

2026 Proposed Changes Quality Payment Program

Changes proposed under the 2026 PFS Proposed Rule

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Agenda

- QPP Strategic Direction
- Proposed Changes to Quality, IA, PI & Cost
- Proposed Changes MVP Framework
- Proposed Ambulatory Specialty Model
- Proposed Changes MSSP ACOs

2026 PFS Proposed Rule – Strategic Directions

Payment Models for the Future

- CMS proposed a brand new payment model that brings together aspects of MIPS, MVP, and the hospital inpatient TEAM program.

Digital Quality Measurement

- CMS is pushing for a digital measurement future and states that eCQMs are now the gold standard.

Wellness and prevention

- CMS requested information on wellness and nutrition measures.
- CMS incorporated measures into the new ASM model specifically justified because of their focus on prevention.

Quality Payment Program

Medicare Access and CHIP Reauthorization Act

Established the *Quality Payment Program* in 2015

GOAL

High-quality,
cost-efficient care

Budget
Neutral

Merit-based Incentive Payment System (MIPS)

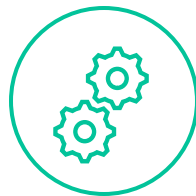
Advanced Alternative Payment Models (APMs)



Quality



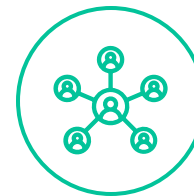
Cost



IA
*Improvement
Activities*



PI
*Promoting
Interoperability*



Accountable Care
Organizations
(ACOs)



Bundled Payment
Models

QPP Reporting Frameworks

1

• TRADITIONAL MIPS

- This is the usual MIPS framework made up of four categories and a composite score.

2

• APM PERFORMANCE PATHWAY

- The APP Framework is available to MIPS APM Entities and required for ACOs if they are part of MSSP.

3

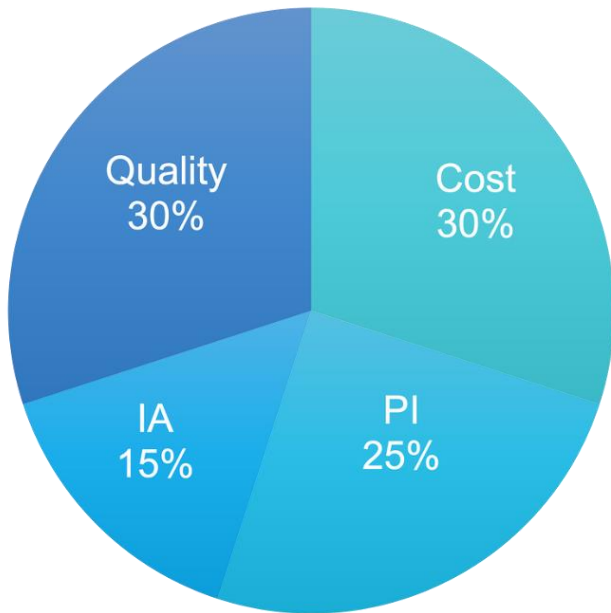
• MVP

- This is a new framework and is made up of four categories with measures specific to the specialty the MVP addresses.

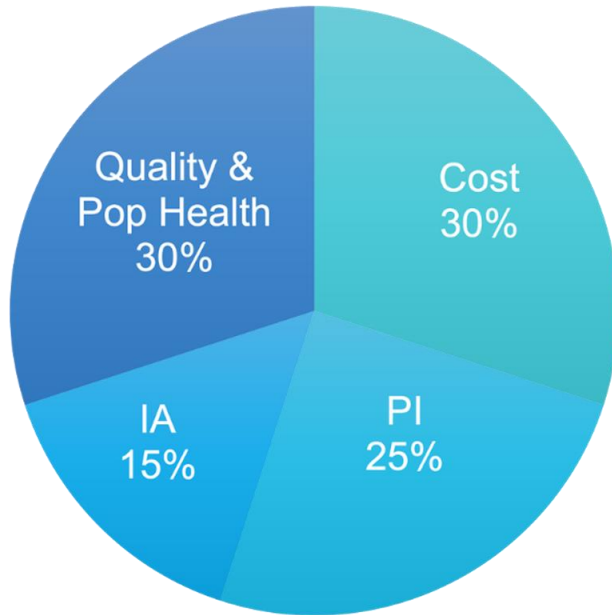
"[We] anticipate that we may be ready to fully transition to MVPs by CY 2029."

