

2026 Proposed Changes to the Quality Payment Program (QPP)

Recorded 08/20/25

Hello everyone, welcome in welcome to our webinar today 2026 proposed changes to the Quality Payment program. So we are talking today about the changes that have recently been proposed under the 2026 PFS proposed rule, which governs the CMS programs quality payment program and want to go through those reporting frameworks and exciting, I suppose news, there's a new ambulatory surgical model, specialty model that's been introduced in this proposed rule as well. So we can't wait to give you some of those details today. My name is Erin Heilman, I'm the SVP of Advisory Services and Regulatory Affairs here at Medisolve and I'm joined by my colleague Jen Miller.

And Jen, I am sorry that I have to ask you to come off already mute and give me your title. And I forgot to put our introductory slides in here. My fault. Yeah, no problem. So hi everyone. Jen Miller, I'm the Product Manager here at Medisolve. Great. Thanks, Jen. Yes, so Jen and I have a really great packed agenda review of the strategic direction CMS appears to be taking on these quality payment program.

We're going to go through those proposed changes step by step within MIPS and MVP. I'm going to do a brief overview of the ambulatory specialty model, and then we'll finish it out with proposed changes to the MSSPACOS. So like always, this is being recorded. If you have questions along the way, you may enter them into the Q&A box. We do have a full session today. We might not be able to get to questions live. However, you can answer them and then if we can answer it right away, we can type in a response to you.

If any of your questions aren't answered, we do have a radio show that we do in coordination with this presentation and and where we answer all take a take some time to get the real answers from CMS. Often times the questions you ask tend to be technical. So we try and get accurate answers and then do a radio show after. I've got information about that in the last of this slide as well as you'll get it in a follow up. So thank you for being here today. We're going to start on our with our strategic direction. So CMS releases these proposed rules and in all of those times that they release these proposed rules, I really enjoy getting in there and kind of trying to decipher where does this ruling fall within the narrative of what CMS is trying to broadly do.

And I think these are, in my opinion, the three major themes that I have seen specifically this year come through their proposed rules, not just within the quality payment program, but across multiple rulings on the inpatient side and psych side and outpatient side, and now the ambulatory PFS rule, which governs quality payment program as well. The big one I want to point you to, and we're going to spend some time on this today, is the payment models for the future. CMS in this ruling proposed a brand new payment model that brings together aspects of myths, MVP and the hospital inpatient team program, which if you haven't followed that one, that is also a payment model and that focuses on inpatient care coordination, on quality and cost.

And you'll see how that ties in here. What CMS appears to be doing through these payment models is trying to force fee for service out and really get into a value based, value based care approach. That is in the form payment models and both in the Team 1 and in this ASM, they've used some really specific language around if

2026 Proposed Changes to the Quality Payment Program (QPP)

Recorded 08/20/25

this is successful, this could be how we do payments in the future. So even if you are not a group that has these specific clinicians that are selected for this payment model, you'll want to pay attention to how they're thinking about it for the future. Because you can sort of see through what CMS is doing in these actions that they're going to try these models out.

But they may push more people to them very quickly. They may change the timelines. If these work, save CMS money, and push an advanced quality improvement, they're going to double down and move quicker than they had in the past on them. So keep that in mind. The other major theme in the middle there is the digital quality measurement. Digital quality measurement has been talked about for a while, DQMSDEQMS, you know, they have all these terms, but essentially thematically this year they've their push for digital measurement across all of the different places that it lives. So like even within the ACOs who had been using something called CMS work kind of a little bit attestation based where you just kind of filled in Excel sheets, they specifically said, no, we're not.

We're definitely not allowing that back in. And ECQMS are the gold standard. And I can remember when they were talking about abstracted measures on the hospital side as being the gold standard where you could really see what the clinician has done. CMS is changing their tone and saying ECQMS are the gold standard and what we want everyone pushing to. So data and understanding where your data lives going to be super key for you guys because if you have a situation where you have multiple Ehrs, the bringing together of that data to see it in a digital fashion is going to be key. So as we talk about this, you're going to see something called MIT CQMS, which are like an abstracted version, but the ECQMS is really where they want to push people future strategically.

