Where Are We Headed in **2027**? Yikes: Hit the Reset Button!!

The 2027 Physician Fee Schedule Proposed Rule

Ohio State Medical Association

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August 13, 2026

CliniSync PLUS

Your trusted advisor for Health IT

Moving Ahead with New Priorities

Shifting focus from chronic disease management to prevention and restoring foundational wellness

Moving away from MIPS to MVP Reporting

Requiring more targeted reporting by specialty and use of digital quality reporting using FHIR APIs

Emphasis on High Tech in Alternative Payment Models

Many of the newer programs call for documenting quality using remote monitors or focusing reporting only on Medicare patients

Making America Healthy Again (MAHA)

Shifting focus from chronic disease management to prevention and restoring foundational wellness

This is "one of several proposed rules that reflect a broader…strategy to create a healthcare system that results in better quality, efficiency, empowerment, and innovation for all Medicare beneficiaries."

2027 EMPHASIS

Requests for Information (RFIs)

CMS seeking comments on many business questions and new payment models

Comments must be received by September 14, 2026

To submit electronically: You may submit electronic comments on this regulation to https://www.regulations.gov/docket/CMS-2026-2377. Follow the "Submit a comment“ instructions. Make sure you list the rule number: CMS-1848-P

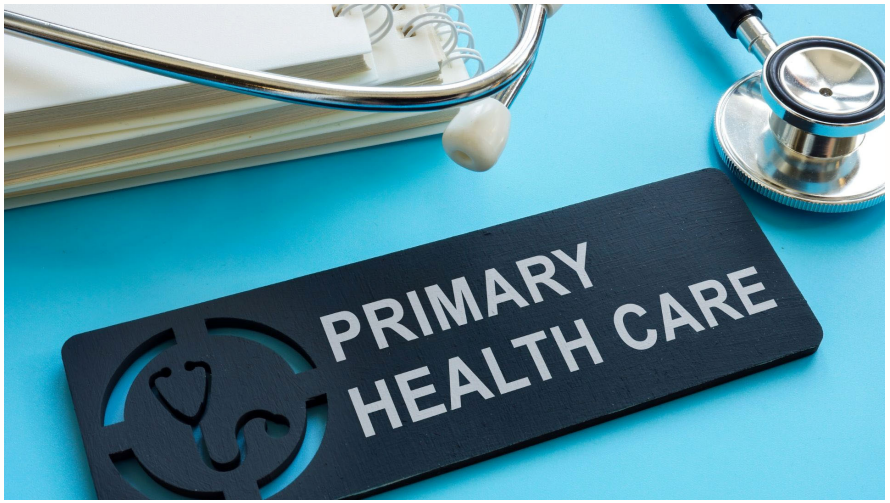
Seeking Comments on Business and Payment Models

- **Payment implications of technology-enabled primary care:** Seeking input on how technology and AI are impacting primary care; how should this be reimbursed?
- **New payment models:**
  - Considering team-based delivery supported by **"hybrid" payment models** that combine prospective monthly and visit-based payments
  - **Prospective payments** for the Medicare Shared Savings program
  - **E/M visit codes for Primary Care:** Creating separate categories of E/M visit codes for primary care to distinguish between a one-time consultative visit and care that is part of a longitudinal care relationship
  - Establishing payments for **outcome-based results**

Request for Information on Primary Care Payment Structure

CMS seeking comments in these areas:

- Relative primary care payments in the PFS (versus hospital outpatient departments or specialty providers).
- Payment concerns if include technology in primary care payments.
- Establishment of primary care prospective payments in shared savings models for ACOs and traditional Medicare.



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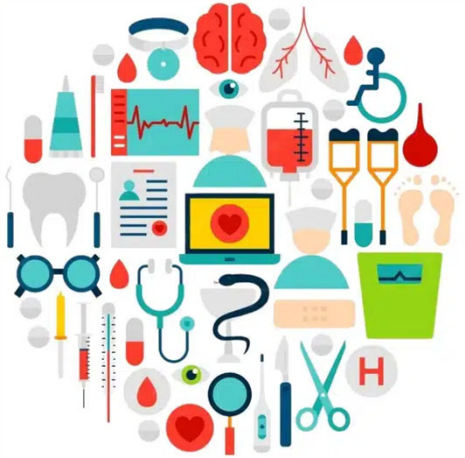
Adoption of Transitional Care

Reconsidering Relative Primary Care Payments in the PFS

- **Transitional Care Management codes** and those for managing Beneficiaries with Multiple Chronic Conditions or Chronic Care Management codes are **only used on a very limited basis**.
  - Cost-sharing and non-trivial documentation requirements noted as primary barriers to adoption.
  - **Seeking comments** on **how** the requirements for this series of **E/M codes could be modified for greater uptake in Primary Care.**

Calculation of RVUs for Specialty Specific Codes for Practice Expenses

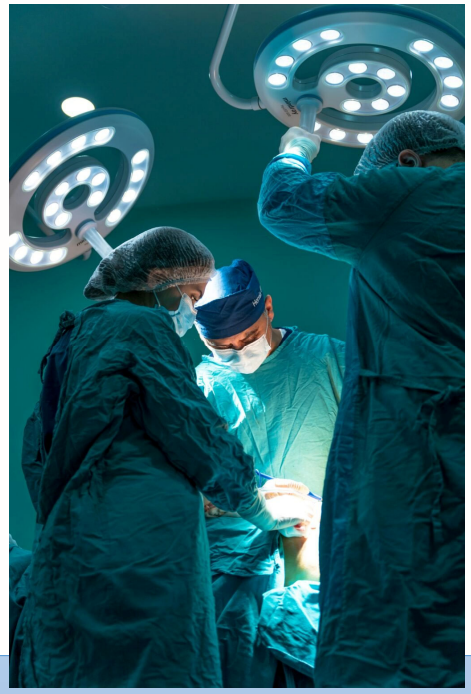
- CMS seeking a more predictable, auditable model for establishing **practice expenses by specialty** than just AMA survey information.
- **Specialty and Primary Care Practice Expenses:** Seeking comments on how to better capture **practice expenses** for office/outpatient (O/O) evaluation and management and (E/M) services, especially **for practices that are facility-based** (e.g., to pay for such expenses as coding, billing and scheduling).