Category Weights

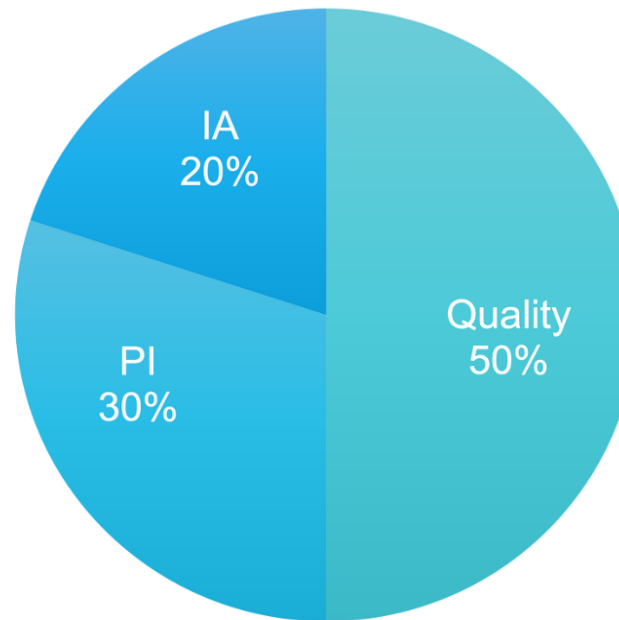
Traditional MIPS



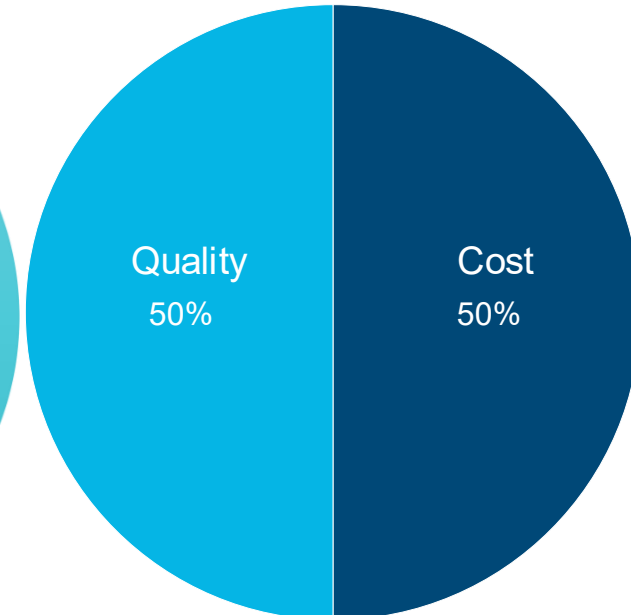
MVP



APP



ASM



Quality Category

2026 Proposed Changes

Quality Category



Category Weight

30% of total score – MIPS & MVP
50% of total score – APP



Performance Period

365 days



Requirements

1. Number of required measures specific to reporting framework. Must report outcome measure or high priority measure.
 - MIPS – 6 measures
 - MVP – 4 measures
 - APP – APP Measure Set
2. Meet data completeness threshold
3. Meet case minimum criteria
4. Can use combination of collection types

Collection Types

1. eCQMs
2. MIPS CQMs
3. QCDR Measures
4. Administrative claims quality measures
5. CAHPs for MIPS Survey
6. Medicare CQMs

Note:

- Only small practices may submit quality measures using claims
- Medicare CQMs are only available to MSSP ACOs

Data Completeness

Data completeness to remain at 75% through performance year 2028.

- CQMs - “is calculated by considering both the total number of patients seen who are eligible for a measure, and the total number of patients for which you report.”
- eCQMs – if you report through a certified health record, include all data, you will achieve 100% data completeness.
- If a measure does not meet the 75% data completeness threshold, the measure will earn 0 points in 2026.
 - Exception is Small Practices that will continue to earn 3 points

CQM Data Completeness Requirement for the 2026 Performance Period:

Numerator: The number of patients for which you report performance data
(performance met, not met, denominator exceptions)

**> =
75%**

Denominator: The total number of patients eligible for the measure

Case Minimum

- 20 denominator eligible instances
- If a measure does not meet case minimum requirements, the measure will earn 0 decile points

Quality Category

CMS is proposing to add 5 new Quality measures

eCQMs

1. CMS1173: Diagnostic Delay of Venous Thromboembolism in Primary Care (Intermediate Outcome)
2. CMS1154: Screening for Abnormal Glucose Metabolism in Patients at Risk of Developing Diabetes (Process)

