Quality Payment
PROGRAM

Calendar Year (CY) 2027 Medicare Physician Fee Schedule (PFS) Proposed Rule: Quality Payment Program (QPP) Fact Sheet and Policy Comparison Table

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QPP Policy Overview: Proposals and Requests for Information

In the CY 2027 Medicare PFS Proposed Rule, we're proposing a limited number of significant policy changes for QPP, designed to move the program into the future with a focus on prevention and wellness in patient care, reducing administrative burden, and promoting more meaningful participation that drives quality and value.

Since 2019, we've signaled that Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs) are the future reporting path for MIPS, and that eventually traditional MIPS would no longer be a reporting option. In this proposed rule, we're proposing to sunset the traditional MIPS reporting option following the CY 2028 performance period/2030 MIPS payment year. This proposal provides a clear and ample timeframe for MIPS eligible clinicians to identify the MVP most relevant for them, develop the workflows needed to implement the quality measures and activities in that MVP, and establish systems for collecting data at the subgroup level if applicable.

We're expanding the MVP portfolio to include Diabetic Disease and Hypertension MVPs that address the prevention of chronic illnesses and aim to reduce the incidence and impact of long-term conditions. In alignment with the goal of promoting preventive care and fostering a more proactive and holistic approach to health management, we're also proposing new improvement activities under the Advancing Health and Wellness subcategory within the improvement activities performance category. The proposed improvement activities integrate concepts that address nutrition, implement lifestyle approaches to disease management, and support patient wellness to promote a healthier future.

We're also proposing to update the MIPS Promoting Interoperability measure inventory in ways that move us forward while reducing burden. Proposals related to the Electronic Prior Authorization measure and the addition of the new Electronic Prior Authorization for Prescription Drugs measure would modernize a system that currently creates unnecessary delays for patients, burdens health care providers with excessive paperwork, and erodes trust between patients and their health care providers. Proposals to remove the Office of the National Coordinator for Health Information Technology (ONC)-related attestations and the Security Risk Analysis measure focus on cost and burden reduction.

In addition to policy proposals, we're including several Requests for Information (RFIs) to obtain feedback from interested parties on a variety of topics before we propose related policies through future rulemaking. These RFIs are focused on MVP scoring, a timeline for implementing Fast Healthcare Interoperability Resources® (FHIR)-based digital quality reporting, and the star rating methodology for publicly reporting administrative claims measures on Care Compare.

Proposal Highlights

For a more comprehensive look at QPP proposals, review the Policy Comparison Table later in this resource.

MIPS Value Pathways (MVPs) Development & Strategy

- We're proposing to **sunset the traditional MIPS reporting option after the CY 2028 performance period**; MVPs would be the only MIPS reporting option for MIPS eligible clinicians that don't participate in a MIPS Alternative Payment Model (APM) beginning in the CY 2029 performance period. Clinicians in a MIPS APM would continue to be able to report the APM Performance Pathway (APP).
- We're proposing that **virtual groups would be able to report MVPs** beginning with the CY **2029** performance period.
- We're proposing **3 new MVPs** to be available for reporting in the CY 2027 performance period.
  - Diabetic Disease
  - Hospitalist
  - Hypertension
- We're proposing to **modify all 27 existing MVPs** to include MIPS core measure selections for each MVP, add measures that expand upon a clinical concept or capture additional specialties most applicable to report an MVP, address maintenance requests from the public, and remove measures and activities that would either be finalized for removal from their respective MIPS inventory or replaced by more robust measures. We're also proposing to rename the Rehabilitative Support for Musculoskeletal Care MVP to Rehabilitative Support MVP to better reflect the measures and activities included in the MVP.

MIPS Performance Categories

- We're proposing a MIPS **core measure** designation for the quality performance category and **to replace the outcome / high priority measure reporting requirement** in traditional MIPS and MVPs **with a MIPS core measure reporting requirement.**
- We're proposing to **remove** the **ONC (Office of the National Coordinator for Health Information Technology) attestations** (one required, one optional) for the CY 2026 performance period **and the Security Risk Analysis measure** for the CY 2027 performance period for the Promoting Interoperability performance category.
- We're proposing to make the **Electronic Prior Authorization measure an optional/bonus measure for the CY 2027 performance period** for the Promoting Interoperability performance category; it would become required starting with the CY 2028 performance period.

- We're proposing to create **the new Electronic Prior Authorization for Prescription Drugs measure** that would become required starting with the **CY 2028 performance period** for the Promoting Interoperability performance category.

Advanced APMs

- We're proposing to **apply** Qualifying APM Participant **(QP) and Partial QP determinations at the** Taxpayer Identification Number/National Provider Identifier (**TIN/NPI) level** instead of the NPI level, ensuring that financial incentives are directed only to TINs actively participating in Advanced APMs.
- We're also proposing **updates to the QP and Partial QP thresholds and APM Incentive Payment**, as a result of the Consolidated Appropriations Act, 2026.

Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs)

- We're proposing to **extend the availability of the MIPS Clinical Quality Measures (CQMs)** collection type for Shared Savings Program ACOs and the MIPS CQM reporting incentive for the CY 2027 performance period and subsequent years.
- We're proposing that all measures of the Medicare CQMs for ACOs Participating in the Medicare Shared Savings Program (**Medicare CQMs) collection type would be scored using flat benchmarks for the CY 2027 performance period and subsequent performance periods**; and proposing to **retroactively apply flat benchmarks** to 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 Controlling High Blood Pressure (Quality ID: 236), if reported via the Medicare CQMs collection type in the **CY 2026 performance period**.
- We're proposing to **establish a new collection type for Shared Savings Program ACOs** reporting the APM Performance Pathway (APP) Plus quality measure set for the CY 2027 performance period and subsequent performance periods: Medicare Electronic Clinical Quality Measures for Accountable Care Organizations Participating in the Medicare Shared Savings Program **(Medicare eCQMs)**. The Medicare eCQM patient population would be based on the ACO's assigned beneficiaries.
- We're proposing to revise the definition of a "beneficiary eligible for Medicare CQMs" for the CY 2027 performance period and subsequent performance periods, to align with the population of beneficiaries assigned to the ACO.
- We're proposing to **modify the Shared Savings Program Certified Electronic Health Record Technology (CEHRT) use requirements** and seeking comment on applying electronic prior authorization measures to ACOs participating in the Shared Savings Program in future years.
- For more information on the proposals specific to participation in the Shared Savings Program, review the **Medicare Shared Savings Program Proposals Fact Sheet.**

Requests for Information (RFIs) Highlights

Fast Healthcare Interoperability Resources (FHIR) Timeline

- We're issuing an RFI to solicit feedback on the future transition to FHIR-based digital quality reporting for QPP, including the overall transition timeline, key milestones, and implementation considerations.
- We're seeking feedback on a 2-year transition period, beginning with the CY 2028 performance period, that maintains existing reporting options while also supporting FHIR-based reporting for selected measures.
- We are also seeking feedback on mandatory FHIR-based reporting for applicable measures beginning with the CY 2030 performance period, during which prior electronic reporting approaches would no longer be available for those measures.

MVP Scoring Methodology

- We're issuing an RFI to solicit feedback on a scoring methodology that would allow us to more fairly compare performance of clinicians within the same MVP, with each MVP focusing on measures and activities that are relevant to a given specialty or medical condition.
- We're seeking feedback on whether we should consider MVP score normalization within an MVP to ensure scoring fairness across MVPs. Specifically, MIPS eligible clinicians reporting a given MVP would have their scores normalized by comparing to their peers reporting the same MVP, prior to MIPS payment adjustment determination. We're also seeking feedback on whether that normalization should occur at the final score level or at a performance category level.
- We're also seeking feedback on the timing for implementing a new MVP scoring methodology: beginning with the CY 2029 performance period/2031 MIPS payment year, consistent with the proposed timeline for full MVP implementation, or whether an earlier pilot rollout would be appropriate to give clinicians experience with the new scoring approach while traditional MIPS reporting is available.

Star Rating Assignment Methodology

- We're issuing an RFI to solicit feedback on improvements and alternative options to the current star rating assignment methodology for quality measure scores collected under the administrative claims collection type.
- We're seeking feedback on whether interested parties support changing the current 5-star benchmarking methodology to one that better reflects the revised scoring methodology for administrative claims quality measures.

QPP Policy Comparison Table: Current Policies vs. Proposed Policies

- MIPS Overview
- Public Reporting Overview
- Advanced APMs Overview
- How Do I Comment on the Proposed Rule?

Appendices

- Appendix A: Previously Finalized Policies for the 2027 Performance Period
- Appendix B: New Quality Measures Proposed for the 2027 Performance Period and Future Years
- Appendix C: New Quality Measures Proposed for the 2028 Performance Period and Future Years
- Appendix D: Quality Measures Proposed for Removal in the 2027 Performance Period and Future Years
- Appendix E: APP Plus Quality Measure Set and Collection Types Proposed for the 2027 Performance Period and Future Years
- Appendix F: New Improvement Activities Proposed for the 2027 Performance Period and Future Years
- Appendix G: Improvement Activities Proposed for Removal in the 2027 Performance Period and Future Years

The **2027 Proposed and Modified MVPs Guide (PDF)** documents information about the newly proposed MVPs and proposed changes to previously finalized MVPs.

The **Medicare Shared Savings Program Proposals Fact Sheet** documents information about proposals specific to Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs).