Global Surgery Payment Modifications Proposed

In 2020, CMS started to collect data on post-operative surgical visits (10-day and 90-day) that were included in the **global surgery payment.**

- In 2025, the Office of Inspector General audited the visit data and found that a high % of the visits did not match the global fees paid.
- In this 2027 proposed rule, CMS is recommending that data collection on the post-op visits be paused to allow time to analyze the results and make recommendations about global surgical fees.
- CMS soliciting comments about data collection for global surgical fees.



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Payment Adjustments Proposed for Physician 2027 Reimbursement

PFS CY 2027	Rate Adjustment And Payment Rate For 2027	Increase/Decrease From 2026 Conversion Factor For 2027
QPs: Qualifying Alternative Payment Model (APM) Participants	+0.75%	• Conversion factor of $33.17 is a **decrease of $0.40** from 2026 conversion factor. • For 2026 performance year, the **APM Incentive Payment is 3.1%**
Non-QP (MIPS, non-QPs or Non-Reporting Providers)	+0.25%	• Conversion factor of $32.84 is a **decrease of $0.56** from 2026
RVU Adjustment	+0.53% Adjustment for RVU for certain services	—
PFS Conversion Factor	0.0%	• -2.5% from 2026 PFS conversion factor rate
Adjustment for E/M visits on same day as a 0-, 10- or 90-day global procedure	• 100% of the more expensive service being billed; 50% of the secondary service	• -50% for the secondary billed service
Change in HCPCS Code G2211 for E/M Complexity Code	• Replace G2211 with HCPCS modifier MOD1 for Medicare claims	• Increases E/M reimbursement by 16% rather than a flat payment of $16 - $17
Complexity Code for Shared Savings ACOs or REACH APM models	• HCPCS code MOD2	• Increases payment visit by 32% for **ALL** beneficiary E/M visits for providers in ACO

Proposed Updates to the MIPS Program at the 30,000-Foot Level

CMS proposals to encourage and ease the transition to MIPS Value Pathways

Current MIPS/QPP Proposed Reporting for CY 2027

General reporting for MIPS and QPP programs proposed for 2027

General QPP Changes

- CMS continuing the goal to move all clinicians to alternative payment models by 2030.
- In this rule, working on alignment between MIPS and APM tracks thus giving clinicians a means to participate in more meaningful ways.
- The APM Incentive Payment is **1.88% for payment year 2026 and 3.1% for payment year 2028. There is no APM Incentive Payment currently being proposed for payment year 2027 (performance year 2025).**

CMS proposing that the traditional MIPS reporting option would sunset in CY2028 and that MVPs (MIPS Value Pathways) will be the only reporting option for MIPS beginning with CY2029.

- CMS proposing policies supporting MVP (MIPS Value Pathways) only reporting for MIPS.
- CY2029 marks the end of Traditional MIPS, so eligible clinicians not achieving QP status or not reporting the APM Performance Pathway (APP) **would be required to report a selected MVP**.

General QPP Changes

Reporting Category Weighting

CMS has proposed to continue with the same base category weighting as used in the last several years

- Quality – 30%
- Cost – 30%
- Promoting Interoperability – 25%
- Improvement Activities – 15%

Hardship/Reweighting Requests

- Beginning with the CY2025 performance period, clinicians/groups would be able to submit **reweighting requests on or before December 31st of the year preceding the relevant MIPS payment year** if data was not submitted by a Third-Party intermediary.

CMS also removing certain EHR criteria as outlined in the ONC HTI-5 proposed rule.

75 Points remains the threshold to avoid penalty!

Proposed Changes to Care Compare Public Reporting

CMS is proposing a change in policy: Data reported via an MVP on a new Improvement Activity or PI measure: Even if reported during the first year, the Improvement Activity or PI measure will still be included in information about the MVP that **will be publicly shared**.

CMS seeking feedback on improvements to the current star rating assignment methodology.