MIPS CQMs

1. Patient Reported Falls and Plan of Care (Process)
2. Prevalent Standardized Kidney Transplant Waitlist Ratio (PSWR) (Process)
3. Hepatitis C Virus (HCV): Sustained Virological Response (SVR) (Outcome)

Quality Category

CMS is proposing to remove 10 Quality measures

MIPS

MVP

APP

MIPS CQMs

1. Q185: Colonoscopy Interval for Patients with a History of Adenomatous Polyps
2. Q264: Sentinel Lymph Node Biopsy for Invasive Breast Cancer
3. Q29: Assessment of Mood Disorders and Psychosis for Patients with Parkinson's Disease
4. Q322: Cardiac Stress Imaging Not Meeting Appropriate Use Criteria
5. Q419: Overuse of Imaging for the Evaluation of Primary Headache
6. Q424: Perioperative Temperature Management
7. Q443: Non-Recommended Cervical Cancer Screening in Adolescent Females
8. Q487: Screening for Social Drivers of Health
9. Q498: Connection to Community Service Provider for SDOH
10. Q508: Adult COVID-19 Vaccination Status

Improvement Activities

2026 Proposed Changes

Improvement Activities



Category Weight

15% of total score



Performance Period

90 days



Requirements

Submit 1 to 2 activities to receive the max score of 40 points

- **MIPS**

- 1 Activity – Clinicians, Groups and Virtual Groups with a special status

- 2 Activities – All other Clinicians, Groups and Virtual Groups

- **MVP**

- 1 Activity – All Clinicians, Groups and Subgroups (regardless of special status)

IA Category

MIPS

MVP

APP

CMS is proposing to add 3 new IA measures

Improvement Activities:

1. Improving Detection of Cognitive Impairment in Primary Care
2. Integrating Oral Health Care in Primary Care
3. Patient Safety in Use of Artificial Intelligence (AI)

IA Category

CMS is proposing to remove 8 IA measures

MIPS

MVP

APP

Improvement Activities:

1. IA_AHE_5: MIPS Eligible Clinician Leadership in Clinical Trials or CBPR
2. IA_AHE_8: Create and Implement an Anti-Racism Plan
3. IA_AHE_9: Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols
4. IA_AHE_11: Create and Implement a Plan to Improve Care for Lesbian, Gay, Bisexual, Transgender, and Queer Patients
5. IA_AHE_12: Practice Improvements that Engage Community Resources to Address Drivers of Health
6. IA_PM_26: Vaccine Achievement for Practice Staff: COVID-19, Influenza, and Hepatitis B
7. IA_PM_6: Use of Toolsets or Other Resources to Close Health and Health Care Inequities Across Communities
8. IA_ERP_3: COVID-19 Clinical Data Reporting with or without Clinical Trial

IA Category

CMS is proposing to remove the "Achieving Health Equity (AHE)" subcategory and add a new "Advancing Health and Wellness (AHW)" subcategory



Promoting Interoperability

2026 Proposed Changes

Promoting Interoperability



Category Weight

25% of total score – MIPS & MVP
30% of total score - APP



Performance Period

180 days



Requirements

- [Submit the required measures](#) (next slide)
- Attest to these two measures: [Actions to Limit or Restrict the Compatibility of CEHRT & ONC Direct Review](#)
- Have CEHRT functionality that [meets ONC's certification criteria in 45 CFR 170.315](#) in place **by the first day** of your MIPS Promoting Interoperability performance period
- Have your EHR certified by ONC to the certification criteria in [45 CFR 170.315](#) **by the last day** of your performance period
- Provide your EHR's CMS Identification code from the [Certified Health IT Product List \(CHPL\)](#)
- Conduct or review a [Security Risk Analysis](#) on your CEHRT functionality on an annual basis
- Attest to conducting an annual assessment of the [Safety Assurance Factors for EHR Resilience Guides \(SAFER Guides\)](#)