MIPS Overview

The following table outlines finalized policies applicable to one or more MIPS reporting options. There are 3 MIPS reporting options available:

- Traditional MIPS
- MIPS Value Pathways (MVPs)
- Alternative Payment Model (APM) Performance Pathway (APP)

The **2027 Proposed and Modified MVPs Guide** for information about the new and modified MVPs proposed for the CY 2027 performance period.

MIPS Value Pathways (MVPs) Development and Strategy

POLICY AREA	EXISTING POLICY	CY 2027 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Full MVP Implementation	**Sunsetting Traditional MIPS** No existing policy, but since 2019 we've signaled our intent to sunset the traditional MIPS reporting option through future rulemaking.	**Sunsetting Traditional MIPS** We're proposing to sunset the traditional MIPS reporting option after the CY 2028 performance period. Beginning with the CY 2029 performance period, MVPs would be the only MIPS reporting option for clinicians who don't participate in a MIPS APM. Clinicians participating in a MIPS APM would continue to have the option to report the APM Performance Pathway (APP)/APP Plus.	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2027 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
MVP Development and Maintenance	**MVP Inventory** There are 27 MVPs finalized for reporting in the CY 2026 performance period.	**MVP Inventory** We're proposing to add 3 new MVPs to the MVP inventory, for a total of 30 MVPs in the CY 2027 performance period including: • Diabetic Disease • Hypertension • Hospitalist We're also proposing to modify the 27 previously finalized MVPs, including a proposal to rename the Rehabilitative Support for Musculoskeletal Care MVP to Rehabilitative Support MVP.	• **MVPs**
Virtual Group Reporting	**MVP Reporting** Virtual groups can't report an MVP.	**MVP Reporting** We're proposing that virtual groups would be able to report an MVP beginning with the CY 2029 performance period.	• **MVPs**

Quality Performance Category

POLICY AREA	EXISTING POLICY	CY 2027 NPRM PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Quality Measures	**Quality Measure Inventory** There are 190 quality measures available for the 2026 performance period, excluding Qualified Clinical Data Registry (QCDR) measures which are approved outside the rulemaking process and are excluded from this total.	**Quality Measure Inventory** We're proposing a total of 180 quality measures for the CY 2027 performance period. QCDR measures are approved outside the rulemaking process and are excluded from this total. These proposals reflect: • Addition of 2 quality measures that focus on prevention and chronic disease management; one of these is proposed with a 1-year implementation delay to the CY 2028 performance period. (See Appendix B and Appendix C) • Adoption of 4 current QCDR measures as MIPS CQMs. (See Appendix B) • Replacement of 7 existing, functional improvement MIPS measures with 5 functional outcome measures for orthopedic patients. The 5 new measures are currently QCDR measures that are being proposed as MIPS CQMs. (See Appendix B) • Removal of 20 quality measures from the MIPS quality measure inventory. (See Appendix D). • Substantive changes to 43 existing quality measures.	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2027 NPRM PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Quality Measures	**High Priority Measure Designation** A high priority measure is defined as an outcome (including intermediate-outcome and patient-reported outcome), appropriate use, patient safety, efficiency, patient experience, care coordination, or opioid quality measure. A quality measure that otherwise meets the criteria for removal may be retained based on considerations including whether the quality measure is designated as high priority or not.	**High Priority Measure Designation** We're proposing to **remove the high priority designation** for quality measures**.** To align with the proposed removal of the high priority designation from MIPS quality measures, we're also proposing that we would no longer include the use of a high priority measure designation as one of the considerations for retaining a MIPS quality measure.	• **Traditional MIPS** • **MVPs**
Quality Measures	**MIPS Core Measure Designation** No existing policy	**MIPS Core Measure Designation** We're proposing a MIPS **core measure designation** for MVPs and traditional MIPS**.** We're proposing that this designation would apply to 78 measures in the MIPS inventory.	• **Traditional MIPS** • **MVPs**
Quality Reporting Requirements	**Requirement to Report an Outcome or High Priority Measure** MIPS eligible clinicians must report at least one outcome measure. If an applicable outcome measure isn't available, they can report a high priority measure instead.	**Requirement to Report an Outcome or High Priority Measure** We're proposing to **remove the requirement** that MIPS eligible clinicians report at least one outcome measure as one of their required measures, or a high priority measure if an applicable outcome measure isn't available.	• **Traditional MIPS** • **MVPs**

POLICY AREA	EXISTING POLICY	CY 2027 NPRM PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Quality Reporting Requirements	**Requirement to Report a MIPS Core Measure** No existing policy	**Requirement to Report a MIPS Core Measure** We're also proposing that, instead of reporting an outcome measure (or high priority measure if an outcome measure isn't available), MIPS eligible clinicians would be required to report a MIPS core measure. **Small practices would be exempt from this requirement.** Specifically: • For traditional MIPS, clinicians would be required to report a MIPS core measure as 1 of their 6 quality measures. They would be able to select any measure in the MIPS quality measure inventory with the MIPS core measure designation, or from a specialty measure set as applicable and available. • For MVPs, clinicians would be required to report a MIPS core measure as 1 of their 4 quality measures. They would be able to select any measure with the MIPS core measure designation for their selected MVP.	• **Traditional MIPS** • **MVPs**

POLICY AREA	EXISTING POLICY	CY 2027 NPRM PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Quality Reporting Requirements	**Requirement to Report a MIPS Core Measure** No existing policy	**Requirement to Report a MIPS Core Measure** (Proposed Policy Continued) If a clinician, group, virtual group, subgroup, or APM Entity reporting an MVP or traditional MIPS doesn't have an applicable MIPS core measure available to report, we're proposing to implement a self-attestation process: • The clinician would be required to attest that there wasn't an applicable MIPS core measure available for them to report. • The clinician would then choose another measure to report in place of the MIPS core measure. **Small practices would be exempt from the MIPS core measure requirement and the self-attestation process.**	• **Traditional MIPS** • **MVPs**

POLICY AREA	EXISTING POLICY	CY 2027 NPRM PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Quality Measure Scoring	**Scoring MIPS Core Measures** No existing policy	**Scoring MIPS Core Measures** We're proposing that if a MIPS eligible clinician, group, virtual group, subgroup, or APM Entity reporting an MVP or traditional MIPS doesn't report a MIPS core measure and isn't a small practice, they would receive 0 out of 10 points for one of their required measures unless they: • Submitted an attestation that they didn't have an applicable MIPS core measure. **AND** • Submitted another measure in its place.	• **Traditional MIPS** • **MVPs**

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<tr><th>POLICY AREA</th><th>EXISTING POLICY</th><th>CY 2027 NPRM PROPOSED POLICY</th><th>APPLICABLE MIPS REPORTING OPTION(S)</th></tr>
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<td>Quality Measure Scoring</td>
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Defined Topped Out Measure Benchmarks
We apply an alternative benchmarking methodology to a subset of topped out measures (those that belong to specialty sets and MVPs with limited measure choice, a high proportion of topped out measures that are subject to the 7-point scoring cap, and in areas that lack measure development, which precludes meaningful participation in MIPS.)
Specifically, we'll apply the following benchmarks:
<table>
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<tr><td>86-87.9%</td><td>2- 2.9</td></tr>
<tr><td>88-89.9%</td><td>3-3.9</td></tr>
<tr><td>90-91.9%</td><td>4-4.9</td></tr>
<tr><td>92-93.9%</td><td>5-5.9</td></tr>
<tr><td>94-95.9%</td><td>6-6.9</td></tr>
<tr><td>96-97.9%</td><td>7-7.9</td></tr>
<tr><td>98-98.9%</td><td>8-8.9</td></tr>
<tr><td>99-99.99%</td><td>9-9.9</td></tr>
<tr><td>100%</td><td>10</td></tr>
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Defined Topped Out Measure Benchmarks
We're proposing that 17 quality measures receive the previously defined topped out measure benchmarks for the CY 2027 performance period, including 2 measures that aren't currently receiving the defined topped out measure benchmark. These measures belong to specialty sets and MVPs with limited measure choice and a high proportion of topped out measures, in areas that lack measure development, which precludes meaningful participation in MIPS.
We're also proposing that these measures would be published and maintained on the QPP website instead of the Federal Register.
We're proposing that, beginning in the CY 2027 performance period, topped out MIPS core measures subject to the 7-point scoring cap (i.e., are topped out for 2 or more consecutive performance period) would no longer be subject to that cap and would instead be scored according to the defined topped out measure benchmark (with a 10-point maximum).
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Traditional MIPS
MVPs
APP
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POLICY AREA	EXISTING POLICY	CY 2027 NPRM PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Alternative Payment Model (APM) Performance Pathway (APP)	**APP Plus Quality Measure Set** Shared Savings Program ACOs are required to report the APP Plus quality measure set. The existing APP Plus quality measure set was established for the CY 2025 performance period and subsequent performance periods. (We note that the measure set was updated in the CY 2026 PFS final rule to reflect changes to the MIPS quality measure inventory.) **Measures Available Beginning with Performance Period 2025:** 1. Diabetes: Glycemic Status Assessment Greater than 9% (Quality ID: 001) 2. Preventive Care and Screening: Screening for Depression and Follow-up Plan (Quality ID: 134) 3. Controlling High Blood Pressure (Quality ID: 236) 4. CAHPS for MIPS (Quality ID: 321) 5. Hospital-Wide, 30-day, All Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups (Quality ID: 479) 6. Breast Cancer Screening (Quality ID: 112) **Additional Measures Available Beginning with Performance Period 2026:** 7. Colorectal Cancer Screening (Quality ID: 113) 8. Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions measure (Quality ID: 484)	**APP Plus Quality Measure Set** We're proposing to remove 2 previously finalized measures from the APP Plus quality measure set: • Initiation and Engagement of Substance Use Disorder Treatment (Quality ID: 305) • Adult Immunization Status (Quality ID: 493) If finalized, there would be 8 measures in the APP Plus quality measure set in the CY 2027 performance period and subsequent performance periods. Please refer to Appendix E for the proposed APP Plus quality measure set, including the proposed collection types.	• **APP**

