided by the date specified by CMS, the TPI's status would be terminated. This would enable CMS to terminate the TPI's status during the applicable performance period year instead of having to wait until the following year.

[42] Regulations for remedial action and termination are under §414.1400(e).

H. Calculating Final Score[43]

1. Proposal to Use Alternative Data Sources to Determine Clinician Eligibility for Automatic Extreme and Uncontrollable Circumstances (EUC)

Performance category weights may be redistributed to another performance category if MIPS eligible clinicians are subject to, or located in an area affected by, an EUC. There are two forms through which an EUC reweighting may be applied – through an approved application-based EUC reweighting request or automatic reweighing for a clinician identified as located in a CMS designated region affected by an EUC, such as a FEMA-designated major disaster or public health emergency determined by the Secretary. CMS identifies clinicians based on practice location address listed in the Provider Enrollment, Charin and Ownership System (PECOS). CMS has observed use of PECOS data has resulted in clinicians being incorrectly excluded from the automatic EU policy because of inaccurate or outdated address data.

Therefore, CMS proposes that beginning with the 2027 performance period/2029 MIPS payment year, CMS will use the most current and reliable data available to determine if an individual MIPS eligible clinician is located in an area affected by an EUC.

2. Proposal to Update Deadline for Clinicians to Inform CMS that TPI Did Not Submit Data

CMS proposes to change the deadline by which clinicians are able to submit reweighting requests for the quality, IA, and PI performance categories due to cases where a TPI did not submit data on their behalf in accordance with data submission deadlines. Beginning with the 2025 performance period/2027 MIPS payment year, clinicians would be able to submit reweighting requests on or before December 31st of the year before the relevant MIPS payment year.

I. Public Reporting[44]

1. Proposal to Remove Public Reporting Requirements for MVPs at §414.1395(c)(2)

Currently, CMS does not publicly report any MVP data, or MIPS performance data reporting through an MVP, on a new IA or PI measure, objective, or activity for the first year it is included in an MVP. Since adoption of that policy, CMS has observed there have not been enough new PI measures or IAs included in MVPs to provide enough data to continue supporting the policy. Therefore, CMS proposes to remove its current policy of not publicly reporting MVP data on new IAs and PI measures, objectives, and activities during the first year included in an MVP, and to instead include all eligible performance information for new IAs and PI measures in public reporting on the Compare Tools.

[43] These proposals are included in section IV. D of the rule.
[44] These proposals are included in section IV.E of the rule.

2. RFI: Star Rating Assignment Methodology for Administrative Claims Quality Measures

MACRA requires the continuous public display of individual MIPS eligible clinician and groups' performance information in an easily understandable format on the CMS Compare Tool on Medicare.gov. CMS uses a 5-star rating based on a benchmark as part of this public reporting.

CMS is looking into improvements to the star rating assignment methodology for administrative claims quality measures, specifically to provide a more easily understandable distribution of the measure scores on clinician profile pages for patients through the Compare Tool. Currently, CMS calculates star rating cutoffs for the Achievable Benchmark of Care (ABC) 5-star methodology through an equal ranges method for a subset of MIPS quality and PI measures. This method is based on the difference between an established ABC methodology benchmark and the lowest performance score for a measure and the range is used to assign star ratings of one to four star. Clinicians who meet or exceed the ABC benchmark receive five stars for the measure.

CMS is interested in a new option that would instead assign star ratings using a standard-deviation-based approach for administrative claims quality measure scores. CMS may also consider extending this method for cost measures on clinician profile pages as well since cost measure scores are also automatically calculated and risk-adjusted using administrative claims data.

CMS requests comments on the following topics:

- The current star rating assignment methodology and whether the agency should change the process for administrative claims quality measures.
- Transitioning the current methodology to a standard deviation-based methodology for administrative claims quality measures.
- Applying a standard deviation-based methodology to public reporting of cost measures.
- Any unintended consequences or impacts to providers or patients CMS should consider before proposing changes to the star rating assignment methodology for the administrative claims collection type.

J. Advanced APMs[45]

1. Qualifying APM Participant (QP) Determinations

a. 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.[46] A QP performance period is from January 1 through August 31 of the year that is 2 years prior to the payment year. If an eligible clinician is included on such a list on any such snapshot date, the clinician is included in the APM entity group. Thresholds scores for QP determinations are calculated by the payment amount method and patient count method. If the Threshold Score (using either method) meets or exceeds the relevant QP threshold

[45] Note that these proposals are included under section IV.E.5 of the rule.
[46] The QP determination policy is under §414.1425.