Promoting Interoperability

Objective	Measure	Maximum Pts	Required/Optional
Electronic Prescribing	E-Prescribing	10	Required
	Query PDMP	10	Required
Health Information Exchange	Option 1: Sending Health Information AND Receiving and Reconciling Health Information	15	Required to choose 1 of 3 options
		15	
	Option 2: HIE Bi-Directional Exchange	30	
	Option 3: Enable Exchange Under TEFCA	30	
Provider to Patient Exchange	Provide Patients Electronic Access to Health Information	25	Required
Public Health and Clinical Data Exchange	Electronic Case Reporting	25	Electronic Case Reporting and Immunization Registry Required
	Immunization Registry		
	Public Health Registry	5 Bonus Points for 1	Optional
	Syndromic Surveillance		
	Clinical Data Registry		
	Public Health Reporting using TEFCA	5 Bonus Points for 1	*Proposed

PI Category

MIPS

MVP

APP

Security Risk Analysis

Security Risk Analysis

Measure: Adding a second attestation component for security risk management

New Attestation Statement

You must attest “Yes” or “No” to **having conducted security risk management** as required in addition to the existing measure requirement to attest “Yes” or “No” to **having conducted or reviewed a security risk analysis.**

A “No” response for the measure would continue to result in a total score of zero points for the Promoting Interoperability performance category.

PI Category

MIPS

MVP

APP

New SAFER Guides

- **SAFER Guide Measure:** Updating to require use of the 2025 SAFER Guides instead of 2016

New Bonus Measure

- New Optional Bonus Measure: Public Health Reporting Using TEFCA

Electronic Case Reporting

- Electronic Case Reporting: Proposing to suppress this measure for CY 2025 due to CDC pausing onboarding

Cost

2026 Proposed Changes

Cost



Category Weight

30% of total score



Performance Period

365 days



Requirements

CMS will evaluate your performance via claims

- MIPS – all cost measures
- MVP – cost measures specific to MVP selected

Cost Category

CMS is proposing a 2-year
informational-only feedback period
for new cost measures



Under this proposal, MIPS eligible clinicians
would receive informational-only scoring
feedback on new cost measures for 2 years
before they contribute to their final score.

Cost Category

CMS is proposing to modify the Total Per Capita Cost (TPCC) measure with updated candidate event and attribution criteria



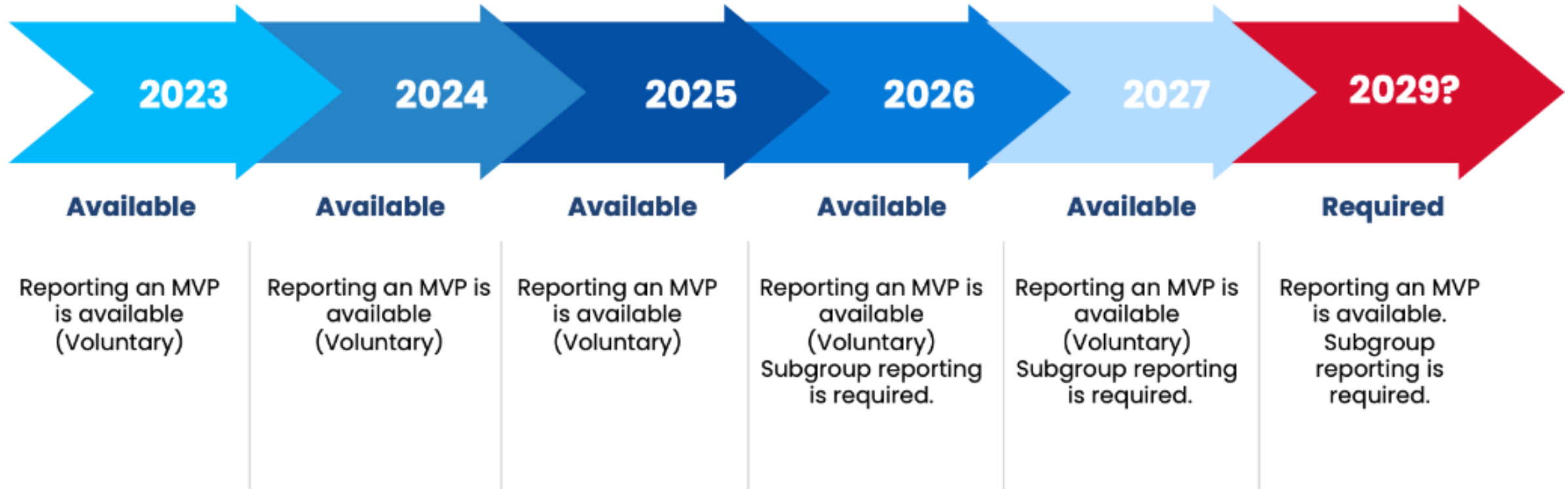
CMS is NOT proposing any new cost measures for the CY 2026 performance period

MIPS Value Pathways (MVP)

2026 Proposed Changes

MVP Reporting Framework Timeline

CMS is phasing in the MVP Reporting Framework over the next several years.