POLICY AREA	EXISTING POLICY	CY 2027 NPRM PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Alternative Payment Model (APM) Performance Pathway (APP)	**APP Plus Quality Measure Set** (Continued) **Additional Measures to be Available Beginning with Performance Period 2027:** 9. Initiation and Engagement of Substance Use Disorder Treatment (Quality ID: 305) **Additional Measures to be Available Beginning with Performance Period 2028** (or the performance period that is one year after the eCQM specification becomes available, whichever is later): 10. Adult Immunization Status (Quality ID: 493)	**APP Plus Quality Measure Set** We're proposing to remove 2 previously finalized measures from the APP Plus quality measure set: • Initiation and Engagement of Substance Use Disorder Treatment (Quality ID: 305) • Adult Immunization Status (Quality ID: 493)	• **APP**
APP Plus Quality Reporting Requirements	**Collection Types for Shared Savings Program ACOs** In addition to ACOs administering the CAHPS for MIPS Survey and 2 administrative claims measures that are calculated by CMS, there are 3 collection types available to Shared Savings Program ACOs when reporting the APP Plus quality measure set: • eCQMs • Medicare CQMs • MIPS CQMs (available through the CY 2026 performance period)	**Collection Types for Shared Savings Program ACOs** We're proposing to **extend the availability of the MIPS CQMs collection type** for Shared Savings Program ACOs reporting the APP Plus quality measure set. • If finalized, the MIPS CQMs collection type would remain available for ACO reporting in the CY 2027 performance period and subsequent performance periods. We're proposing to **revise the definition of a "beneficiary eligible for Medicare CQMs"** for the CY 2027 performance period and subsequent performance periods, to align with the population of beneficiaries assigned to the ACO.	• **APP**

POLICY AREA	EXISTING POLICY	CY 2027 NPRM PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
	Medicare eCQMs No existing policy	**Medicare eCQMs** For the CY 2027 performance period and subsequent performance periods, we're also proposing to establish a new collection type, Medicare eCQMs, which would only be available to Shared Savings Program ACOs reporting the APP Plus quality measure set. • Similar to Medicare CQMs, the Medicare eCQM patient population would be based on the ACO's assigned beneficiaries. The Medicare eCQM would generally follow the eCQM measure specifications; however, they would be reported on a different population and use a different identifier to distinguish that the submission is for a Medicare eCQM rather than for an eCQM. ACOs that choose to report Medicare eCQMs wouldn't be eligible for the Complex Organization Adjustment or the eCQM/MIPS CQM reporting incentive under the Shared Savings Program.	• **APP**
APP Plus Quality Scoring	**Medicare CQM Benchmarks** Medicare CQMs are scored according to flat benchmarks for their first 2 years in MIPS, after which they're eligible to receive a historical benchmark.	**Medicare CQM Benchmarks** We're proposing that all measures of the Medicare CQMs collection type would be scored using flat benchmarks for the CY 2027 performance period and subsequent performance periods.	• **APP**

POLICY AREA	EXISTING POLICY	CY 2027 NPRM PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
	Medicare CQM Benchmarks Medicare CQMs are scored according to flat benchmarks for their first 2 years in MIPS, after which they're eligible to receive a historical benchmark.	**Medicare CQM Benchmarks** (Continued) We're also proposing to retroactively apply flat benchmarks to 3 Medicare CQMs for the CY 2026 performance period: • Diabetes: Glycemic Status Assessment Greater Than 9% (Quality ID: 001) • Preventive Care and Screening: Screening for Depression and Follow-up Plan (Quality ID: 134) • Controlling High Blood Pressure (Quality ID: 236) If finalized, all Medicare CQMs would be scored using flat benchmarks for the CY 2026 performance period and subsequent performance periods.	• **APP**
APP Plus Quality Scoring	**Medicare eCQM Benchmarks** No existing policy	**Medicare eCQM Benchmarks** We're proposing that measures of the Medicare eCQMs collection type would be scored using flat benchmarks for the CY 2027 performance period and subsequent performance periods.	• **APP**

Cost Performance Category

POLICY AREA	EXISTING POLICY	CY 2027 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Cost Measures	**Operational List of Care Episode and Patient Condition Groups and Codes** Section 1848(r)(2)(H) of the Act requires that not later than November 1 of each year, CMS revise the operational list of care episode and patient condition codes through rulemaking. This list is updated annually in conjunction with any newly added, removed, or modified cost measures in MIPS or to reflect any changes to codes used in the measure that are identified as part of measure maintenance.	**Operational List of Care Episode and Patient Condition Groups and Codes** We're proposing to update this list to reflect non-substantive measure maintenance updates. The operational list will be posted in tandem with the proposed rule for public comment. There are no proposed cost measure inventory updates for the CY 2027 performance period.	• Traditional MIPS • MVPs

Improvement Activities Performance Category

POLICY AREA	EXISTING POLICY	CY 2027 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Improvement Activities	**Inventory** There are 95 improvement activities available for the 2026 performance period.	**Inventory** We're proposing the following changes to the improvement activities inventory for the 2027 performance period: • Addition of 6 new activities (See Appendix F) • Modification of 5 existing activities • Removal of 11 activities (See Appendix G)	• Traditional MIPS • MVPs

Promoting Interoperability Performance Category

POLICY AREA	EXISTING POLICY	CY 2027 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
CEHRT Requirements	**Definition of Certified Electronic Health Record Technology (CEHRT)** The definition of CEHRT is as follows. For 2019 and subsequent years, electronic health record (EHR) technology (which could include multiple technologies) certified under the Office of the National Coordinator for Health Information Technology (ONC) Health Information Technology (IT) Certification Program that meets the 2015 Edition Base EHR definition, or subsequent Base EHR definition (as defined in 45 CFR 170.102), and has been certified to the ONC health IT certification criteria as adopted and updated in 45 CFR 170.315— (i) At 45 CFR 170.315(a)(12) (family health history) and 45 CFR 170.315(e)(3) (patient health information capture); and (ii) Necessary to report on applicable objectives and measures specified for MIPS including the following: (A) The applicable measure calculation certification criterion at 45 CFR 170.315(g)(1) or (2) for all certification criteria that support an objective with a percentage-based measure. (B) Clinical quality measure certification criteria that support the calculation and reporting of clinical quality measures at 45 CFR 170.315(c)(2) and (c)(3)(i) and (ii) and optionally (c)(4) and can be electronically accepted by CMS.	**Definition of Certified Electronic Health Record Technology (CEHRT)** We're proposing modifications to the definition of CEHRT at 42 CFR 414.1305 to align with the decertification proposals for the ONC Health IT Certification Criteria as outlined in the Health Data, Technology, and Interoperability: ASTP/ONC Deregulatory Actions to Unleash Prosperity (HTI-5) Proposed Rule. The following ONC Health IT Certification Criteria are proposed for decertification and would be removed from the definition of CEHRT: • Family Health History – 45 CFR 170.315 (a)(12) • Patient Health Information Capture - 45 CFR 170.315 (e)(3) • Automated Numerator Recording - 45 CFR 170.315 (g)(1) • Automated Measure Calculation – 45 CFR 170.315 (g)(2) • Clinical Quality Measures – Filter – 45 CFR 170.315 (c)(4) Additionally, we would modify the reference to the "clinical quality measures -report" (45 CFR 170.315(c)(3)) ONC health IT certification criterion from "(c)(3)(i) and (ii)" to "(c)(3)," which would align with the proposed revisions in the HTI-5 Proposed Rule.	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2027 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Promoting Interoperability Measure Inventory	**ONC Direct Review Attestation and ONC-Authorized Certified Bodies (ACB) Surveillance Attestation** The ONC Direct Review attestation is a required attestation. The ONC Authorized Certified Bodies (ACB) Surveillance attestation is an optional attestation.	**ONC Direct Review Attestation and ONC-ACB Surveillance Attestation** We're proposing to **remove** the **required ONC Direct Review attestation and the optional ONC-ACB Surveillance attestation** starting with the CY **2026** performance period (data submission in CY 2027).	• **Traditional MIPS** • **MVPs** • **APP**
Promoting Interoperability Measure Inventory	**Security Risk Analysis Measure** The Security Risk Analysis measure is a required measure.	**Security Risk Analysis Measure** We're proposing to **remove** the required **Security Risk Analysis measure** starting with the CY **2027** performance period.	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2027 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Promoting Interoperability Measure Inventory	**Electronic Prior Authorization Measure** This is a "Yes"/ "No" attestation measure within the Health Information Exchange (HIE) objective. • MIPS eligible clinicians must attest that they have requested a prior authorization electronically via a Prior Authorization API using data from CEHRT for at least one medical item or service (excluding drugs) during the reporting period. This measure was finalized for inclusion in Promoting Interoperability performance category starting with the CY 2027 performance period as outlined the 2024 CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F).	**Electronic Prior Authorization Measure** We're proposing to modify the measure in the following ways: • Change the measure to an optional/bonus measure for the CY 2027 performance period. ○ The measure would be required starting with the CY 2028 performance period. • Require the use of CEHRT that includes health IT modules certified to at least one of the 3 electronic prior authorization criteria to complete at least one prior authorization request for at least one medical item or service (excluding drugs) for the CY 2027 performance period. • Require the use of CEHRT that includes Health IT Modules certified to all 3 ONC electronic prior authorization criteria beginning with the CY 2028 performance period.	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2027 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Promoting Interoperability Measure Inventory	**Electronic Prior Authorization for Prescription Drugs Measure** No existing measure	**Electronic Prior Authorization for Prescription Drugs Measure** We're proposing a **new measure, Electronic Prior Authorization for Prescription Drugs**, which would require the use of CEHRT that includes health IT modules certified to ONC's electronic prescribing and real-time prescription benefit criteria (which rely on National Council for Prescription Drug Programs (NCPDP) standards) to complete at least one prior authorization request for prescription drugs and medications starting with the CY **2028** performance period/2030 MIPS payment year. This proposal aligns with proposals in the 2026 CMS Interoperability Standards and Prior Authorization for Drugs Proposed Rule (CMS-0062-P).	• **Traditional MIPS** • **MVPs** • **APP**

