medisolv

✦ THANK YOU FOR JOINING

2027 QPP Proposed Changes Webinar.

Questions? Reach out any time — we'll share the slides and recording with all registrants.

info@medisolv.com medisolv.com

✦ INTRODUCTIONS

Presenters

Erin Heilman, CPHQ

SVP, Regulatory Affairs

Erin Heilman is a distinguished leader in the healthcare quality regulatory space, known for her innovative approach to simplifying simplifying complex regulations. For over a decade, Erin has developed developed award-winning content, including articles, guides, and tools and tools that empower quality leaders to excel in their reporting reporting obligations.

medisolv

AGENDA

6 things to know

01 Traditional MIPS ends after 2028. MVPs required in 2029.

02 A new core measure requirement starts in 2027.

03 The FHIR transition: options in 2028, mandatory in 2030.

04 Electronic prior authorization joins Promoting Interoperability.

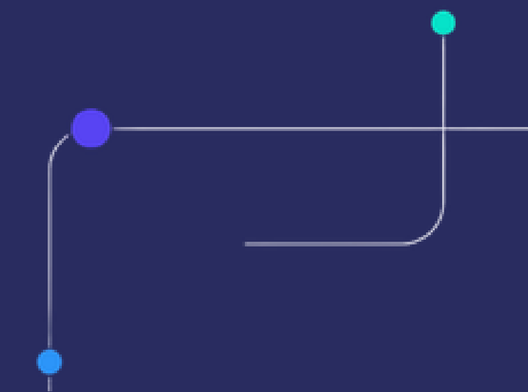
05 The Ambulatory Specialty Model and the push for specialty data.

06 Patient-reported outcomes infiltrate the ambulatory system.

PART 01

The MVP Transition.

CMS proposes to sunset traditional MIPS and make MIPS Value Pathways the only MIPS reporting MIPS reporting option.



MIPS

Traditional MIPS sunset

Proposed: MVPs become the required MIPS reporting option beginning with the CY 2029 performance period / 2031 payment year.

- Traditional MIPS remains available through the CY 2028 2028 performance period, then sunsets.
- Beginning CY 2029, clinicians must report the measures and activities of a selected MVP for all specialties in their TIN, unless they are in the APM Performance Pathway (APP).
- 3 new MVPs are proposed (Diabetic Disease, Hypertension, Hypertension, Hospitalist), bringing the total to 30 MVPs in MVPs in 2027.
- CMS says these 30 MVPs cover 98% of all specialty types. types.

CY 2029

First performance period requiring MVP reporting

2031

MIPS payment year when the sunset takes effect

medisolv

THE MVP TRANSITION

What this means for you

Start your MVP strategy now

You've got two years to sort out your MVP strategy. Determine which MVPs apply to your clinicians and test the process with a voluntary submission before 2029. It can be a lot of measure implementations, so start early.

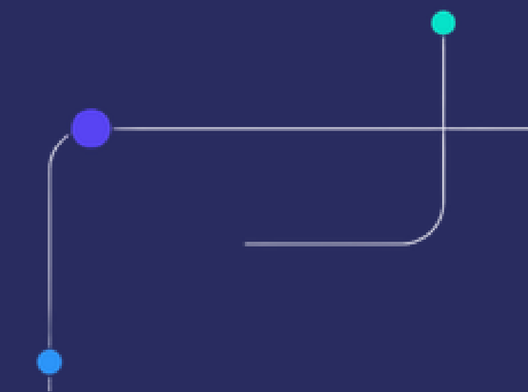
Use the MVP Planning Tool

Map your clinicians to the 30 proposed MVPs with the MVP Planning Tool in the Quality Academy toolbox at academy.medisolv.com. Multispecialty groups: work out subgroup reporting logistics now, not in 2029.

PART 02

Core Measures.

A new quality reporting requirement arrives in 2027, two years ahead of the MVP mandate.
mandate.



QUALITY · CY 2027

One core measure in every submission

78

Core measures

CMS designates 78 quality measures as MIPS core measures, selected from each MVP with a minimum of three per MVP.

1 of 6

Or 1 of 4 in an MVP

Traditional MIPS reporters include a core measure as one of their six quality measures; MVP reporters as one of four.

Zero

If you skip it

No core measure and no attestation attestation that none applies means means zero points on one required required measure. Small practices are practices are exempt.

10

Points still available

Core measures that stay topped out out for two consecutive years escape escape the 7-point scoring cap and and can earn the full 10 points.