Moving away from MIPS to MVP Reporting **2027 - 2029**

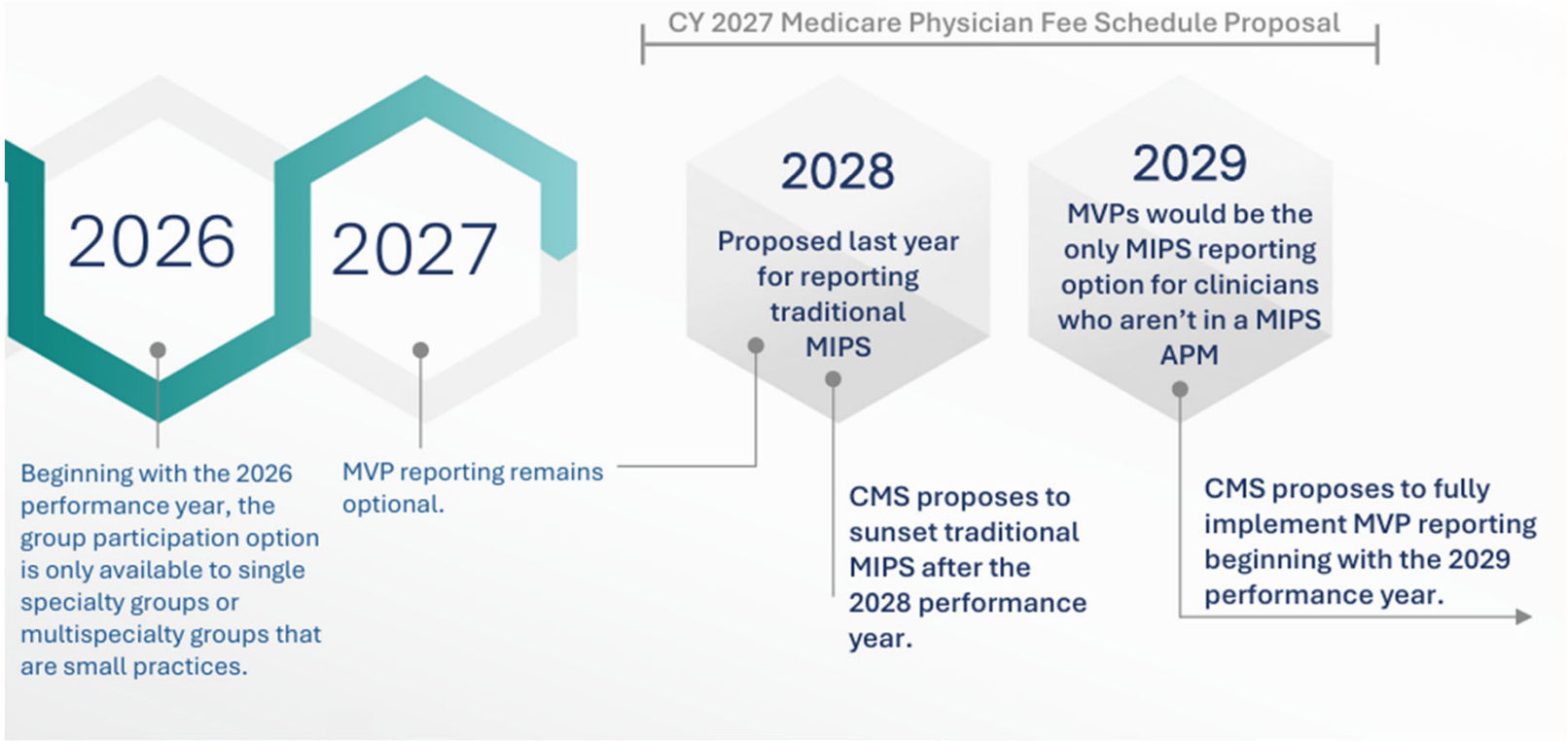
Requiring more targeted reporting by specialty and use of digital quality reporting using FHIR APIs

Proposed Changes to the Quality Measures

- For CY2027 MIPS will have a measure set of 180 MIPS quality measures, 177 of which are available in Traditional MIPS.
- **Increased reliance on Registry reporting of measures**; less emphasis on eCQMs reported from the EHR system. Registry is used because of increase in PRO-PM measures and in specialty-specific measures.
- **New data collection category** captured for **Medicare CQMs** (submission of quality data that only includes Medicare traditional patients).
- Proposing to **delete outcome/high-priority designations**; moving back to Core Measures (similar idea to the previous Medicaid core measures) but haven't been identified for Medicare yet.

- Other changes include:
  - **10 new registry-based** measures for CY2027 (See slides listed under Resources at back)
  - **1 new eCQM** measure for CY2028
  - 43 measures with **substantive changes**
    - Includes 2 **MVP-only** measures with **substantive changes**
  - 20 measures **removed** starting with CY2027

Proposed Transition to MVP Reporting



Why the Change to MVP Reporting?

MVP = MIPS Value Pathways, subgrouping along specialty or diagnoses lines.

MVP reporting offers **aligned measures & activities** across quality, cost & improvement activities.

MVPs focus on **specific specialties, conditions or patient populations** to make reporting more meaningful.

Represents an evolution towards **value-based payment** by using a meaningful set of measures and activities that includes specialists.

Allows for closer **comparisons of the performance of clinicians** within the same specialty.

Exceptions to MVP Reporting Requirement for 2029

Eligible clinicians/groups/virtual groups **would be required to report via MVPs** beginning with the CY2029 performance period, **except for**:

- Eligible clinicians in an advanced APM that achieve QP status
- Eligible clinicians participating in an APM and reporting via the APP pathway

Groups with the **Small Practice designation may report via a single MVP** without the need to form subgroups.

CMS is considering a process for clinicians to indicate at the time of MVP registration that no available MVP in the inventory includes applicable and available measures and activities.

Proposed Changes to MVPs

The number of available MVPs increases to thirty (30) if the three newly proposed MVPs are finalized.

- List of MVPs results in coverage of approximately 98% of specialties for MIPS eligible clinicians, based on self-reported specialty designations.

Proposed New MVPs

- Diabetic Disease
- Hospitalist
- Hypertension

Proposed modifications to 27 of the previously finalized MVPs, including the renaming of Rehabilitative Support for Musculoskeletal Care to Rehabilitative Support.

- Replacing **outcome/high-priority** quality measures with at least one **core measure.**

List of all Available MIPS Value Pathways (MVP)

Adopting Best Practices and Promoting Patient Safety within Emergency Medicine	Gastroenterology Care	Podiatry
Advancing Cancer Care	Hospitalist	Prevention and Treatment of Infectious Disorders Including Hepatitis C and Human Immunodeficiency Virus (HIV)
Advancing Care for Heart Disease	Hypertension	Pulmonology Care
Advancing Rheumatology Patient Care	Improving Care for Lower Extremity Joint Repair	Quality Care for Patients with Neurological Conditions MVP;
Complete Ophthalmologic Care	Interventional Radiology	Quality Care for the Treatment of Ear, Nose, and Throat Disorders
Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes	Neuropsychology	Quality Care in Mental Health and Substance Use Disorder
Dermatological Care	Optimizing Chronic Disease Management	Rehabilitative Support for Musculoskeletal Care
Diabetic Disease	Optimal Care for Kidney Health	Surgical Care
Diagnostic Radiology	Pathology	Value in Primary Care
Focusing on Women's Health	Patient Safety and Support of Positive Experiences with Anesthesia;	Vascular Surgery

Proposed Changes to the APM Performance Pathway (APP)

Alternative attestation for clinicians in an ACO that do not meet full QP status

Overview of the APM Performance Pathway

- The APP provides a predictable and consistent set of MIPS reporting options, with reduced burden, for APM participants.
- ACOs were required to report quality data for the purposes of the Shared Savings Program via the APP.
- 7-point scoring cap on core quality measures determined to be topped out is not applied.