And then the last one, Wellness and prevention. This is a current administration's push this year, and there are themes that I've heard in the past, but never quite as explicitly stated as this year's. So this year they requested information on Wellness and nutrition measures, not just in this ruling, but across all of them. So in the inpatient side, psych side, they want to know how they can measure Wellness nutrition. And in that new ASM model, they specifically justified the measures they selected as one of the one of the justifications for measures was because some of them focused on prevention.

So Wellness and prevention at least thematically within this administration is going to be a a regular push for now through the next several years at least. So those are the major proposed rules, strategic directions I wanted to review. Now we're going to really get into the quality payment program. I won't spend a lot of time but on this slide, but just know the quality payment program was actually established under something called macro, what people know as macro something back in 2015. And the goal was to have high quality, cost efficient care and make it budget neutral.

2026 Proposed Changes to the Quality Payment Program (QPP)

Recorded 08/20/25

So originally CMS passed this legislation, developed the quality payment program, and then split it into two different groups, the merit based dented payment system known as MIPS. This is what usually people use in just all sorts of categorizations. They just say MIPS, MIPS, MIPS, right? That's what they mean here. And then the other one is the advanced alternative payment models or Apms. So these are advanced AC OS, this is the bundled payment model. And you're going to see how MIPS as being transformed and also now how this bundle payment model is being considered to be transformed within this new payment model approach that they're they're showing.

So now under Quality payment program, I'm going to try and be as very specific as possible. Under the quality payment program, you'll see language around traditional MIPS. So this is how it was originally established. Usual MIPS framework made of four categories and a composite score. Then APM Performance pathway #2 this is the APP framework and this is available for MIPS APM entities. So could be an ACO or other APM entities, but it is required if you are an MSSPACO so that you have to go through the APP framework. And then lastly is MVP is the newest of the frameworks and this is made-up of four categories with measures, but they are specific to specialty.

The MVP addresses and I'm won't go into the details here, but just as a a note, they're attempting, they have used language before that they are attempting to move everyone out of MIPS who's in that MIPS and move them into MVP. Well, this new ambulatory specialty model is kind of a, a mash up of MIPS MVP and maybe the future direction of where they're going with that. So keep that in mind as we're looking through that. These are the category weights within all of the different models. So the three on the left are under the quality payment program and now our new ASM.

It has the same thematic elements, all the same 4 categories, but the weighting of each category is slightly different based on each one of them. So this is more of a reference for you here to under each category plays into the overall configuration. You'll see that EP both consider quality and cost at 30%. There is another category that gets lumped in with quality on MVP and that is the population health. And then IA and P only interoperability are the same in those programs. In the APP framework, because cost is part of the MSPMSSP arrangements, cost is not considered here.

And so they a quality worth. If this new ASM model, quality and cost are split equally at 50%. But we'll get into the details of where Pi and IA get put into there a little bit later. So for now, we're going to focus first on traditional MIPS and MVP and we'll work our way through ASM and the APP. And for that, I'm going to pass it over for Jen to begin the quality category review. Sounds good. Thanks, Aaron. So I'm going to take you through each of these performance categories, review the overall basic category requirements, and then point out those specific proposed changes that came through in this 2026 proposed rule.

2026 Proposed Changes to the Quality Payment Program (QPP)

Recorded 08/20/25

So to start things off, we have the quality category. So as Aaron just explained, the category weight of this is different depending on the reporting framework that you choose. So if you're reporting through MIPS or MVP, 30% of your total score through the APP, the quality category is at 50% of the total score. The performance period is the same for all reporting frameworks and it's the full year, the full 365 days, meaning that it starts on January 1st and will end on December 31st. Now for the overall requirements, you are required to submit a specific number of measures, and that number of measures is specific to the reporting framework for which you've selected.

In addition to submitting those required measures, you must also make sure that you are reporting an outcome measure or a high priority measure. If you're submitting through traditional MIPS, you're required to submit at least six measures. If you submit through the MVP framework, you have to submit at least 4 measures and then through the APP, they have a defined measure set list. And so for the APP, you have to submit all measures within that measure set. In addition, you also have to meet the data completeness requirement and the case minimum criteria. And you can choose to use a combination of collection types to submit the quality measures.