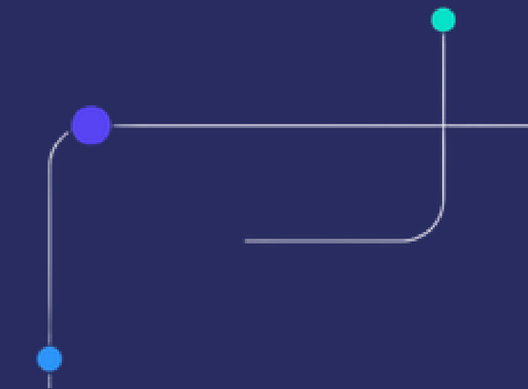
The MIPS core measure requirement replaces the outcome / high-priority measure requirement; the high-priority designation is removed. Small practices removed. Small practices are exempt.

CMS updated the Quality measure set inventory too — 180 measures for CY 2027: 20 removals, 10 additions, and 43 substantive changes to measures already in use.

PART 03

The dQM Transition.

CMS is planning a phased move from CQMs and QRDA-based eCQMs to FHIR-based digital quality measures — across QPP and other clinician and hospital quality programs.



FHIR TRANSITION

Planned FHIR reporting timeline

A 2-year transition period, then mandatory FHIR-based reporting for transitioned measures.

CY / FY 2028

Transition Year 1

FHIR-based dQM reporting becomes available for available for selected measures. Existing CQM and and eCQM options remain available.

CY / FY 2029

Transition Year 2

FHIR-based options continue alongside existing existing reporting, with CMS encouraging broader broader use of FHIR-based reporting.

CY 2030+

Mandatory FHIR reporting

FHIR-based dQM reporting required for transitioned transitioned measures (2032 MIPS payment year). year). Prior CQM/eCQM options end for those measures.

New data standard. dQMs use standardized, interoperable FHIR data FHIR data in place of QRDA file submission — built on USCDI+ Quality USCDI+ Quality and CMS implementation guides.

Program-wide scope. Applies to QPP and other CMS clinician and hospital quality programs too — including MSSP ACOs. Adoption timelines may vary by measure and program.

medisolv

THE DQM TRANSITION

What this means for you

Expect this in next year's rule

This timeline sits in a request for information, but CMS has already already published draft FHIR eCQM specifications for 49 clinician clinician measures, released the USCDI+ Quality standard, and built the built the MADiE tool. They seem to be giving us a heads up.

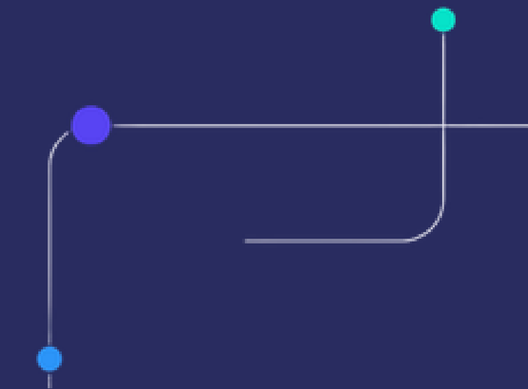
eCQMs are the on-ramp

Organizations that report eCQMs today have the stronger foundation. ACOs reporting MIPS CQMs or Medicare CQMs should plan for those collection types to sunset around 2030. Start mapping where your quality data lives and how it moves.

PART 04

Electronic Prior Auth.

Promoting Interoperability carries a more significant compliance consequence beginning in 2028.
2028.



✦ PROMOTING INTEROPERABILITY · MIPS | MVP | ASM

e-Prior Auth: optional in 2027, required in 2028

Change	2027 performance year	2028 performance year
e-Prior Auth	Optional. Attest to one ePA request through a payer's API using certified certified health IT and earn 10 bonus points.	**Required. No attestation and no exclusion means the PI category scores zero — 25% of the MIPS final score.**
e-PA for Rx drugs	—	**New required measure for prescription drugs, same zero-score consequence.**
Burden relief	Security Risk Analysis measure removed (2027) · ONC Direct Review and ONC-ACB Surveillance attestations removed (2026) · CEHRT definition simplified per HTI-5. definition simplified per HTI-5. HIPAA obligations continue.	

What this means for you: talk with your EHR vendor now, confirm your payers support the required APIs, and treat 2027 as your test year.

PART 05

The ASM and Specialty Data.

The model begins January 1, 2027, and it shows exactly how CMS plans to measure specialists.

✦ AMBULATORY SPECIALTY MODEL

ASM at a glance

Mandatory

A required Innovation Center payment model — selected specialists must participate.

2 cohorts

Specialists managing heart failure and and low back pain in Original Medicare. Medicare.

2027–31

Five performance years, starting January January 1, 2027.

+2 years

Payment adjustments hit Part B claims claims two years after each performance performance year.