Proposed Changes to Quality Measures in APP

The following quality measures are being **removed from the APM Performance Pathway**:

- **(QID: 305)** Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- **(QID: 493)** Adult Immunization Status

These measures were removed due to operational issues impacting the development of collection types that were finalized in the CY2025 PFS final rule.

APP+ Quality Measures for **CY2026**

#	Measure Title	Collection Type	Submitter Type	Measure Type
001	Diabetes: Glycemic Status Assessment Greater Than 9%	eCQM, Registry, Claims	Individual, APM Entity	Intermediate Outcome
134	Preventive Care and Screening: Screening for Depression and Follow-up Plan	eCQM, Registry, Claims	Individual, APM Entity	Process
236	Controlling High Blood Pressure	eCQM, Registry, Claims	Individual, APM Entity	Intermediate Outcome
321	CAHPS for MIPS	CAHPS Survey	Third Party	Patient Engagement – Experience
479	Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups	Claims	N/A	Outcome
484	Risk-Standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	Claims	N/A	Outcome

APP+ Quality Measures for **CY2027**

#	Measure Title	Collection Type	Submitter Type	Measure Type
001	Diabetes: Glycemic Status Assessment Greater Than 9%	eCQM, Registry, Claims	Individual, APM Entity	Intermediate Outcome
112	**Breast Cancer Screening**	eCQM, Registry, Claims, Medicare eCQM	Individual, APM Entity	Process
113	**Colorectal Cancer Screening**	eCQM, Registry, Claims, Medicare eCQM	Individual, APM Entity	Process
134	Preventive Care and Screening: Screening for Depression and Follow-up Plan	eCQM, Registry, Claims	Individual, APM Entity	Process
236	Controlling High Blood Pressure	eCQM, Registry, Claims	Individual, APM Entity	Intermediate Outcome
321	CAHPS for MIPS	CAHPS Survey	Third Party	Patient Engagement – Experience
479	Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups	Claims	N/A	Outcome
484	Risk-Standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	Claims	N/A	Outcome

Emphasis on High Tech Used in Different Models

- *New codes for remote monitoring*
- *Improvement Activities focusing on AI*
- *Electronic prior authorization included in "Promoting Interoperability" reporting*
- *FHIR-Based Quality Reporting*

Remote Therapy Monitoring (RTM) Services

RPT: Remote Patient Monitoring or Physiologic Monitoring	RTM: Remote Therapy Monitoring
Covers patients with chronic conditions that wear a monitor that can produce constant readings	
Monitors objective **physiologic data** (e.g., blood pressure, weight, glucose) using FDA-approved medical devices that automatically transmit data to healthcare providers.	Tracks **non-physiologic, therapeutic data** (e.g., therapy/medication adherence, pain levels). RTM focuses on respiratory and musculoskeletal conditions and can involve subjective, patient-reported outcomes via apps.
Billing for RTM services will be restricted to monitoring of established patients.	
• Must have separately reportable initiating visit	• **Must** have separately reportable initiating visit
• Monitoring must be provided by clinical staff at the practice; can't use 3rd party contractors	
• Reimbursement codes for monitoring may change from CPT codes to 4 HCPCS G codes that are bundled together.	

Priority Item for CMS in 2027: Part of Health and Wellness Initiative

Note: *"The time spent by clinical staff providing RPM or RTM services can be counted, provided that the clinical staff are under the general supervision of the billing practitioner, all other requirements of the 'incident to' regulations at § 410.26 are met, and the clinical staff is a direct employee of the practitioner or the practitioner's practice."*

IA: Clinical Use of AI to Improve Patient Care

Proposed New Improvement Activity	
Subcategory:	Advancing Health & Wellness
Activity Title:	**Clinical Use of Artificial Intelligence (AI) to Improve Patient Care**
Activity Description:	MIPS-eligible clinicians implement and participate in structured organizational initiatives that improve patient care through the responsible and transparent use of artificial intelligence (AI) in clinical and operational workflows. This activity supports the safe adoption of AI-enabled technologies while encouraging the development, evaluation, and refinement of AI resources designed to improve patient outcomes, care-team efficiency, and population health management. As part of this activity, participating clinicians and organizations must: • Establish and maintain organizational policies and procedures for AI use in healthcare settings that guide the evaluation, deployment, and monitoring of AI-enabled tools • Engage in or support innovative initiatives that encourage the creation, piloting, and/or enhancement of AI-enabled tools, workflows, and/or resources

Proposed Activities to be Modified

Act ID	Activity Title	Change
IA_PSPA_16	Use decision support—ideally platform-agnostic, interoperable clinical decision support (CDS) tools and standardized treatment protocols to manage workflow on the care team to meet patient needs	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
IA_BMH_4	Depression Screening	Combining IA_BMH_4 & IA_BMH_5 into activity titled “Depression Screening, Treatment, and Prevention”
IA_CC_8	Implementation of documentation improvements for practice/process improvements	Implementation of Documentation **and/or Operational** Improvements for Practice/Process Improvements

Technology for Interoperability: Promoting Interoperability (PI) Proposed Changes