So speaking of those collection types, there's six that are available. The first one are ECQMS. These are your electronic clinical quality measures. The next one that's available are the MIPS CQMS. These are sometimes referred to as the chart abstracted measures. There are QCDR measures available and you'll really notice these when you're looking at those MVPS, but these are measures that are developed and supported by a particular QCDR typical. Typically these are very specially specialized base measures that are supported. There are also administrative claims quality measures. So these are measures that are calculated by CMS using claims data and these are only available to small practices.

There is the CAPS for MIP survey, this measure that's available. So this is a survey measure that is administered and this can be used in place of one of the quality measures. And then finally, we have the newest collection type Medicare CQMS. These are essentially the same thing as a MIP CQM. However, they're only looking at the Medicare patient population and the Medicare CQMS can only be used by MSSPACOS for the data completeness requirement. So this is set to remain at 75% and that is through performance year 2028.

So no changes here for data completeness. I did want to provide a little bit of context about how this is calculated because we often get a lot of questions about this. So this is calculated depending on the collection type that you are using. So if you are using CQMS, then your data completeness will be calculated by considering both the total number of patients who are seen and eligible for measure and the total number of patients for which you report. So what you want to do is you want to take your numerator which includes your performance met, performance not met and any denominator exceptions.

2026 Proposed Changes to the Quality Payment Program (QPP)

Recorded 08/20/25

You would add all that together and then you would divide that by the denominator or the total number of patients that are eligible for the measure. This number needs to be greater than 75% in order to meet the data completeness requirement for a CQM. Now for ECQMS it's a little bit different because ECQMS are generated through a certified health record and all of the data is included. If you are including all of your data from all of your sources, you automatically achieve 100% data completeness. Now note here that if a measure does not meet that minimum requirement of 75%, it would earn 0 decile points when you go to submit it.

There is one exception to this, and this is if you're part of a small practice. If you are part of a small practice then you would earn 3 decile points for the case minimum. This is still set to stay at 20 denominator eligible instances. So this means that in order to submit a measure and earn decile points, you have to have at least 20 patients in the denominator. If you do not, then this measure would earn 0 decile points. For the quality category, CMS is proposing to add five new quality measures starting with performance year 2026. So there are two ECQMS that are being proposed.

The first one is CMS 1173, which is diagnostic delay of venous thrombolysis in primary care. This is an episode based measure, it's an inverse measure and it's looking at patients with the documented BTE symptom in the primary care setting. The second ECQM that's being proposed is CMS 1154. This measure is screening for abnormal glucose metabolism in patients at risk for developing diabetes. So this is a measure that's focusing on the at risk patient population and then is looking for that appropriate screening for that patient population. In addition, there's three MIPS CQMS that are being proposed. The first one is patient reported falls in plan of care.

Then there is prevalent standardized kidney transplant weightless ratio and then a third MIPS CQM being proposed for hepatitis C virus with sustained biological response. So 5 new quality measures that you'll have the option of selecting for reporting next year. They're also proposing to remove 10 quality measures. We have all ten of those quality measures listed for you here on the slide. And consistent with what we've seen in other CMS rulings this year, they are removing the screening for social drivers of health and the COVID-19 vaccination status. So both of those are being proposed to be removed. And if all of these changes are finalized, there would be a total of 190 quality measures that would be available for 2026.

Next, we're going to switch gears and look at the improvement activities category. For this category, it is worth 15% of your total score. The performance period is a full continuous 90 days throughout the year. And for the requirements, you're required to submit one to two activities to receive the maximum score of 40 points. If you're submitting through traditional means and you are a clinician group, virtual group and you have a special status, so that special status could be hospital based, facility based, small practice, any of those special statuses, you are only required to submit one improvement activity.

2026 Proposed Changes to the Quality Payment Program (QPP)

Recorded 08/20/25

For all other clinician groups and virtual groups without a special status, you are required to submit 2 improvement activities. And then if you are reporting through the MVP reporting framework, all clinician groups and subgroups, regardless of special status are required to submit one activity. CMS is proposing to add 3 new improvement activities. So they are proposing to add an improvement activity for improving detection of cognitive impair in primary care, integrating oral healthcare in primary care, and then a third improvement activity that would be focusing on patient safety and use of artificial intelligence or AI. They're also proposing to remove 8 improvement activities. We have the full list for you on this slide.