Measure set changes

Added — MRI lumbar spine for low back pain: a claims-calculated utilization measure. No submission required, but participants are scored on it.

Replaced — Functional Status Change (Q220) retires; Functional Assessment (Q182) takes its place. Oswestry and PROMIS both qualify.

New submission flexibility

CMS is proposing to allow attestation at the group (TIN) or individual (TIN/NPI) level (TIN/NPI) level rather than only group, as it is today. Applicable to small practices as practices as well.

Once submitted, you're committed — any group-level submission assigns the group score to everyone.

medisolv

SPECIALTY ACCOUNTABILITY

Specialty data from three directions

The ASM is one piece of a larger effort to measure specialists.

MVP score normalization

CMS is considering comparing clinicians only against others reporting the same MVP, so specialty peers set the bar (RFI).

Specialty care in ACOs

A lengthy RFI on integrating specialists: 57% of specialists don't know they're in an ACO, and APP Plus can't assess their contributions.

The ASM itself

A mandatory specialty accountability model with payment adjustments that that start at ±9% and grow to ±12%.

What this means for you: you need a data plan that accounts for every specialist, with regular review of their performance, so performance, so you know how they look before CMS publishes it for patients.

PART 06

Patient-Reported Outcomes.

CMS is blurring the lines between hospital and ambulatory settings by using the same PRO tools to drive PRO-PM results throughout the healthcare system.

✦ PRO-PM SPOTLIGHT

From "Did you assess?" to "Did patients improve?"

TODAY: PROCESS MEASURES

Q377 (heart failure) and Q182 (low back pain) credit you for completing a functional status assessment.

FUTURE: PRO-PMS

Measures built on data collected directly from patients — did care improve, improve, or slow decline in, what patients report?

20 patients, twice

Baselines for at least 20 beneficiaries, then follow-ups on those same patients about six months later.

Every data element

Instrument and version, item-item-level responses, raw and and standardized scores, mode mode of administration.

Risk variables

A minimum set for every patient assessed — age, comorbidities, baseline severity.

On time

By March 31 after the performance year. Late submissions and corrections are rejected.

+5 **Points on the quality category score for voluntary PRO submission — half the maximum achievement points of one quality measure. Your category score still can't exceed its normal maximum.**

PRO-PMS

What this means for you

CMS will gradually introduce more PRO-PMs

Throughout the rule, CMS made it clear that it wants to introduce more PRO-PMs to the system. It added PRO-PMs to the Quality measure inventory and introduced a PRO bonus for ASM participants.

Build a lightweight survey workflow now

The key will be for your organization to easily and quickly spin up (or down, or modify) surveys as applicable. In a repeatable manner, you'll need to gather the lists of patients, distribute the surveys, collect the responses, and move the data to CMS. The goal is a systematic process that doesn't slow down your operations.

TIMELINE

Key dates if finalized

2027

Core measure requirement begins · quality inventory changes take effect · new MVPs available · e-Prior Auth Auth optional with 10 bonus bonus points · ASM performance year 1 opens January 1.

2028

FHIR-based dQM reporting options introduced · electronic prior authorization becomes required · last performance period for traditional MIPS.

2029

Traditional MIPS sunsets — an MVP or the APP is required for all MIPS eligible clinicians, virtual groups included.

2030

FHIR-based reporting becomes becomes mandatory for measures transitioned to dQM dQM specifications.

All dates reflect proposals. Final policies are set in the CY 2027 PFS final rule, expected November 2026.

✦ WHERE THIS LEAVES YOU

Six regulatory changes, one operational problem

More measures, more more often

A core measure in every every submission, 43 changed specifications, 30 specifications, 30 MVPs to MVPs to choose among, among, and a per-clinician clinician score in the ASM. ASM.

More collection types types at once

eCQMs, CQMs, claims-calculated measures, and and FHIR dQMs coexisting coexisting through a two-two-year transition — each with its own data path.

Data that isn't in the the EHR yet

Patient-reported outcomes, prior-auth API attestations, and specialty detail your current reports were never built to surface.

Consequences that arrive late

A zero on the PI category category or a missed core core measure shows up up two years after the performance year — long long past the point of fixing it.

None of this is hard to understand. It is hard to keep track of — measure by measure, clinician by clinician, all year long .

medisolv

✦ NEXT: LIVE IN THE SOFTWARE

Let's look at how this gets managed

Every measure, every clinician

Performance across measures measures and collection types, types, in one place, all year. year.

Drill to the record

Understand where patients fell patients fell out of the population using drill-down down functionality.

Submissions managed

Proactive submission management ensures your team has the best possible submission.

See it in action. Book a demo: sales@medisolv.com

medisolv

SEE IT IN ACTION

Solution demo.