Removing several attestations for burden reduction while adding new measures to support electronic prior auth

Changes to P.I. Attestation Process

CY2026 Performance Period Change	CY2027 Performance Period Change

• Proposing to remove two questions from the attestation process:
  • ONC Direct Review attestation
  • ONC-Authorized Certification Bodies (ACB) Surveillance questions from the attestation process.
	• Proposing to remove the Security Risk Analysis measure and question from the attestation process.
	  • **Still a required yearly activity under HIPAA!**
	  • Removed from attestation as part of burden reduction

Proposed Changes to Promoting Interoperability

Proposing the **addition of a new measures** to the **Health Information Exchange** objective

- **Electronic Prior Authorization**
  - Optional measure for the CY2027 performance period, worth 10 bonus points.
  - Required starting with the CY2028 performance period, no points associated.
    - Submission of a "No" response, starting with the CY2028 performance period, will results in a zero (0) score for the entire Promoting Interoperability category.

- **Electronic Prior Authorization for Prescribed Drugs**
  - Required starting with the CY2028 performance period, no points associated.
  - Submission of a "No" response and failing to claim an exclusion will result in a zero (0) score for the entire Promoting Interoperability category.

Proposed **2027** Change to Electronic Prior Auth Measure

The **Electronic Prior Authorization** Measure was first adopted in the 2024 Interoperability & Prior Authorization Final Rule.

This will be a bonus (+10 points) measure for the CY2027 performance year only.

Measure Description: For at least one medical item or service (excluding drugs) ordered by the MIPS eligible clinician during the performance period, the prior authorization is requested electronically through a Prior Authorization API using CEHRT.

Reporting Requirements: Yes/No response

Exclusions: None

Proposed Electronic Prior Auth for Drugs Measure

Measure Description for Medication Prior Authorization: For at least one prescription drug ordered by the MIPS eligible clinician during the performance period for which prior authorization is required, the prior authorization is requested electronically using CEHRT.

Reporting Requirements: Yes/No response

Exclusion: Any MIPS eligible clinician who:

- Does not prescribe drugs that require prior authorization during the applicable performance period.
- Only Prescribes drugs requiring prior authorization where the payer does not support the specified electronic prior authorization standard during the reporting period.
- Prescribes fewer than 100 permissible prescription drugs during the reporting period.

CY2027 MIPS Promoting Interoperability

OBJECTIVE	MEASURE	POINTS
Electronic Prescribing	E-Prescribing	10 points
	Query of PDMP	10 points
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information; **AND**	15 points
	Support of Electronic Referral Loops by Receiving & Reconciling Health information; **OR**	15 points
	Health Information Exchange Bi-Directional Exchange; **OR**	30 Points
	Enabling Exchange under TEFCA	30 Points
	Electronic Prior Authorization (Yes/No) optional	**+10 Bonus**
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	25 Points
Public Health and Clinical Data Exchange	Report two (2) measures: Immunizations Registry & Electronic Case Reporting	25 points
	(BONUS) Report one of following: Syndromic Surveillance, Public Health Registry, or Clinical Data Registry	5 points (Bonus)

CY2028 MIPS Promoting Interoperability

OBJECTIVE	MEASURE	POINTS
Electronic Prescribing	E-Prescribing	10 points
	Query of PDMP (Yes/No)	10 points
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information; **AND**	15 points
	Support of Electronic Referral Loops by Receiving & Reconciling Health information; **OR**	15 points
	Health Information Exchange Bi-Directional Exchange; **OR**	30 Points
	Enabling Exchange under TEFCA	30 Points
	Electronic Prior Authorization (Yes/No) Yes response required	**0 Points**
	Electronic Prior Authorization for Drugs (Yes/No) Yes response required	**0 Points**
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	25 Points
Public Health and Clinical Data Exchange	Report two (2) measures: Immunizations Registry & Electronic Case Reporting	25 points
	(BONUS) Report one of following: Syndromic Surveillance, Public Health Registry, or Clinical Data Registry	5 points (Bonus)

FHIR-Based Digital Quality Measures in the QPP & Other Programs

Advancing quality measurement by transitioning existing quality measures and reporting process to digital approaches

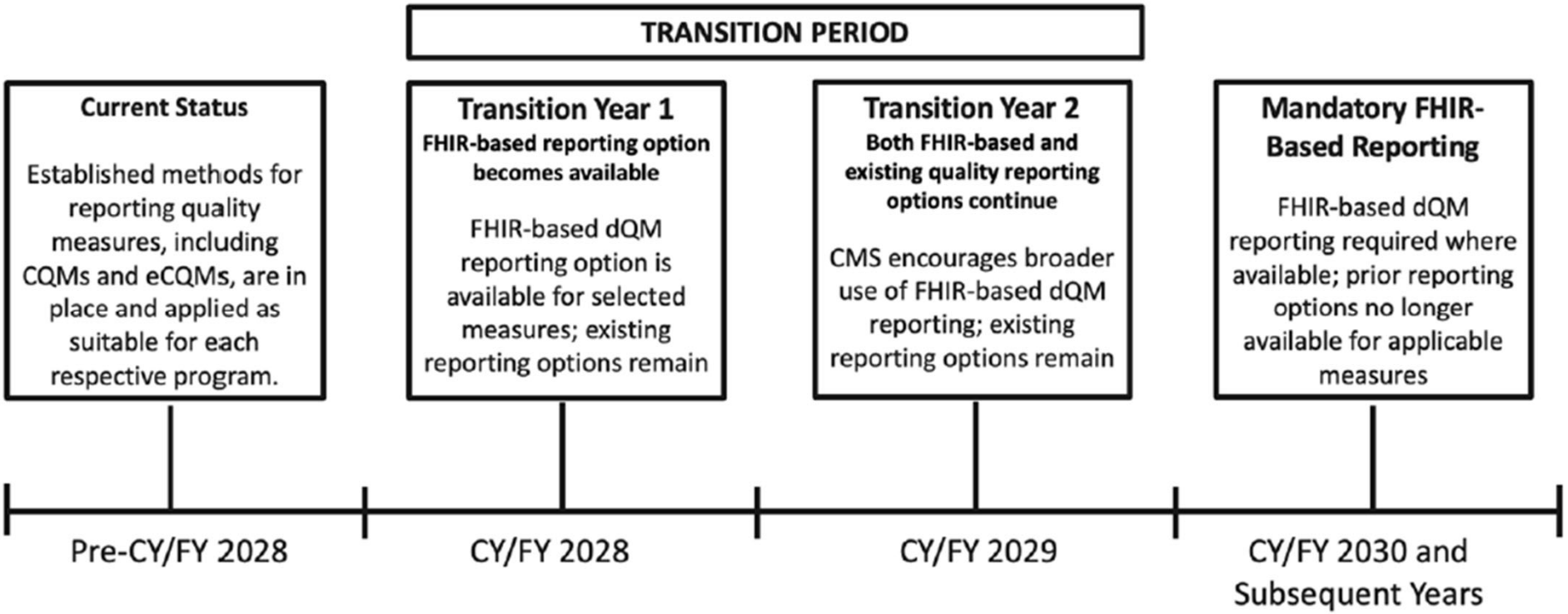
Why Change to FHIR-Based dQMs?