Final Scoring

POLICY AREA	EXISTING POLICY	CY 2027 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Reweighting Performance Categories	**Automatic Extreme and Uncontrollable Circumstances Reweighting** We will determine if an individual MIPS eligible clinician is in an impacted area based on the practice location address listed in the Provider Enrollment, Chain and Ownership System (PECOS).	**Automatic Extreme and Uncontrollable Circumstances Reweighting** Beginning with the CY 2027 performance period/2029 MIPS payment year, we're proposing to remove the specification of a data source (PECOS), so we have more flexibility to use the most up to date and accurate data source available to determine eligibility for reweighting under the automatic extreme and uncontrollable circumstances (EUC) policy.	• **Traditional MIPS** • **MVPs** • **APP**
	Reweighting in Cases Where Data Aren't Submitted by a Third Party Intermediary MIPS eligible clinicians must notify CMS by November 1 of the data submission year if their data wasn't submitted by their third party intermediary due to circumstances outside of the clinician's control.	**Reweighting in Cases Where Data Aren't Submitted by a Third Party Intermediary** We're proposing, beginning with the CY 2025 performance period/2027 MIPS payment year, to extend the deadline for clinicians to notify CMS from November 1 to December 31 of the data submission year.	• **Traditional MIPS** • **MVPs** • **APP**

Third Party Intermediaries

POLICY AREA	EXISTING POLICY	CY 2027 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Qualified Clinical Data Registries (QCDRs) and Qualified Registries	**Performance Feedback** QCDRs and qualified registries must provide performance feedback at least 4 times a year to "clinicians and groups", including specific feedback on how QPP participants compare to others who have submitted data on a given measure. **Third Party Intermediaries with Fewer Than 10 QPP Participants** Our sampling methodology for data validation purposes requires that the third party intermediary must sample a combination of 3 percent of QPP participants for which the QCDR or qualified registry will submit MIPS data for the particular participation option. The sample size may be no fewer than a combination of 10 individual clinicians, groups, virtual groups, subgroups and APM entities, and no more than a combination of 50 individual clinicians, groups, virtual groups, subgroups and APM entities.	**Performance Feedback** We're proposing to replace "clinicians and groups" with "individual clinicians, groups, virtual groups, subgroups, and APM entities" to clarify that the performance feedback should be provided at the level at which the data was submitted to reduce confusion. **Third Party Intermediaries with Fewer Than 10 QPP Participants** We're proposing to clarify that if the QCDR or qualified registry submits MIPS data to CMS for fewer than 10 QPP participants, then the data validation audit sample must include all QPP participants to ensure that the data submitted are true, accurate, and complete.	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2027 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Qualified Clinical Data Registries (QCDRs) and Qualified Registries	**QPP Participants with Fewer Than Five Patient Records** Our sampling methodology for patients' records data for auditing purposes requires that the third party intermediary must submit a sample that includes at least 25% of the patients of each participation type in the sample, except that the sample for each must include a minimum of 5 patients and need not include more than 50 patients. **Submit a Participation Plan When Not Submitting Data for One Year** If a third party intermediary doesn't submit data for either of the 2 years preceding the applicable self-nomination period, they must submit a participation plan with their self-nomination.	**QPP Participants with Fewer Than Five Patient Records** We're proposing to clarify that if the 25% of the patient records sample is fewer than 5 patient records, the patient record audit sample must include all patient records to ensure that the data submitted are true, accurate, and complete. **Submit a Participation Plan When Not Submitting Data for One Year** We're proposing that a third party intermediary will be required to submit a participation plan with their self-nomination if they don't submit data for the year preceding the applicable self-nomination period. For example: • The 2028 self-nomination period will be July 1, 2027 – September 1, 2027. • The 2026 data submission period will be January 2, 2027 – March 31, 2027. • Qualified Registry X was approved to submit data for the CY 2026 performance period but didn't, so they would be required to submit a participation plan if they were self-nominating for the CY 2028 performance period.	• **Traditional MIPS** • **MVPs** **APP**

POLICY AREA	EXISTING POLICY	CY 2027 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Qualified Clinical Data Registries (QCDRs) and Qualified Registries	**Changes to Qualified Posting** Third party intermediaries are asked to review the "Qualified Posting", which is a CMS-generated posting that includes information about the measures/activities supported, the cost of the service, and the services included in the cost. <u>Termination When Not Submitting Data for One Year</u> A third party intermediary that doesn't submit data for the performance period for which they submitted a self-nomination participation plan will be terminated.	**Changes to Qualified Posting** We're proposing that if a third party intermediary has changes in information, then this qualified posting may not be updated for the public, even if the information is provided to CMS. <u>Termination When Not Submitting Data for One Year</u> We're proposing that third parties with a participation plan would also need to provide CMS with documentation that they have contracted with QPP participants who will submit MIPS data for the given MIPS performance period. • If documentation can't be provided by the date specified by CMS, the third party intermediary will be terminated.	• **Traditional MIPS** • **MVPs** **APP**

Public Reporting Overview

POLICY AREA	EXISTING POLICY	CY 2027 PROPOSED POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Public Reporting Delays	There's a 1-year delay to publicly report new improvement activities and Promoting Interoperability measure and attestation information for MVP participants on Compare Tools.	We're proposing to remove the requirement that we would not publicly report any MVP data on new improvement activity or Promoting Interoperability measure, objective, or activity during the first year in which it is included in an MVP.	• **MVPs**

Advanced APMs Overview

<table>
<tr><th>POLICY AREA</th><th>EXISTING POLICY</th><th>CY 2027 PROPOSED POLICY</th></tr>
<tr><td>Qualifying APM Participants (QPs)</td><td>Application of QP and Partial QP Status

Clinicians participating in Advanced APMs (e.g., ACOs) who meet specific thresholds become Qualifying APM Participants (QPs) and receive payment incentives in lieu of MIPS participation. Beginning in 2026, QPs receive a higher fee schedule update that grows by 0.5% annually relative to non-QPs.

Under current policy, QP determinations are made at the NPI level, meaning financial incentives flow to all TINs a clinician bills under, including those not participating in any Advanced APM.

• Clinicians who achieve QP status are exempt from MIPS at every TIN they bill under.</td><td>Application of QP and Partial QP Status

CMS proposes to apply QP and Partial QP determinations at the TIN/NPI level, ensuring that financial incentives are directed only to TINs actively participating in Advanced APMs.

• Clinicians would only be exempt from MIPS at the TIN (or TINs) in which they achieved QP status.</td></tr>
<tr><td>Qualifying APM Participants (QPs)</td><td>QP thresholds

Under existing policy, the QP thresholds are as such:

<table><tr><th>Performance Year</th><th>Payment Year</th><th>QP Payment Amount</th><th>QP Patient Count</th></tr><tr><td>2024</td><td>2026</td><td>50%</td><td>35%</td></tr><tr><td>2025 and beyond</td><td>2027 and beyond</td><td>75%</td><td>50%</td></tr></table></td><td>QP thresholds

As a result of the Consolidated Appropriations Act, 2026, we’re proposing to update the QP thresholds as such:

<table><tr><th>Performance Year</th><th>Payment Year</th><th>QP Payment Amount</th><th>QP Patient Count</th></tr><tr><td>2024</td><td>2026</td><td>50%</td><td>35%</td></tr><tr><td>2025</td><td>2027</td><td>75%</td><td>50%</td></tr><tr><td>2026</td><td>2028</td><td>50%</td><td>35%</td></tr><tr><td>2027 and beyond</td><td>2029 and beyond</td><td>75%</td><td>50%</td></tr></table></td></tr>
</table>

<table>
<tr><th>POLICY AREA</th><th>EXISTING POLICY</th><th>CY 2027 PROPOSED POLICY</th></tr>
<tr>
<td>Qualifying APM Participants (QPs)</td>
<td>
Partial QP thresholds
Under existing policy, the Partial QP thresholds are as such:
<table>
<tr><th>Performance Year</th><th>Payment Year</th><th>Partial QP Payment Amount</th><th>Partial QP Patient Count</th></tr>
<tr><td>2024</td><td>2026</td><td>40%</td><td>25%</td></tr>
<tr><td>2025 and beyond</td><td>2027 and beyond</td><td>50%</td><td>35%</td></tr>
</table>
</td>
<td>
Partial QP thresholds
As a result of the Consolidated Appropriations Act, 2026, we're proposing to update the Partial QP thresholds as such:
<table>
<tr><th>Performance Year</th><th>Payment Year</th><th>Partial QP Payment Amount</th><th>Partial QP Patient Count</th></tr>
<tr><td>2024</td><td>2026</td><td>40%</td><td>25%</td></tr>
<tr><td>2025</td><td>2027</td><td>50%</td><td>35%</td></tr>
<tr><td>2026</td><td>2028</td><td>40%</td><td>25%</td></tr>
<tr><td>2027 and beyond</td><td>2029 and beyond</td><td>50%</td><td>35%</td></tr>
</table>
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</tr>
</table>

How Do I Comment on the CY 2027 PFS Proposed Rule?