But looking at this, this is very consistent with what we saw with the quality measures and with the other CMS rulings. They're really removing those measures that are focusing on HealthEquity and social drivers of health for the improvement activities category. In addition to removing those measures, CMS has proposed to remove the achieving HealthEquity improvement subcategory, and they are proposing to add a new subcategory for advancing health and Wellness. So this subcategory is a category that all of the improvement activities are under. So I'm expecting once this is finalized, if this is finalized, that the following year we would have additional improvement activities underneath this advancing health and Wellness subcategory.

Next, for the promoting interoperability category, the category weight for this for MIPS MVP is 25% of the total score for the APP. This one is weighted at 30%. The performance period is a full 180 days and you are required to submit all of the required measures. We'll go through those on the next slide. But in addition to the required measures, you also have to attest to the actions to limit or restrict the compatibility of CERT and the ONC direct review. You have to make sure that you have a CERT functionality that meets ON CS certification criteria and that has to be in place by the first day of the MIPS promoting interoperability period.

And you have to have your EHR certified by ONC by the specific certification criteria by the last day of the performance period. In addition to that, you also have to provide your EHRCMS identification code from the Certified Health IT product list, and you have to do that at the time of your submission. You also have to conduct a review of the security risk analysis on an annual basis and you have to attest to conducting an annual assessment of the safety assurance factors for EHR resilient guides or the safer Guides measure. Now in addition to all of that, you also have to meet all of the promoting and probability objectives.

So under the electronic prescribing objective, there are two measures that are required, both E prescribing and the query of the PDMP. Both of these are currently attestation. The query of the PDMP is currently an attestation measure. There was an RFI out in the proposed rule requesting feedback on changing this from an attestation measure to a performance based measure. So if you have strong feelings about that, I suggest you know, reaching out with some information to CMS about how you feel about changing that measure. Underneath that, for the health information exchange objective, there are three options to meeting this.

2026 Proposed Changes to the Quality Payment Program (QPP)

Recorded 08/20/25

So you can choose option one, which is submitting both the sending health information and the receiving and reconciling health information measures. You need to submit both of those, so that's option one. Option 2 is attesting to have a bidirectional exchange and then option 3 is attesting to enabling exchange under TEFKA. So any of those options will fulfill that Pi objective. Under the provider to patient exchange, there's one measure that is required and that is to provide patients electronic access to their health information. And then under the public health and clinical data exchange, there are two measures that are required, both electronic case reporting and immunization registry.

So both of those are required and then you can choose an optional measure to submit for five bonus points. So currently you can choose from the public health registry, syndromic surveillance and the clinical data registry. And they did propose to add one additional option here. So they are proposing to add the public health reporting using TEFKA. So that would be another attestation measure that you could select for five bonus points. Some additional proposals for the Pi category. CMS is proposing a change to the security risk analysis measure. They are proposing to add a second component to the existing measure for security risk management.

So if this proposal is finalized, clinicians and groups would be required to attest to both conducting a security risk analysis and conducting a security risk management. So both components of that measure would be required and a testing with a no response to either of those components would result in a 0 score for the entire promoting in our probability category. Some additional proposals for the Pi category, they are proposing to modify the existing safer guides measure by requiring the use of the updated safer guides. Currently, they're still using the 2016 version of the SAFER guide, so they are proposing to update that to the 2025 version, and that measure would remain required.

They're also proposing that new bonus measure. So that new bonus measure is the public health reporting using TEFKA, just an attestation measure. If you're able to attest to that, that would give you 5 bonus points. And then for electronic case reporting, I'm really glad that they proposed this. We've heard from a lot of customers and clients that they're struggling with this this year due to the CDC temporarily pausing onboarding for this. So CMS did listen to that feedback and they are proposing to suppress this measure for performance year 2025 S for 2025, they're proposing to suppress this.

You would still be required to submit the measure. So you would submit it with either the yes or no response to that attestation and then the measure would be excluded from scoring calculations. Next, we're going to look at the cost category. For the cost category, this is worth 30% of the total score and the performance period is the full 365 days. For the cost measures, CMS automatically evaluates your performance on these through claims data. As long as you're meeting that case minimum, which is generally 20 eligible episodes, they will automatically evaluate the the cost measures.