- **Digital quality measures (dQMs)** use standardized, interoperable digital data from multiple sources.
- Enables more comprehensive and timely assessment of care while reducing reporting burden.
- Standards supporting transition to dQMs defined in previous rulemaking:
  - USCDI+ Quality Version 1 identifies a common set of quality-related data elements to support reusability of data for quality measurement across programs.
  - 2026 US Quality Core Implementation Guide version 0.5.0.
  - Data Exchange for Quality Measures (DEQM) FHIR implementation guide.

Transitioning to FHIR-Based dQMs in QPP

- Currently quality is reported through the use of CQMs and eCQMs with eCQM reporting supported through QRDA files.
- CMS developing a **phased transition to FHIR-based reporting.**
  - Planning to introduce a 2-year transition period beginning with CY2028 where CQM and eCQM reporting would still be available with FHIR-based dQM options introduced for select measures.
  - FHIR-based reporting would be required for available FHIR-based dQMs in CY2030.
    - Those measures now available as FHIR-based dQMs would be no longer available as an CQM or eCQM.
    - CQMs and eCQMs, not yet converted to dQMs, would still be available for use in reporting.
  - Transition would begin with a limited set of dQMs and would expand over time.

Transitioning to FHIR-Based dQMs in QPP



Making America Healthy Again (MAHA)

Shifting focus from chronic disease management to prevention and restoring foundational wellness

Making America Healthy Again (MAHA)

- **Goals for MAHA:** Reduce chronic disease rates, improve nutrition, promoting preventative care, and increasing transparency.

- Changes appear throughout the rule and affect areas such as:

  - **MIPS Value Pathways** (MVP): New pathways created for Diabetes Disease and Hypertension
  - **Alternative payment models** (APM)
  - **Quality** reporting for **MIPS, MVP, APP**
  - **Improvement activities** category added for Health & Wellness; new Improvement Activity that would track referrals and social needs, including those related to food needs.

New Chronic Illness, BH and Advance Care Planning Codes

Based on comments received in the 2026 PFS rule, CMS is proposing to add some codes for **patient E/M visits**:

- **Shared Medical Appointments:** CMS adding codes for shared medical appointments to allow beneficiaries to receive multidisciplinary clinical support support as well as peer support.
- **BH Visits:** CMS proposing an increase in RVUs for psychotherapy visits.
- **Smoking and Tobacco Use Cessation:** Increase IN RVUs is included in BH codes.
- **SBIRT:** Screening, brief intervention, and referral for treatment increase included in increased BH codes.
- **Codes for Advance Care Planning Conducted by Clinical Staff under Physician Supervision:** 2 new HCPCS codes to allow for billing for clinical staff assisting in ACP.

IA: Systematic Screening & Intervention…

Proposed New Improvement Activity	
Subcategory:	Advancing Health & Wellness
Activity Title:	**Systematic Screening and Intervention for Nutrition and other Health-Impacting, Non-Clinical Issues**
Activity Description:	This activity supports the implementation of standardized health-related, non-clinical issues screening tools and workflows to identify and address wellness-impacting factors such as poor nutrition, housing instability, transportation barriers, and financial strain. It may include: • Training staff on screening protocols • Embedding validated screening tools into the electronic health record (EHR) • Establishing referral pathways to community-based resources • Tracking follow-up and resolution of identified needs.

Clinical Lab Trials

- CMS is asking for input on whether a HCPCS code should be added that would reimburse providers for discussions with patients about joining clinical trials.

- This would be a G-code added to counsel the patient for 20 minutes about clinical trials.

Resources for Physician Fee Schedule

- Quality Measures
  - New Proposed MIPS Quality Measures
  - Quality Measures Proposed for Removal
- Digital Quality Measures
- Improvement Activities
  - Newly Proposed Improvement Activities
  - Improvement Activities Proposed for Removal
  - Improvement Activity for screening for nutrition and non-clinical needs
  - Improvement Activity for Use of Artificial Intelligence
- APM Performance Pathway (APP) and APP+ Quality
- ACO, MSSP Changes
- Et Cetera

Quality Category Proposed Changes

CMS moves to Core Measures concept while pushing forward the transition to digital quality measures

Core Measures Reporting Proposal (cont.)

Under **Traditional MIPS**, a group/clinician would be required to **report one (1) MIPS Core Measure** as one of their six required quality measures.