The proposed rule includes directions for submitting comments. We must receive comments within the 60-day comment period which closes Monday, September 14, 2026. When commenting, refer to file code: CMS-1848-P.

We don't accept FAX transmissions.

Use 1 of the 3 following ways to officially submit your comments:

- **Electronically**: https://www.regulations.gov
- **Regular mail**: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1848-P, P.O. Box 8016, Baltimore, MD 21244-8016.
- **Express or overnight mail**: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1848-P, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.

You can access the proposed rule using the "Regulatory Resources" filter of the QPP Resource Library.

Contact Us

We encourage clinicians to contact the QPP Service Center. Contact the Quality Payment Program Service Center by emailing QPP@cms.hhs.gov, submitting a QPP Service Center ticket, or calling at 1-866-288-8292 (Monday-Friday, 8 a.m. - 8 p.m. ET). People who are deaf or hard of hearing can dial 711 to be connected to a TRS Communications Assistant. You can also visit the Quality Payment Program website for educational resources, information, and upcoming webinars.

Version History

Date	Change Description
07/27/2026	Clarified proposed changes to the Electronic Prior Authorization Measure and the newly proposed Electronic Prior Authorization for Prescription Drugs Measure (Promoting Interoperability).
07/17/2026	Added links to the CY 2027 Medicare PFS Proposed Rule and the 2027 Proposed and Modified MVPs Guide. Corrected the link to the Medicare Shared Savings Program Proposals Fact Sheet. Added the comment period end date and updated the link for electronic comment. Minor formatting updates.
07/10/2026	Original Version.

Appendix A: Previously Finalized Policies for the 2027 Performance Period

The table below identifies policies finalized in an earlier rule that apply to the 2027 performance period.

Policy Area	Previously Finalized Policy Applicable to the CY 2027 Performance Period
Final Scoring	
Performance Threshold	We previously finalized that the performance threshold is set at 75 points through the CY 2028 performance period.

Appendix B: New Quality Measures Proposed for the 2027 Performance Period and Future Years

Measure Title And Steward	Description	Collection Type	Measure Type	Rationale for Inclusion
Low Density Lipoprotein Cholesterol (LDL-C) Monitoring and Management American Heart Association	Percentage of patients aged 18 years and older with clinical atherosclerotic cardiovascular disease (ASCVD) who received a low-density lipoprotein cholesterol (LDL-C) test via lipid panel and achieved an LDL-C of <70mg/dL on the most recent test during the performance period.	MIPS CQM	Intermediate Outcome	We are proposing this outcome measure because it addresses care for adult patients with clinical atherosclerotic cardiovascular disease (ASCVD), ensuring they are tested annually for LDL-C and have achieved a desired LDL-C outcome. Studies support that lowering LDL-C produces marked reduction in clinical ASCVD and that lower is better for LDL-C. This measure aims to ensure that patients receiving cholesterol lowering treatment, such as statin therapy, achieve an LDL-C of <70 mg/dL, resulting in a reduction in ASCVD risk and improved patient outcomes.
Functional Improvement for Patients with Neck Impairments Limber Health, Inc. and Patient360, LLC	Percentage of patients aged 18 years and older with a neck impairment that met the risk-adjusted Predicted Moderate Clinical Improvement (P-MCI) on the PROMIS Pain Interference (PPI) or the alternative (legacy) patient-reported outcome measure (PROM), the Neck Disability Index (NDI).	MIPS CQM	Patient-Reported Outcome-Based Performance Measure (PRO-PM)	We are proposing this current QCDR patient-reported outcome-based performance measure to replace current MIPS CQM, Q478: Functional Status Change for Patients with Neck Impairments. This new measure addresses the same clinical topic but allows for broader implementation by including widely available tools to assess physical function improvement. Additionally, this measure's analytic allows independent calculation of performance by the clinician, or easy and free collaboration with the steward, allowing for more streamlined reporting of rehabilitative care.

Measure Title And Steward	Description	Collection Type	Measure Type	Rationale for Inclusion
Functional Improvement for Patients with Upper Extremity Impairments Limber Health, Inc. and Patient360, LLC	Percentage of patients aged 18 years and older with an upper extremity impairment that met the risk-adjusted Predicted Moderate Clinical Improvement (P-MCI) on the PROMIS Upper Extremity (PUE) or the alternative (legacy) patient-reported outcome measure (PROM), the Quick Disabilities of the Arm, Shoulder, & Hand (QDASH).	MIPS CQM	Patient-Reported Outcome-Based Performance Measure (PRO-PM)	We are proposing this current QCDR patient-reported outcome-based performance measure to replace current MIPS CQM, Q222: Functional Status Change for Patients with Elbow, Wrist or Hand Impairments. This new measure addresses the same clinical topic but allows for broader implementation by including widely available tools to assess physical function improvement. Additionally, this measure's analytic allows independent calculation of performance by the clinician, or easy and free collaboration with the steward, reducing burden for reporting this important aspect of rehabilitative care.
Functional Improvement for Patients with Back Impairments Limber Health, Inc. and Patient360, LLC	Percentage of patients aged 18 years and older with a back impairment that met the risk-adjusted Predicted Moderate Clinical Improvement (P-MCI) on the PROMIS Pain Interference (PPI) or the alternative (legacy) patient-reported outcome measure (PROM), the Modified Low Back Disability Questionnaire (MDQ).	MIPS CQM	Patient-Reported Outcome-Based Performance Measure (PRO-PM)	We are proposing this current QCDR patient-reported outcome-based performance measure to replace current MIPS CQM, Q220: Functional Status Change for Patients with Low Back Impairments. This new measure addresses the same clinical topic but allows for broader implementation by including widely available tools to assess physical function improvement. Additionally, this measure's analytic allows independent calculation of performance by the clinician, or easy and free collaboration with the steward, reducing burden for reporting this important aspect of rehabilitative care.

Measure Title And Steward	Description	Collection Type	Measure Type	Rationale for Inclusion
Functional Improvement for Patients with Lower Extremity Impairments Limber Health, Inc. and Patient360, LLC	Percentage of patients aged 18 years and older with a lower extremity impairment—not including knee impairments—that met the risk-adjusted Predicted Moderate Clinical Improvement (P-MCI) on the PROMIS Physical Function (PPF) or alternative (legacy) patient-reported outcome measure (PROM), the Lower Extremity Functional Scale (LEFS).	MIPS CQM	Patient-Reported Outcome-Based Performance Measure (PRO-PM)	We are proposing this current QCDR patient-reported outcome-based performance measure to replace current MIPS CQMs, Q218: Functional Status Change for Patients with Hip Impairments and Q219: Functional Status Change for Patients with Lower Leg, Foot or Ankle Impairments. This new measure addresses the same clinical topic but allows for broader implementation by including widely available tools to assess physical function improvement. Additionally, this measure's analytic allows independent calculation of performance by the clinician, or easy and free collaboration with the steward, reducing burden for reporting this important aspect of rehabilitative care.
Functional Improvement for Patients with Knee Impairments Limber Health, Inc. and Patient360, LLC	Percentage of patients aged 18 years and older with a knee impairment that met the risk-adjusted Predicted Moderate Clinical Improvement (P-MCI) on the PROMIS Physical Function (PPF) or the alternative (legacy) patient-reported outcome measure (PROM), the Knee Outcome Survey (KOS).	MIPS CQM	Patient-Reported Outcome-Based Performance Measure (PRO-PM)	We are proposing this current QCDR patient-reported outcome-based performance measure to replace current MIPS CQM, Q217: Functional Status Change for Patients with Knee Impairments. This new measure addresses the same clinical topic but allows for broader implementation by including widely available tools to assess physical function improvement. Additionally, this measure's analytic allows independent calculation of performance by the clinician, or easy and free collaboration with the steward, reducing burden for reporting this important aspect of rehabilitative care.