MVP Reporting Framework

CMS is proposing to add 6 new MVP options.

New MVP Options:

1. Diagnostic Radiology
2. Interventional Radiology
3. Neuropsychology
4. Pathology
5. Podiatry
6. Vascular Surgery

MVP Reporting Framework

CMS is proposing modifications to all 21 existing MVPs to align with quality measure and improvement activity inventory updates.

MVP Reporting Framework

MVP

Can Self-Select MVPs

- Groups are allowed to attest to their specialty composition (single or multi-specialty) during MVP registration instead of waiting for CMS to tell them

Small Practices Exempt from Subgroups

- Multispecialty small practices (15 or fewer clinicians) would be able to report MVPs as a group

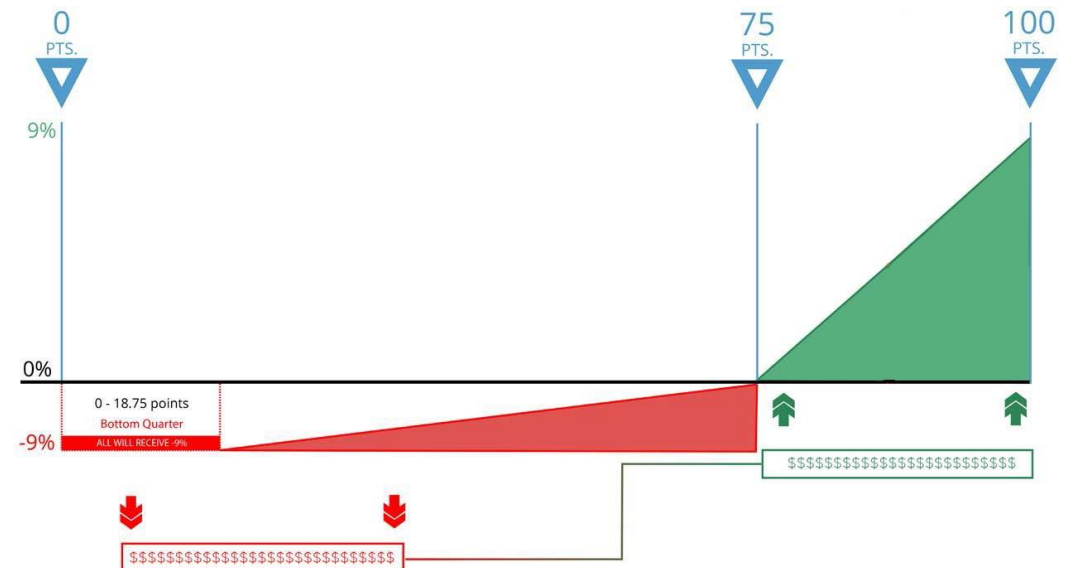
QCDRs & QRs

- Have 1 year after MVP finalization to support MVP

Performance Threshold

Performance Threshold

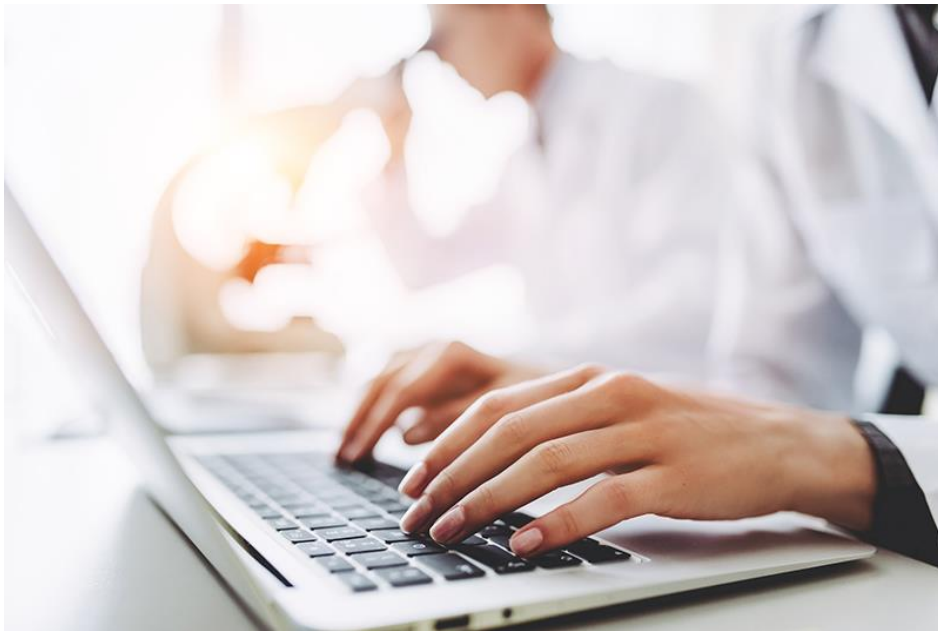
- **0-18.75 Points**
If your score is between 0 and 18.75 points in 2026, you will lose -9% from your 2028 Medicare fee schedule.
- **18.76-74.99 Points**
If your score is between 18.76 and 74.99 points you will receive a reduction to your 2028 Medicare fee schedule between -8.99% and 0%
- **75 -100 Points**
75 points is the performance threshold. CMS will take the funds of those who did not meet the threshold and distribute them among those who did meet the threshold. Anyone whose MIPS score is between 75 and 100 points will receive some portion of those funds – up to a 9% increase to their 2028 Medicare fee schedule.



Ambulatory Specialty Model (ASM)

2026 Proposal for a New Payment Model

Ambulatory Specialty Model



- ❑ Focus: Outpatient specialty care of chronic conditions
 - ❑ Mandatory for selected participants who are excused from MIPS reporting.
- ❑ Two-sided risk adjustment (-9% - 9%)
- ❑ Direct competition between specialists – no predetermined thresholds
- ❑ 5 years: 2027 – 2031
- ❑ List of participants in 2025/2026
- ❑ Reporting at Clinician level
- ❑ Quality, IA, PI, Cost

ASM Participant

ASM Participant

- Individual clinician who, for at least one ASM performance year, satisfies the ASM eligibility criteria and has been selected for participation.