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. As finalized in the 2026 PFS final rule (90 FR 50012), (i) each eligible clinician receives both an APM entity-level calculation and an individual-level calculation for the QP determination; and (ii) QP determinations are performed using both an E/M services approach and a covered professional services approach.

b. Applying QP Determinations at TIN/NPI Level

CMS applies QP status at the NPI level, such that for a given eligible clinician (NPI), if one of their TIN/NPI relationships is determined to be a QP, then QP status applies to all of their TIN/NPI relationships for purposes of being excluded from MPS and the application of QP financial incentives. CMS has paid the APM incentive payments by prioritizing sending the lump sum to TINs participating in advanced APMs but allowing payment to be sent to other, non-participating TINs if that was the only place it could find the clinician active at the time of payment.

Beginning with payment year 2026, QPs will receive a higher qualifying conversion factor update than non-QPs on their covered professional services claims – meaning that a QP financial incentive will go directly to TINs in the form of claims payment. CMS is concerned that under the current policy of applying QP status at the NPI level, a significant proportion of incentives paid for QP status with the higher conversion factor update will be paid to TINs that are not part of an Advanced APM.

CMS therefore proposes to apply QP and partial QP status strictly to an eligible clinician at the TIN that is participating with the APM entity in the Advanced APM so that the financial incentives in the form of both the APM incentive payment and the QP conversion factor would apply to the NPI's claims only with those TINs, and the ability of a partial QP to opt into or out of MIPS would similarly apply with respect to those TINs (i.e., partial QPs would opt out of MIPS at the TIN/NPI level).

If the eligible clinician attains QP status at the individual level from participation in multiple APM entities, CMS would assign QP status at each of the clinician's TINs participating across those APM entities. If the clinician attains QP status not at the individual level but as part of a specific APM entity level determination, QP status would be assigned to the clinician only at the TIN associated with the APM entity or entities that collectively attained QP status. The same preference for highest status would apply for partial QP status. This would maintain the policy to give the clinician the highest possible outcome available to them. CMS recognizes this proposal would at times result in some eligible clinicians being a QP with one TIN and participating in MIPS with another TIN.

2. <u>Clarification for APMs without a Participation List</u>

The existing definition of "participation list" at §414.1305 does not expressly address the circumstances in which an APM does not require or generate a participation list for its APM entities. CMS proposes to clarify that in cases where a participation list is not operationally practicable, it would not include those APMs for MIPS scoring or QP determinations.

3. APM Incentive Payment

Section 1833(z)(1) of the Act establishes an incentive payment for participation in eligible payment models. The incentive payment was initially enacted as a temporary annual incentive through payment year 2024 in a lump sum amount equal to 5 percent of the estimated aggregate payments for covered professional services furnished during the year preceding the payment year. Congress has repeatedly extended the incentive payment, though at different percents, resulting in the statute specifying 5 percent for payment years 2019 through 2024, 3.5 percent for payment year 2025, and 1.88 percent for payment year 2026. The CAA, 2026 provided for a 3.1 percent APM incentive payment in payment year 2028. There is no statutory incentive payment in 2027.

CMS proposes to codify in regulation the most recent legislative extension of the incentive payment for payment year 2028.

4. QP and Partial QP Thresholds

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 (or partial QP). There are two options under which level of participation can be determined: (i) the Medicare option, which is based on part B payments for covered professional services or counts of patients furnished covered professional services under part B, and (ii) the all-payer combination option, through which QP status is calculated using the Medicare option plus the clinician's participation in other payer advanced APMs. Congress has repeatedly extended the thresholds (and delayed implementation of increased thresholds) so that the thresholds from payment 2022 are in effect through payment year 2026. CAA, 2026 extended the 2026 thresholds for payment year 2028, but did not extend those thresholds (i.e., allowed the increased thresholds to apply) for payment year 2027 and for each payment year after 2028.

Therefore, CMS proposes changes to the QP and partial QP thresholds at §414.1430(a) and (b) to take into account the legislative changes made by CAA, 2026:

- For payment years 2026 and 2028, for QP status: (i) Under the Medicare option, the threshold under the payment method remains 50 percent and under the patient count method remains 35 percent; and (ii) Under the all payer option, the threshold under the payment method also remains 50 percent and under the patient count method remains 35 percent and the minimum Medicare option threshold required under the all payer option remains 25 percent for the payment amount method and 20 percent for the patient count method.
- For payment years 2026 and 2028, for partial QP status: The thresholds remain at 40 percent for the payment amount method and 25 percent for the patient count method; the minimum Medicare option threshold required under the all-payer option is 20 percent for the payment amount method and 10 percent for the patient count method.
- For payment year 2027 and payment years after 2028, for QP status: Under the Medicare option and the all-payer option, the threshold under the payment amount

method increases to 75 percent and under the patient count threshold increases to 50 percent.

- For payment year 2027 and payment years after 2028, for partial QP status: The thresholds increase to 50 percent for the payment amount method and 35 percent for the patient count method.