Measure Title And Steward	Description	Collection Type	Measure Type	Rationale for Inclusion
Age-Related Hearing Loss: Comprehensive Audiometric Evaluation American Academy of Otolaryngology - Head and Neck Surgery Foundation	Percentage of patients aged 50 years and older who failed a hearing screening and/or who report suspected hearing loss or tinnitus who were ordered or referred for a comprehensive audiometric evaluation on the day of diagnosis/office visit OR received a comprehensive audiometric evaluation within 4 weeks of the office visit.	MIPS CQM	Process	We are proposing this current QCDR measure as it fills a gap in the Quality Care for the Treatment of Ear, Nose, and Throat Disorders MVP, is specific to audiology, and ensures that patients that fail a hearing screen receive a comprehensive audiometric evaluation. Age-related hearing loss is a prevalent condition, though often undiagnosed in patients aged 50 and older. Deleterious downstream health risks include dementia, depression, cardiovascular disease, and falls. Implementation of this measure as a MIPS CQM will allow wider availability for reporting by MIPS eligible clinicians.
Patient-Reported Experience with Anesthesia American Society of Anesthesiologists Anesthesia Quality Institute	Percentage of patients, aged 18 and older, who were surveyed on their patient experience and satisfaction with anesthesia care and who reported a positive experience.	MIPS CQM	Patient-Reported Outcome-Based Performance Measure (PRO-PM)	We are proposing this current QCDR patient-reported outcome-based performance measure as it fills a gap in the Anesthesiology Specialty Set and is a potential addition to the Patient Safety and Support of Positive Experiences with Anesthesia MVP. It would be the only patient experience of care measure for that specialty and is reported for each procedure. It ensures patients receive a valid survey and assesses for reports of a positive experience with their anesthesia care. The assessment of patient satisfaction with anesthesia care provides important feedback allowing clinicians to improve the quality of care delivered. There is a vast array of tools available for practices and individual clinicians to implement based upon local patient populations.

Measure Title And Steward	Description	Collection Type	Measure Type	Rationale for Inclusion
Intraoperative Hypotension (IOH) Among Non-Emergent Noncardiac Surgical Cases Anesthesia Quality Registry (AQR QCDR) in Collaboration with Anesthesia Quality Institute (AQI) and American Society of Anesthesiologists (ASA)	Percentage of general, neuraxial, or regional anesthesia care cases performed during the performance period in which the mean arterial pressure (MAP) fell below 65 mmHg for a cumulative total of 15 minutes or more.	MIPS CQM	Intermediate Outcome	We are proposing this current QCDR measure as it fills a gap in the Anesthesiology Specialty Set and is a potential addition to the Patient Safety and Support of Positive Experiences with Anesthesia MVP. This inverse, intermediate outcome measure ensures a patient's MAP does not fall below 65mmHg for greater than 15 minutes during a procedure as this clinical event is associated with adverse outcomes such as kidney or myocardial injury.
SGLT2 Inhibitors for Patients with Chronic Kidney Disease (CKD) With or Without type 2 Diabetes Mellitus A Value-Based Care Registry	The percentage of patients aged 18 years and older with chronic kidney disease (CKD) stages 2 and 3 who are prescribed an SGLT2 inhibitor during the measurement period.	MIPS CQM	Process	We are proposing this current QCDR measure as it fills a gap in the MIPS Quality Measure Inventory and promotes appropriate, evidence based treatment of patients diagnosed with CKD with SGLT2 inhibitors. These medications have been shown to slow the progression of CKD and reduce cardiovascular events in this patient population. This measure has potential to be included in multiple Specialty Sets and MVPs, as it could be reported by Cardiology, Endocrinology, Family Medicine, Geriatrics, Internal Medicine, Nephrology, and Primary Care.

Appendix C: New Quality Measure Proposed for the 2028 Performance Period and Future Years

Measure Title And Steward	Description	Collection Type	Measure Type	Rationale for Inclusion
Rate of Timely Follow-up on Abnormal Screening Mammograms for Breast Cancer Detection Brigham and Women's Hospital	This electronic Clinical Quality Measure (eCQM) reports the percentage of female patients aged 40 to 75 years with at least one abnormal screening (BI-RADS 0) or screening-to-diagnostic (BI-RADS 4, 5) mammogram during the measurement period (i.e., calendar year) who received timely diagnostic resolution defined as either follow-up imaging with negative/benign/probably benign results or a breast biopsy within 60 days after their index (i.e., first) abnormal screening mammogram.	eCQM	Process	We are proposing this eCQM because it addresses timely follow up diagnostic testing for patients with an abnormal mammogram. Additionally, it fills a gap in the Diagnostic Radiology specialty set with potential for inclusion in an MVP. We are proposing a one-year delay in implementation to allow time for clinicians to adapt their workflows and therefore ensure greater feasibility of reporting this measure within MIPS.

Appendix D: Quality Measures Proposed for Removal in the 2027 Performance Period and Future Years

Quality #	Collection Type / Measure Type	Measure Title and Description	Measure Steward	Rationale for Removal
006	MIPS CQM Process	**Coronary Artery Disease (CAD): Antiplatelet Therapy:** Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease (CAD) seen within a 12-month period who were prescribed aspirin or clopidogrel.	American Heart Association	No longer maintained by measure steward
007	eCQM, MIPS CQM Process	**Coronary Artery Disease (CAD): Beta-Blocker Therapy – Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF ≤ 40%):** Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12-month period who also have a prior MI or a current or prior LVEF ≤ 40% who were prescribed beta-blocker therapy.	American Heart Association	No longer maintained by measure steward
143	eCQM, MIPS CQM Process	**Oncology: Medical and Radiation – Pain Intensity Quantified:** Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified.	American Society of Clinical Oncology	End of topped out lifecycle with limited opportunity to improve clinical outcomes
217	MIPS CQM Patient-Reported Outcome-Based Performance Measure	**Functional Status Change for Patients with Knee Impairments:** A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with knee impairments. The change in FS is assessed using the FOTO Lower Extremity Physical Function (LEPF) PROM. The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk-adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.	Focus on Therapeutic Outcomes, Inc.	Duplicative of new measure: Functional Improvement for Patients with Knee Impairments

Quality #	Collection Type / Measure Type	Measure Title and Description	Measure Steward	Rationale for Removal
218	MIPS CQM Patient-Reported Outcome-Based Performance Measure	**Functional Status Change for Patients with Hip Impairments:** A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with hip impairments. The change in FS is assessed using the FOTO Lower Extremity Physical Function (LEPF) PROM. The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.	Focus on Therapeutic Outcomes, Inc.	Duplicative of new measure: Functional Improvement for Patients with Lower Extremity Impairments
219	MIPS CQM Patient-Reported Outcome-Based Performance Measure	**Functional Status Change for Patients with Lower Leg, Foot or Ankle Impairments:** A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with foot, ankle or lower leg impairments. The change in FS is assessed using the FOTO Lower Extremity Physical Function (LEPF) PROM. The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk-adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.	Focus on Therapeutic Outcomes, Inc.	Duplicative of new measure: Functional Improvement for Patients with Lower Extremity Impairments
220	MIPS CQM Patient-Reported Outcome-Based Performance Measure	**Functional Status Change for Patients with Low Back Impairments:** A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with low back impairments. The change in FS is assessed using the FOTO Low Back FS PROM. The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.	Focus on Therapeutic Outcomes, Inc.	Duplicative of new measure: Functional Improvement for Patients with Back Impairments

Quality #	Collection Type / Measure Type	Measure Title and Description	Measure Steward	Rationale for Removal
221	MIPS CQM Patient-Reported Outcome-Based Performance Measure	**Functional Status Change for Patients with Shoulder Impairments:** A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with shoulder impairments. The change in FS is assessed using the FOTO Shoulder FS PROM. The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.	Focus on Therapeutic Outcomes, Inc.	Duplicative of new measure: Functional Improvement for Patients with Upper Extremity Impairments
222	MIPS CQM Patient-Reported Outcome-Based Performance Measure	**Functional Status Change for Patients with Elbow, Wrist or Hand Impairments:** A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with elbow, wrist, or hand impairments. The change in FS is assessed using the FOTO Elbow/Wrist/Hand FS PROM. The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.	Focus on Therapeutic Outcomes, Inc.	Duplicative of new measure: Functional Improvement for Patients with Upper Extremity Impairments
320	Medicare Part B Claims Measure, MIPS CQM Process	**Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients:** Percentage of patients aged 45 to 75 years of age receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of 10 years for repeat colonoscopy documented in their colonoscopy report.	American Gastroenterological Association	End of topped out lifecycle with limited opportunity to improve clinical outcomes
326	MIPS CQM Process	**Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy:** Percentage of patients aged 18 years and older with atrial fibrillation (AF) or atrial flutter who were prescribed an FDA-approved oral anticoagulant drug for the prevention of thromboembolism during the measurement period.	American Heart Association	No longer maintained by measure steward

Quality #	Collection Type / Measure Type	Measure Title and Description	Measure Steward	Rationale for Removal
332	MPS CQM Process	**Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use):** Percentage of patients aged 18 years and older with a diagnosis of acute bacterial sinusitis that were prescribed amoxicillin, with or without clavulanate, as a first line antibiotic at the time of diagnosis.	American Academy of Otolaryngology – Head and Neck Surgery Foundation	Duplicative of existing measure: Q331: Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse)
350	MIPS CQM Process	**Total Knee or Hip Replacement: Shared Decision-Making: Trial of Conservative (Non-surgical) Therapy:** Percentage of patients regardless of age undergoing a total knee or total hip replacement with documented shared decision- making with discussion of conservative (non-surgical) therapy (e.g., non-steroidal anti-inflammatory drug (NSAIDs), analgesics, weight loss, exercise, injections) prior to the procedure.	American Association of Hip and Knee Surgeons	Process measure
378	eCQM Outcome	**Children Who Have Dental Decay or Cavities:** Percentage of children, 1 - 20 years of age at the start of the measurement period, who have had tooth decay or cavities during the measurement period as determined by a dentist.	Centers for Medicare & Medicaid Services	The robustness of the quality measure (assesses incidence only)
384	MIPS CQM Outcome	**Adult Primary Rhegmatogenous Retinal Detachment Surgery: No Return to the Operating Room Within 90 Days of Surgery:** Patients aged 18 years and older who had surgery for primary rhegmatogenous retinal detachment who did not require a return to the operating room within 90 days of surgery.	American Academy of Ophthalmology	End of topped out lifecycle with limited opportunity to improve clinical outcomes
415	MIPS CQM Efficiency	**Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older:** Percentage of emergency department visits for patients aged 18 years and older who presented with a minor blunt head trauma who had a head CT for trauma ordered by an emergency care provider who have an indication for a head CT.	American College of Emergency Physicians	End of topped out lifecycle with limited opportunity to improve clinical outcomes