- Replaces requirement to submit at least one High Priority/Outcome measure.
- Requirement **does not apply** to groups with "**Small Practice**" designation.

Failure to include a Core Measure or to attest that an applicable Core Measure was available, would result in a zero (0) score for one of the six (6) scored quality measures.

Proposed Data Submission for Medicare CQMs

Expanding definition of collection types to include **Medicare eCQMs**, used in the Shared Savings program, with appropriate data submission criteria and data completeness requirements.

The Medicare CQM collection type can be used only with the APP measure set or the APP Plus measure set.

Medicare CQMs can be submitted by a MIPS eligible clinician (utilizing the APP pathway), group or APM entity.

CMS anticipates the sunsetting of the Medicare CQMs collection type starting with the CY2030 performance period when FHIR-based reporting becomes mandatory.

Medicare CQMs must meet the 75% data completion requirement, as will other collection types.

Proposed **New** MIPS Quality Measures

Proposed New Quality Measures in **CY2027**

CBE	QPP #	Measure	Collection Type	Core Measure
N/A, N/A	TBD	Low Density Lipoprotein Cholesterol (LDL-C) Monitoring and Management	Registry	Yes
N/A, N/A	TBD	Functional Improvement for Patients with Neck Impairments (PRO-PM)	Registry	No
N/A, N/A	TBD	Functional Improvement for Patients with Upper Extremity Impairments (PRO-PM)	Registry	No
N/A, N/A	TBD	Functional Improvement for Patients with Back Impairments (PRO-PM)	Registry	Yes
N/A, N/A	TBD	Functional Improvement for Patients with Lower Extremity Impairments (PRO-PM)	Registry	No

Proposed New Quality Measures in **CY2027**

CBE	QPP #	Measure	Collection Type	Core Measure
N/A, N/A	TBD	Functional Improvement for Patients with Knee Impairments (PRO-PM)	Registry	No
N/A, N/A	TBD	Age-Related Hearing Loss: Comprehensive Audiometric Evaluation	Registry	Yes
N/A, N/A	TBD	Functional Improvement for Patients with Upper Extremity Impairments (PRO-PM)	Registry	No
N/A, N/A	TBD	Patient-Reported Experience with Anesthesia (PRO-PM)	Registry	No
N/A, N/A	TBD	Intraoperative Hypotension (IOH) Among Non-Emergent Noncardiac Surgical Cases	Registry	Yes
N/A, N/A	TBD	SGLT2 Inhibitors for Patients with Chronic Kidney Disease (CKD) With or Without Type 2 Diabetes Mellitus	Registry	No

Proposed New Quality Measure in **CY2028**

CBE	QPP #	Measure	Collection Type	Core Measure
N/A, 4700e	TBD	Rate of Timely Follow-up on Abnormal Screening Mammograms for Breast Cancer Detection	eCQM	No

Quality Measures Proposed for **Removal**

Measures Proposed for Removal in CY2027

CBE	QPP#	Measure	Collection Type
0067, N/A	6	Coronary Artery Disease (CAD): Antiplatelet Therapy	Registry
0070, 0070e	7	**Coronary Artery Disease (CAD): Beta-Blocker Therapy – Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF ≤ 40%)**	eCQM, Registry
0384, 0384e	143	Oncology: Medical and Radiation – Pain Intensity Quantified	eCQM, Registry
N/A, N/A	217	Functional Status Change for Patients with Knee Impairments	Registry
N/A, N/A	218	Functional Status Change for Patients with Hip Impairments	Registry
N/A, N/A	219	Functional Status Change for Patients with Lower Leg, Foot or Ankle Impairments	Registry
N/A, N/A	220	Functional Status Change for Patients with Low Back Impairments	Registry
N/A, N/A	221	Functional Status Change for Patients with Shoulder Impairments	Registry
N/A, N/A	222	Functional Status Change for Patients with Elbow, Wrist or Hand Impairments	Registry

Measures Proposed for Deletion in CY2027

CBE	QPP#	Measure	Collection Type
0658, N/A	320	Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	Claims, Registry
N/A, N/A	326	Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy	Registry
N/A, N/A	332	Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use)	Registry
N/A, N/A	350	Total Knee or Hip Replacement: Shared Decision-Making: Trial of Conservative (Non-surgical) Therapy	Registry
N/A, N/A	378	Children Who Have Dental Decay or Cavities	eCQM
N/A, N/A	384	Adult Primary Rhegmatogenous Retinal Detachment Surgery: No Return to the Operating Room Within 90 Days of Surgery	Registry
N/A, N/A	415	Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older	Registry

Measures Proposed for Deletion in CY2027

CBE	QPP#	Measure	Collection Type
N/A, N/A	430	Prevention of Post-Operative Nausea and Vomiting (PONV) – Combination Therapy	Registry
N/A, N/A	463	Prevention of Post-Operative Vomiting (POV) – Combination Therapy (Pediatrics)	Registry
3461, N/A	478	Functional Status Change for Patients with Neck Impairments	Registry
3568, N/A	483	Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM)	Registry

Improvement Activity Category Proposed Changes

CMS proposing the combining of several like activities, use of AI and standard measure updates and management.