2026 Proposed Changes to the Quality Payment Program (QPP)

Recorded 08/20/25

For MIPS, you are evaluated on all cost measures and there's currently a total of 35 cost measures that you are evaluated on. For the MVP framework, you are only evaluated on the cost measures that are specific to the MVP that is selected. One of the exciting proposals I think that came out of this ruling is for the cost category, and that is that CMS is proposing a 2 year information only feedback period for any new cost measures. So what this means is that clinicians and groups will receive information only feedback on new cost measures for two years before the measure contributes to scoring.

So I think this is their way of hearing the feedback that everyone has been submitting for the past couple years about their frustration with the cost category and with the limited feedback that's been available. So they will be providing that feedback to you through the QPP portal. You'll be able to login, review those cost measure reports. You will get that feedback for two years before the measure contributes to your overall cost category scoring. And also what this means is that there were no cost measures proposed for 2026. So if this is finalized, this means that you would not be scored on a new cost measure until performance year 2029.

So this really gives you a couple of years to focus on the cost category, drill into those measures, look at that feedback, put in some processes into place so that you can impact your cost category results. And then one modification to an existing cost measure. For the total per capita cost measure, CMS is proposing to modify and update the candidate event and attribution criteria for this measure. This is the only cost measure that was proposed with any modifications. Next, we're going to take a look at the MIPS value pathways. So this is the MVP reporting framework timeline that I know you guys have all seen a couple of Times Now.

But just to kind of bring it back to where we started and where we're going with this reporting framework. So 2023 was the very first year that the MVP reporting framework was introduced and it's been voluntary for the past couple of years. CMS has continuously over the past couple of years added additional MVPS that are available for selection. So that's kind of what's been going on for the past couple of years. Now we get to 2026, so next year and this is when subgroup reporting is required. So what does this mean? This means that if you are part of a multi specialty TIN or a group, so multi specialty group, you will be required to form subgroups based on specialty if you intend to report an MVP.

So you will need to start looking at your TIN structure, putting those clinicians providers into groups based on specialty and then reporting out based on those specialties. So that starts next year in 2026, 2027 and 2028, the same thing is true. You'll be required to form those subgroups. Now in 2029. This is when we've been anticipating that MVPS will become required. CMS did say so in the, in the proposed rule that they've been using language like we anticipate that we'll be able to transition to MVP reporting in 2029. And even in some recent CMS webinars, they have thrown off this 2029 day.

So I think it's safe to say that, you know, in 2029, we are fully expecting traditional myths to sunset and that you'll be required to report through the MVP framework. CMS is proposing to add 6 new MVP options

2026 Proposed Changes to the Quality Payment Program (QPP)

Recorded 08/20/25

starting with 2026. So they're adding 2 MVP options for radiologist, neuropsychology, they're adding pathology, dietary and then vascular surgery. So currently, there are 21 MVPS available. They're adding an additional 6. So in 2026, if these are finalized, there would be a total of 27 MVPS available for selection. And then they are also proposing modifications to all of the previously finalized MVPS.

And this is just to update them and align with the quality measure and improvement activity inventory updates that were proposed. Some additional proposals for the NDP framework, they are proposing that groups will be allowed to attest to their specialty composition. So this means during that NDP registration process, you will go in and you will attest to either being a multi specialty or a single specialty group. And that is what will drive if you are required to form subgroups or not. The CMS previously was going to use Pecos and claims data to make this determination, but now they're officially proposing that you will be able to attest to that.

They also proposed a change for small practices in the MDP reporting framework. So they are exempting small practices from forming subgroups. So if you are part of a multi specialty small practice, that means you have 15 or fewer clinicians, you would be able to report an MVP as a group and you would no longer be required to form a subgroup. And then for QCD Rs and Q Rs, you now have one year after an MVP is finalized in order to fully support that MVP. So a little bit of relief there for QCD Rs and Q Rs for the performance threshold.