Quality #	Collection Type / Measure Type	Measure Title and Description	Measure Steward	Rationale for Removal
430	MIPS CQM Process	**Prevention of Post-Operative Nausea and Vomiting (PONV) – Combination Therapy:** Percentage of patients, aged 18 years and older, who undergo a procedure under an inhalational general anesthetic, AND who have three or more risk factors for post-operative nausea and vomiting (PONV), who receive combination therapy consisting of at least two prophylactic pharmacologic antiemetic agents of different classes preoperatively and/or intraoperatively.	American Society of Anesthesiologists	End of topped out lifecycle with limited opportunity to improve clinical outcomes
463	MIPS CQM Process	**Prevention of Post-Operative Vomiting (POV) – Combination Therapy (Pediatrics):** Percentage of patients aged 3 through 17 years, who undergo a procedure under general anesthesia in which an inhalational anesthetic is used for maintenance AND who have two or more risk factors for post-operative vomiting (POV), who receive combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively.	American Society of Anesthesiologists	End of topped out lifecycle with limited opportunity to improve clinical outcomes
478	MIPS CQM Patient-Reported Outcome-Based Performance Measures	**Functional Status Change for Patients with Neck Impairments:** A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with neck impairments. The change in FS is assessed using the FOTO Neck FS PROM. The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk-adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.	Focus on Therapeutic Outcomes, Inc.	Duplicative of new measure: Functional Improvement for Patients with Neck Impairments

Quality #	Collection Type / Measure Type	Measure Title and Description	Measure Steward	Rationale for Removal
483	MIPS CQM Patient-Reported Outcome-Based Performance Measure	**Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM):** The Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM) uses the PCPCM Patient Reported Outcome Measure (PROM) a comprehensive and parsimonious set of 11 patient-reported items - to assess the broad scope of primary care. Unlike other primary care measures, the PCPCM PRO-PM measures the high value aspects of primary care based on a patient's relationship with the clinician or practice.	The American Board of Family Medicine	Limited adoption of this quality measure does not allow for the creation of a benchmark

Appendix E: APP Plus Quality Measure Set and Collection Types Proposed for the 2027 Performance Period and Future Years

Quality #	Measure Title	Collection Type
001	Diabetes: Glycemic Status Assessment Greater Than 9%	• eCQMs • Medicare eCQMs (Shared Savings Program ACOs only) • Medicare CQMs (Shared Savings Program ACOs only) • Medicare Part B Claims (excluding Shared Savings Program ACOs) • MIPS CQMs
112	Breast Cancer Screening	• eCQMs • Medicare eCQMs (Shared Savings Program ACOs only) • Medicare CQMs (Shared Savings Program ACOs only) • Medicare Part B Claims (excluding Shared Savings Program ACOs) • MIPS CQMs
113	Colorectal Cancer Screening	• eCQMs • Medicare eCQMs (Shared Savings Program ACOs only) • Medicare CQMs (Shared Savings Program ACOs only) • Medicare Part B Claims (excluding Shared Savings Program ACOs) • MIPS CQMs
134	Preventive Care and Screening: Screening for Depression and Follow-up Plan	• eCQMs • Medicare eCQMs (Shared Savings Program ACOs only) • Medicare CQM (Shared Savings Program ACOs only) • Medicare Part B Claims (excluding Shared Savings Program ACOs) • MIPS CQM
236	Controlling High Blood Pressure	• eCQM • Medicare eCQM (Shared Savings Program ACOs only) • Medicare CQMs (Shared Savings Program ACOs only) • Medicare Part B Claims (excluding Shared Savings Program ACOs) • MIPS CQMs
321	CAHPS for MIPS	• CAHPS for MIPS Survey
479	Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups	• Administrative Claims
484	Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	• Administrative Claims

Appendix F: New Improvement Activities Proposed for the 2027 Performance Period and Future Years

Activity Title	Activity Description	Subcategory	Rationale
Use of Data to Improve Practice Workflows	MIPS-eligible clinicians collaborate to design, implement, and continuously refine evidence-based utilization pathways and clinical workflows that support the integration of current research and clinical guidelines into everyday practice. Eligible activities include the creation or maintenance of any algorithm, clinical pathway, process, or order set that is grounded in established clinical practice guidelines or peer reviewed literature. Actions that fulfill this activity may include: • Collecting and analyzing clinical data to identify the need for a new or revised pathway, order set, or process • Developing and deploying the updated pathway, order set, or process within clinical operations • Evaluating adoption, effectiveness, and clinical impact through ongoing monitoring and feedback. Additional qualifying activities may include, for example, conducting annual reviews of existing pathways or algorithms by a pathology group and/or in collaboration with ordering clinician, developing and disseminating educational materials, and identifying or engaging new stakeholders to support pathway improvement and implementation.	Care Coordination	Promoting uptake of best clinical practices from guidelines and other resources is critical for improving quality of patient care. However, translating recommendation statements into action can be challenging for individual practices due to resource constraints. Clinical pathways and algorithms are effective ways to encourage implementation of guidelines. Development of such pathways requires clinical expertise and time, although a 10-step process has been established by other organizations. By including a multi-disciplinary team in the pathway development, care coordination can be maximized and all stakeholders can ensure that the pathway is feasible to implement. Such guidance requires regular review as new clinical practice statements become available, especially if the pathway includes multiple specialties (e.g., oncology, radiology, pathology, pain management, etc.). Therefore, the effort involved in this activity is ongoing and requires input from many members of the care team.

Activity Title	Activity Description	Subcategory	Rationale
Understand and Improve Diagnostic Performance	This activity aims to improve patient safety by reducing diagnostic safety events, including delayed, inaccurate, or missed diagnoses, as well as failures to communicate correct diagnoses to patients and their families. This activity supports diagnostic transparency, builds staff competency through training, and improves the completeness and accuracy of patient data. Understanding and improving diagnostic performance includes establishing a standardized process to monitor diagnostic discrepancies, diagnostic safety events, near misses, and miscommunications. Key components of this activity may include: • Identifying a metric to track (e.g., frozen section discrepancy rate) • Implementing a consistent tracking mechanism • Conducting ongoing monitoring • Initiating mitigation or education efforts when needed. Processes should incorporate both routine tracking and root cause analysis, followed by appropriate corrective actions such as workflow changes, education, and/or targeted training for individuals and/or groups.	Care Coordination	Accurate and timely diagnosis is the cornerstone of effective patient care. Diagnostic performance directly influences treatment decisions, patient outcomes, and healthcare resource utilization. Recent studies have emphasized the importance of addressing diagnostic safety events in clinical settings. A deeper understanding of diagnostic processes--including cognitive, systemic, and technological factors--enables healthcare providers to identify gaps, implement targeted interventions, and promote a culture of continuous learning and accountability. As healthcare becomes increasingly data-driven, integrating diagnostic improvement efforts with quality metrics, patient feedback, and interdisciplinary collaboration ensures that care is not only clinically sound but also patient-centered.

Activity Title	Activity Description	Subcategory	Rationale
Systematic Screening and Intervention for Nutrition and other Health-Impacting, Non-Clinical Issues	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.	Advancing Health and Wellness	This activity addresses a gap for a nutrition-focused improvement activity. It aligns with CMS's focus on wellness and whole-person care, and supports Enhancing Oncology Model (EOM) and MVP efforts by integrating health-related, non-clinical issues into quality improvement strategies. This activity builds on existing patient navigation and care coordination activities but focuses specifically on upstream factors.

Activity Title	Activity Description	Subcategory	Rationale
Advance Care Planning Conversations to Support Patient Wellness and Care Preferences	MIPS-eligible clinicians engage patients and their caregivers in structured, proactive discussions about end-of-life preferences, advance care planning, and palliative care options as part of comprehensive wellness and care management. This activity integrates conversations about goals of care, symptom management, and quality of life into routine encounters with patients who have serious or life-limiting illness. CMS reminds clinicians that they must not, under any circumstances, attempt to influence the ACP-related decisions of their patients. Participating clinicians must document: • Use of standardized communication tools or frameworks (e.g., Serious Illness Conversation Guide, Practitioner Orders for Life Sustaining Treatment (POLST)) to support consistent, high quality discussions • Inclusion of wellness oriented topics, such as symptom relief, emotional wellbeing, social supports, and patient identified priorities • Coordination and alignment of care plans across specialties, including primary care, palliative care, behavioral health, and other involved clinicians; and • Regular review and updates of advance directives or care preferences to ensure they remain accurate and reflective of the patient's evolving goals and clinical status.	Advancing Health and Wellness	End-of-life care planning discussions contribute to improved patient and caregiver well-being by reducing stress, enhancing understanding of care options, and ensuring treatment aligns with patient goals. Integrating these conversations into wellness and/or chronic care management visits supports a holistic approach to health, one that prioritizes quality of life, emotional and physical comfort, and patient autonomy. Evidence indicates that patients who engage in structured end-of-life care planning experience better symptom control, higher satisfaction, and reduced hospitalizations, aligning with MIPS goals of improved care coordination and patient-centered outcomes.