Proposed Changes to Improvement Activities

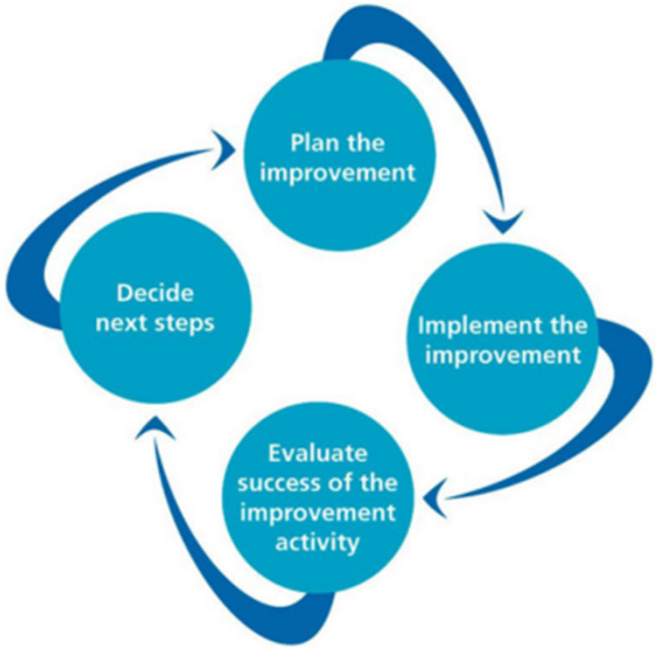
The proposed changes to the Improvement Activities reporting category are limited to the standard yearly maintenance.

- **Adding six (6)** new Improvement Activities into two (2) subcategories:
  - Care Coordination
  - Advancing Health and Wellness
- **Modifying five (5)** existing improvement activities
- **Removing eleven (11)** activities

Proposed **New** Improvement Activities

Newly Proposed Improvement Activities

Act ID	Subcategory	Activity Title
IA_CC_XX	Care Coordination	Use of Data to Improve Practice Workflows
IA_CC_XX	Care Coordination	Understand and Improve Diagnostic Performance
IA_AHW_XX	Advancing Health and Wellness	Systematic Screening and Intervention for Nutrition and other Health-Impacting, Non-Clinical Issues
IA_AHW_XX	Advancing Health and Wellness	Advance Care Planning Conversations to Support Patient Wellness and Care Preferences
IA_AHW_XX	Advancing Health and Wellness	Clinician Use of Artificial Intelligence (AI) to Improve Patient Care
IA_AHW_XX	Advancing Health and Wellness	Lifestyle Approaches to Diabetes Remediation



Improvement Activities with Proposed **Modifications**

Proposed Activities to be Modified

Act ID	Activity Title	Change
IA_CC_9	Implementation of practices/processes for developing regular individual care plans	IA_CC_9 & IA_BE_15 contain similar elements and are being combined into one activity titled “Implementation of Practices/Processes for Developing Regular Individual Care Plans”
IA_PM_4	Glycemic management services	Glycemic Screening, Referral, and Management

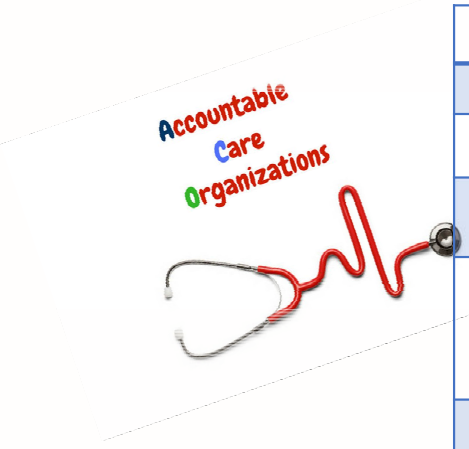
MEDICARE MSSP ACO CHANGES PROPOSED FOR 2027

CMS Increasing ACO Incentives Financially and Relaxing Data Submission Requirements

Risk/Shared Savings Recalculation for BASIC Track E model

- Numerous changes planned for Medicare Shared Savings program to increase the shared savings that could be earned.
- Starting in 2027, data submission methods would be increased to include reporting on only Medicare traditional patients.
- Promoting interoperability measures would be relaxed.

ACO Quality Measures and Types of Reporting



APP+ 2027 ACO Quality Reporting

Quality #	Measure	Type of Reporting
321	• CAHPS for MIPS	• CAHPS for MIPS Survey
479	• 30-day, All-cause Unplanned Readmissions (HWR)	• Administrative Claims
484	• Hospital Admission Rates for Patients with Multiple Chronic Conditions	• Administrative Claims
001	• Diabetes: A1C > 9.0%	• eCQMs **MIPS** • **Medicare** eCQMs • **Medicare** CQMs • CQMs **MIPS**
134	• Screening for Depression & Follow-up	• eCQMs **MIPS** • **Medicare** eCQMs • **Medicare** CQMs • CQMs **MIPS**
236	• Controlling High Blood Pressure	• eCQMs **MIPS** • **Medicare** eCQMs • **Medicare** CQMs • CQMs **MIPS**
112	• Breast Cancer Screening	• eCQMs **MIPS** • **Medicare** eCQMs • **Medicare** CQMs • CQMs **MIPS**
113	• Colorectal Cancer Screening	• eCQMs **MIPS** • **Medicare** eCQMs • **Medicare** CQMs • CQMs **MIPS**

ACO Promoting Interoperability Reporting

Objective	CEHRT Use
E-Prescribing	• At least one permissible prescription was written by an ACO provider in each of the ACO's participating TINs and the prescription was transmitted electronically using CEHRT
Provider to Patient Exchange	• At least one ACO provider from each of the ACO's participant TINs provided at least one patient electronic access to their health information using CEHRT
Health Information Exchange	• At least one ACO provider from each of the ACO's participating TINs participated in HIE bi-directional exchange for at least one patient with an HIE that has the capability to enable secure, bi-directional exchange for all patients, without excluding partners, using CEHRT

Significant Cutback in PI Reporting

Effective 2027, CMS is proposing that ACOs in the MSSP Shared Savings will not be required to meet the MIPS Promoting Interoperability requirements. These will be sunsetted and replaced by the above PI reporting. The ACO would need to attest to ***ONE of the above objectives.***

“Medicaid Fraud War Room” and “Medicare Fraud Defense Operations Center”

Growing use of Artificial Intelligence (AI) to conduct audits and prior authorizations

Questions & Discussion

Thank you & please reach out with any questions.

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