- Bills under Medicare Physician Fee Schedule
- Meets specialty requirements (see 2 boxes)
- Minimum 20 episodes annually (Episode-Based Cost Measures)
- Located in selected geographic area (25% of CBSAs randomly selected)

Heart Failure Cohort

- Clinician with a specialty type of cardiologist whose plurality of Medicare billing is cardiology.

Low Back Pain Cohort

- Clinicians with a specialty type of anesthesiology, interventional pain management, neurosurgery, orthopedic surgery, pain management, and physical medicine and rehabilitation whose plurality of Medicare billing is for low back pain.

Ambulatory Specialty Model

Performance Categories

Quality (50% weight)

- Required measure set specific to specialty
- Performance Period: Calendar Year
- Data Completeness Requirement
- Case Minimum
- 50% of Total Score

Cost (50% weight)

- Required Cost measures specific to specialty
- Performance Period: Calendar Year
- HF – HF Episode Based Cost Measure
- LBP – LBP Episode Based Cost Measure
- 50% of Total Score

Promoting Interoperability (Penalty only)

- Required PI Measures
- 180-day Performance Period
- Negative score for poor performance

Improvement Activities (Penalty only)

- Required 2 Improvement Activates (same for both)
- 90-day Performance Period
- Negative score if not reported

Quality Measures – Heart Failure

Measure ID	Measure Name	Collection Type
Q492	Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates for Patients with HF	Claims
Q008	HF: Beta-Blocker Therapy for LVSD	eCQM, MIPS CQM
Q005	HF: ACE Inhibitor or ARB or ARNI Therapy for LVSD	eCQM, MIPS CQM
Q236	Controlling High Blood Pressure	eCQM, MIPS CQM
Q377	Functional Status Assessments for Heart Failure	eCQM

Quality Measures – Low Back Pain

Measure ID	Measure Name	Collection Type
TBD	MRI Lumbar Spine for Low Back Pain	Claims
Q238	Use of High-Risk Medications in Older Adults	eCQM, MIPS CQM
Q134	Preventative Care and Screening: Screening for Depression and Follow-up Plan	eCQM, MIPS CQM
Q128	Preventative Care and Screening: BMI Screening and Follow-Up Plan	eCQM, MIPS CQM
Q220	Functional Status Change for Patients with Low Back Impairments	MIPS CQM