Activity Title	Activity Description	Subcategory	Rationale
Clinician Use of Artificial Intelligence (AI) to Improve Patient Care	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 ○ These policies incorporate key AI model characteristics including fairness, appropriateness, validity, and effectiveness as foundational criteria for assessing model performance, identifying event patterns, and determining appropriate risk mitigation and escalation actions and/or • Engage in or support innovative initiatives that encourage the creation, piloting, and/or enhancement of AI-enabled tools, workflows, and/or resources ○ Examples include developing risk-stratification models, AI-supported clinical decision support (CDS), predictive analytics for chronic-disease management, and/or tools that expand patient access, wellness interventions, and/or care-coordination capabilities. Additional examples include using AI tools to summarize medical literature for clinical decision making, support documentation (e.g., generate notes with AI for clinician review), and/or support population health management by identifying care gaps, determining patient eligibility for clinical trials, or generating draft responses to patient questions for clinician review.	Advancing Health and Wellness	The rapid expansion of artificial intelligence (AI) in healthcare presents significant opportunities to improve clinical outcomes, reduce clinician burden, and enhance population health management. However, realizing these benefits requires deliberate, responsible, and transparent implementation practices that ensure AI tools are safe, fair, reliable, and aligned with evidence-based care. This improvement activity encourages MIPS-eligible clinicians to adopt AI in a structured, governance driven manner that promotes innovation while safeguarding patient wellbeing. Establishing organizational policies and procedures for AI use provides an essential foundation for ensuring that deployed tools are evaluated using key model characteristics (fairness, appropriateness, validity, and effectiveness). By incentivizing participation in innovation initiatives such as developing or piloting new AI-enabled tools and workflows, this activity further advances the field of applied clinical AI, encouraging clinicians and practices to collaborate in the creation and refinement of AI resources. This activity also aligns with the AI-related goals of the CMS ACCESS (Advancing Chronic Care with Effective, Scalable Solutions) Model, a 10-year voluntary Medicare program testing outcome-aligned payments to expand technology-supported chronic care for common conditions.

Activity Title	Activity Description	Subcategory	Rationale
Lifestyle Approaches to Diabetes Remediation	MIPS eligible clinicians engage patients and their caregivers in structured, evidence-based lifestyle interventions to support the treatment and management of diabetes. Clinicians use the American College of Lifestyle Medicine's (ACLM) Lifestyle Empowerment Approach for Diabetes Remission (LEADR) or a similar diabetes focused lifestyle program to help patients address modifiable behavioral factors and improve overall health status. These programs provide education, coaching, and support across key lifestyle domains such as nutrition, physical activity, sleep, stress management, and reducing harmful behaviors. Participating clinicians may use one or more of the following evidence based programs and resources: • ACLM Lifestyle Empowerment Approach for Diabetes Remission (LEADR) • CDC Diabetes Self-Management Education and Support (DSMES) • American Diabetes Association Institute of Learning – Hands On Webinar: Diet, Lifestyle, Medicine, and Beyond—Cardio Kidney Metabolic Strategies for Managing Obesity in People with Type 2 Diabetes	Advancing Health and Wellness	This activity aligns with CMS's focus on wellness and whole-person care and supports MVP efforts by integrating health-related, non-clinical issues into quality improvement strategies.

Appendix G: Improvement Activities Proposed for Removal in the 2027 Performance Period and Future Years

Activity ID	Subcategory	Activity Title and Description
IA_BMH_5	Behavioral and Mental Health	**MDD prevention and treatment interventions:** Major depressive disorder: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including suicide risk assessment for mental health patients with co-occurring conditions of behavioral or mental health conditions.
IA_CC_10	Care Coordination	**Care transition documentation practice improvements:** In order to receive credit for this activity, a MIPS eligible clinician must document practices/processes for care transition with documentation of how a MIPS eligible clinician or group carried out an action plan for the patient with the patient's preferences in mind (that is, a "patient-centered" plan) during the first 30 days following a discharge. Examples of these practices/processes for care transition include: staff involved in the care transition; phone calls conducted in support of transition; accompaniments of patients to appointments or other navigation actions; home visits; patient information access to their medical records; real time communication between PCP and consulting clinicians; PCP included on specialist follow-up or transition communications.
IA_CC_11	Care Coordination	**Care transition standard operational improvements:** Establish standard operations to manage transitions of care that could include one or more of the following: • Establish formalized lines of communication with local settings in which empaneled patients receive care to ensure documented flow of information and seamless transitions in care; and/or • Partner with community or hospital-based transitional care services.
IA_CC_12	Care Coordination	**Care coordination agreements that promote improvements in patient tracking across settings:** Establish effective care coordination and active referral management that could include one or more of the following: • Establish care coordination agreements with frequently used consultants that set expectations for documented flow of information and MIPS eligible clinician or MIPS eligible clinician group expectations between settings. Provide patients with information that sets their expectations consistently with the care coordination agreements; • Track patients referred to specialist through the entire process; and/or • Systematically integrate information from referrals into the plan of care.

Activity ID	Subcategory	Activity Title and Description
IA_PSPA_2	Patient Safety and Practice Assessment	**Participation in MOC Part IV:** In order to receive credit for this activity, a MIPS eligible clinician must participate in Maintenance of Certification (MOC) Part IV. Maintenance of Certification (MOC) Part IV requires clinicians to perform monthly activities across practice to regularly assess performance by reviewing outcomes addressing identified areas for improvement and evaluating the results. Some examples of activities that can be completed to receive MOC Part IV credit are: the American Board of Internal Medicine (ABIM) Approved Quality Improvement (AQI) Program, National Cardiovascular Data Registry (NCDR) Clinical Quality Coach, Quality Practice Initiative Certification Program, American Board of Medical Specialties Practice Performance Improvement Module or American Society of Anesthesiologists (ASA) Simulation Education Network, for improving professional practice including participation in a local, regional or national outcomes registry or quality assessment program; specialty- specific activities including Safety Certification in Outpatient Practice Excellence (SCOPE); American Psychiatric Association (APA) Performance in Practice modules.
IA_CC_16	Care Coordination	**Primary Care Physician and Behavioral Health Bilateral Electronic Exchange of Information for Shared Patients:** The primary care and behavioral health practices use the same electronic health record system for shared patients or have an established bidirectional flow of primary care and behavioral health records.
IA_BE_15	Beneficiary Engagement	**Engagement of Patients, Family, and Caregivers in Developing a Plan of Care:** Engage patients, family, and caregivers in developing a plan of care and prioritizing their goals for action, documented in the electronic health record (EHR) technology.
IA_PM_19	Population Management	**Glycemic Screening Services:** For at-risk outpatient Medicare beneficiaries, individual MIPS eligible clinicians and groups must attest to implementation of systematic preventive approaches in clinical practice for at least 60 percent for the 2018 performance period and 75 percent in future years, of electronic medical records with documentation of screening patients for abnormal blood glucose according to current US Preventive Services Task Force (USPSTF) and/or American Diabetes Association (ADA) guidelines.

Activity ID	Subcategory	Activity Title and Description
IA_PM_20	Population Management	**Glycemic Referring Services:** For at-risk outpatient Medicare beneficiaries, individual MIPS eligible clinicians and groups must attest to implementation of systematic preventive approaches in clinical practice for at least 60 percent for the CY 2018 performance period and 75 percent in future years, of medical records with documentation of referring eligible patients with prediabetes to a CDC-recognized diabetes prevention program operating under the framework of the National Diabetes Prevention Program.
IA_EPA_4	Expanded Practice Access	**Additional improvements in access as a result of QIN/QIO TA:** As a result of Quality Innovation Network-Quality Improvement Organization technical assistance, performance of additional activities that improve access to services or improve care coordination (for example, investment of on-site diabetes educator).
IA_PM_2	Population Management	**Anticoagulant management improvements:** Individual MIPS eligible clinicians and groups who prescribe anti-coagulation medications (including, but not limited to oral Vitamin K antagonist therapy, including warfarin or other coagulation cascade inhibitors) must attest that for 75 percent of their ambulatory care patients receiving these medications are being managed with support from one or more of the following improvement activities: • Participation in a systematic anticoagulation program (coagulation clinic, patient self-reporting program, or patient self-management program); • Patients are being managed by an anticoagulant management service, that involves systematic and coordinated care, incorporating comprehensive patient education, systematic prothrombin time (PT-INR) testing, tracking, follow-up, and patient communication of results and dosing decisions; • Patients are being managed according to validated electronic decision support and clinical management tools that involve systematic and coordinated care, incorporating comprehensive patient education, systematic PT-INR testing, tracking, follow-up, and patient communication of results and dosing decisions; • For rural or remote patients, patients are managed using remote monitoring or telehealth options that involve systematic and coordinated care, incorporating comprehensive patient education, systematic PT-INR testing, tracking, follow-up, and patient communication of results and dosing decisions; or • For patients who demonstrate motivation, competency, and adherence, patients are managed using either a patient self-testing (PST) or patient-self-management (PSM) program.