Cost Category Details

Cost Category (50% Weight)

- Uses Episode-Based Cost Measures (EBCMs)
- Compares total Medicare spending per episode vs other specialists
- Scoring based on standard deviations from cohort median
- Lower costs = higher scores (generally)
- Adjusts for patient complexity and other factors
- Must have ≥ 20 episodes for scoring

Benchmark Range	Points	Illustrative Methodology for the Bottom of the Benchmark Range (\$)
Benchmark Range 1	1 – 1.9	Median cost + (2.5 × standard deviation)
Benchmark Range 2	2 – 2.9	Median cost + (2 × standard deviation)
Benchmark Range 3	3 – 3.9	Median cost + (1.5 × standard deviation)
Benchmark Range 4	4 – 4.9	Median cost + (1 × standard deviation)
Benchmark Range 5	5 – 5.9	Median cost + (0.5 × standard deviation)
Benchmark Range 6	6 – 6.9	Median cost + (0 × standard deviation)
Benchmark Range 7	7 – 7.9	Median cost - (0.5 × standard deviation)
Benchmark Range 8	8 – 8.9	Median cost - (1 × standard deviation)
Benchmark Range 9	9 – 9.9	Median cost - (1.25 × standard deviation)
Benchmark Range 10	10	Median cost - (1.5 × standard deviation)

Improvement Activities (Penalty Only)

Two Required Improvement Activities

IA-1: Primary Care Connection & HRSN Screening

- Help patients find PCPs if needed
- Communicate with PCPs after every visit
- Ensure patients get health-related social needs screening
 - Yes, the SDOH screening measure questions!

IA-2: Collaborative Care Arrangements

- Execute formal agreement with primary care practice
- Must include 3 of 5 elements: data sharing, co-management, care transitions, closed-loop communication, care coordination integration

Scoring: Both = 0 penalty, One = -10 points, None = -20 points

Collaborative Care Arrangements

Specialists must enter into a CCA with a PCP for ASM

- Specialists can pay primary care practices for coordination services
- Primary care can pay specialists for consultation/training
- Legal protection from anti-kickback violations

Requirements:

- Written agreements
- Fair market value only
- No conditioning on referrals
- Must advance ASM clinical goals

Promoting Interoperability (Penalty Only)

Promoting Interoperability Requirements

- Similar to MIPS PI requirements
 - You do not need to attest to the Actions to Limit or Restrict Compatibility or Interoperability of CEHRT attestation.
- Must report at individual clinician level (not TIN level)
- No bonus points available for optional measures
- **Penalty calculation:** $[(\text{Score} \times 100) - 100] \div 10$
- **Example:** 73% score = -2.7 points penalty
- **Perfect score (100%) = 0 penalty**

Step by Step Calculation

Example: 73% Performance Score (you earned 73 points)

Step 1: Multiply the score by 100

- $73\% \times 100 = 73$

Step 2: Subtract that result from 100

- $100 - 73 = 27$

Step 3: Divide by the maximum negative adjustment (10 points)

- $27 \div 10 = 2.7$

Step 4: Apply as negative adjustment

Final scoring adjustment = **-2.7 points**

Bonus Point Opportunities

Special Scoring Adjustments

Small Practice Bonus:

- 2-15 clinicians: +10 points
- Solo practitioners: +15 points

Complex Patient Bonus:

- Up to +10 points for treating sicker/more disadvantaged patients
- Based on HCC risk scores and dual-eligible percentages
- Must be above cohort median on ≥ 1 indicator to qualify

Final Score Calculation

Putting It All Together

Formula: Final Score = [(Quality × 50%) + (Cost × 50%)] × 100 + IA Adjustment + PI Adjustment + Complex Patient Bonus + Small Practice Bonus

Example: Dr. Flowor

- Quality: 80%, Cost: 75% = Base 77.5 points
- IA: -10, PI: -2.7, Complex: +5.5, Small practice: +10

Final Score: 80.3 points

Score Transformation

From Final Score to Payment Adjustment

Step 1: Final score transformed using logistic function

- Emphasizes differences around median performance
- Dr. Flowor: 80 points → 0.95 transformed score

Step 2: Apply scaling factor (Redistributes the bonus funds after CMS takes 15% cut of it)

- Example scaling factor: 1.5

Step 3: Payment formula

- (Risk Level × Transformed Score × Scaling Factor) - Risk Level
- $(9\% \times 0.95 \times 1.5) - 9\% = +3.85\%$ bonus

Transformation Example

- Dr. Flowor's final score = 80 points
- In this example, let's pretend the whole cohort's median score = 50 points (this becomes the midpoint)

Step-by-step calculation:

- **Calculate the difference:** $80 - 50 = 30$
- **Multiply by steepness:** $-0.1 \times 30 = -3.0$
- **Calculate $e^{-3.0}$:** $e^{-3.0} \approx 0.0498$
- **Add 1:** $1 + 0.0498 = 1.0498$
- **Take reciprocal:** $1 \div 1.0498 = 0.95$

Data Sharing Opportunities

Clinicians will get regular aggregate and patient-level beneficiary files

- De-identified performance trends
- Cost, utilization, quality data
- Regular intervals during performance year

Patient-Level Data (By Request):

- Detailed Medicare Parts A, B, D claims
- For participants' ASM patients only
- Requires signed data sharing agreement
- Can be used for care coordination and quality improvement

The Bigger Picture

Who Will Succeed in ASM

- Winners will be specialists who:
- Embrace systematic quality improvement
- Build strong primary care partnerships
- Invest in care coordination capabilities
- Focus on evidence-based, cost-effective care
- Adapt to data-driven practice management

What ASM Means for the Future

- If successful, expect:
 - Expansion to other chronic conditions and specialties
 - Template for specialty payment reform across Medicare
 - End of volume-based, independent specialist practice
- CMS's message:
 - They want specialty data!
 - Future belongs to collaborative, accountable specialists
 - Patient outcomes and care coordination drive financial rewards

MSSP ACOs

2026 Proposed Changes

2026 CMS Proposed Rule Highlights for ACOs

- No change to CMS Web Interface – still not an option
- Proposed removal of the SDOH measure as a requirement
- Proposed removal of the Health Equity Benchmark Adjustment (PY 2025)
- Keeping the eCQM / MIPS CQM incentives for ACOs 2025 and beyond
- Expanded CAHPS to web-mail-phone administration (PY 2027)
- Expanding EUC Policies for cyberattack including ransomware/malware
- ACOs must make changes to their ACO participant list when an ACO participant experiences a change of ownership (CHOW) OR if an ACO's Skilled Nursing Facility (SNF) affiliate list has a CHOW

PROPOSED Revised Definition of Beneficiary Eligible for Medicare CQMs PY 2025 and Subsequent Years

Medicare CQM beneficiary assignment includes Medicare FFS beneficiaries who either:

- Meet the criteria for a beneficiary to be assigned to an ACO
- Had at least one claim with a date of service during the measurement period from an ACO professional who is a primary care physician OR:
 - has one of the specialty designations OR
 - physician assistant, nurse practitioner, or clinical nurse specialist OR
 - Is assigned because the beneficiary designated an ACO professional participating in an ACO as responsible for their care

In the 2026 Proposed Rule:

- CMS proposed to change the definition to:
- Had at least one primary care service with a date of service during the performance year
- Uses “primary care services” and “performance year,” instead of “claims” and “measurement period”
- All other eligibility bullets on the left side of this slide remain the same

Medicare CQMs

CMS provides ACOs initial list of beneficiaries eligible for Medicare CQMs:

- Minimal data necessary to facilitate reporting
- Not complete list - CMS cannot anticipate claims by FFS beneficiaries
- ACOs must gather and report the full list of eligible beneficiaries
- Gather all FFS beneficiaries who fall into the IPP/ denominator per measure specifications
- Patient match and aggregate data

In the 2026 Proposed Rule:

- CMS will include an additional flag on quarterly list: “beneficiaries eligible for Medicare CQMs”
- This flag indicates the patient had a primary care service visit.
- This will be included starting with the Q2 2025 quarterly file.

ASM Model Overlap Considerations

ASM + Other CMS Programs

Designed to overlap with:

- ACOs and other Innovation Center models
- Advanced APMs

Potential benefits:

- Specialists can get ACO shared savings AND ASM bonuses
- Different payment types avoid legal conflicts

Unresolved questions:

- ACO reporting requirements for ASM participants
- Conflicting quality measure requirements

The Medisolv Minute: 2026 Proposed Changes Quality Payment Program



- **Friday 9/5 at 12:30 PM EST**
- Answering Q&A from today's webinar
- Link to add to calendar will be sent in webinar follow up email



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