The performance threshold is the same for both MIPS and MVP, and it's going to remain at 75 points and that is through calendar year 2028. So in order to receive some sort of a positive payment adjustment, you have to meet that minimum threshold of 75. The higher you get, the closer you get to 100, the more of a positive payment adjustment you'll receive. And then if you score 75 or lower, you will receive a negative payment adjustment. And that can be up to a -9% payment adjustment on your Medicare fee schedule. And I'll hand it back to Erin.

Awesome. Thank you, Jen. Now we're going to transition into the new ambulatory specialty model referred to as ASM. So this is a brand new payment model that has been proposed in this ruling and will be decided whether it's finalized in when this comes out as the final rule sometime in November. So ASM is essentially a mash up between MIPS and MVP. So everything you just kind of heard from Jen there and team and team is that inpatient payment model. And in the team model, they did a lot of similar things to how they're focusing on care coordination.

That is a huge theme of TEAM and it's a huge theme of this ASM as well. CMS is trying to solve the problem of healthcare fragmentation and healthcare fragmentation in their words, is increasing. And in fact, if you read both of those models, the way they rolled them out and the rulings, they actually use the same justification for TEAM that they use for ASM. And it's that healthcare beneficiaries experience with care is fragmented. They go to a lot of different specialists, a lot of different hospitals, a lot of different locations and PCPS, and it's not

2026 Proposed Changes to the Quality Payment Program (QPP)

Recorded 08/20/25

coordinated. And so they point to these research around beneficiaries seeing, you know, 14 different practices, locations, clinicians within like a year time span.

And what they're saying is that this results in worse outcomes, higher costs and frustrated patients. So the ambulatory specialty model is focused on care coordination for guested specialty care. And the other thing I want to note here is that there is a bit of a theme for specialty care and some of the other things that CMS is putting forward. And I really think this has to do with their grand vision of their provider directory that they're talking about. And you saw they released a whole section about their interoperability and getting this provider directory. And I went to the CMS conference and heard Doctor Oz talk about his vision for creating this provider network.

So that directory so that beneficiaries can log in and see what doctors as part of that they really want to get the quality and the cost information at patients fingertips. So this ASM is kind of a mash up that does just that or they're hoping does just that. So it is an outpatient specialty care for chronic conditions and the chronic conditions they first identify that are part of this are cardiologists for heart failure and low back pain, specialist for low back pain. So if the clinician is selected for participation within this model, it's mandatory. They must be reported for and therefore they are excused for MIPS reporting.

So if you think about your specialty, your multi specialty group, if you have one and it's full of cardiologists or people that have the low back pain, you'll see the titles associated with that. Keep in mind that you may have clinicians that are eligible for this. I'm going to go through the eligibility now. There are parts that are like MIPS, there are parts that are like MVP, and there are parts that are like team. So I'll kind of go through a little bit of there. And this, for the most part, you can think of it like MIPS.

It is A2 sided risk adjustment, meaning you can lose -9%, you can gain up to 9%. Kind of the biggest difference here, and we'll see how this plays out, is that the way they're calculating it is direct competition between specialists with no predetermined thresholds. So what Jen just showed you with you got to hit 75 points, what CMS is saying, that means everybody's aiming for 75. And so everybody's trying to get to that to get some money. And also there's not enough for performers to feed some real significant savings. So I'm sure you guys have felt this, but like the Max that people are getting is a 2% payout when they were supposed to get up to 9%.

So CMS isn't happy with how the program really ended up happening. And then the clinicians are and you guys are see not many returns in exchange for the amount of work. So this new calculation should hopefully make bigger payment swings, which is obviously more risky for the negative, but could potentially have more benefit if you're one of the the people that can do this. Well, it is a five year model that is proposed to begin in 2027 and runs through 2031. The list of participants will be released first at the end of this year. So you'll see if

2026 Proposed Changes to the Quality Payment Program (QPP)

Recorded 08/20/25

any of your clinicians are on that list, but then they're going to release the final list in about July time frame of next year.

Another big change from MIT is done at the clinician level. So it is the individual clinician reporting data, not the group. And again, this goes back to their game. They're, they're hoping to gain specialist data and have it be comparative by using these very specific cohorts for submitting clinician level instead of that at 10 level or even a subgroup level. It does have the four categories, quality, IAPIN cost. So you're going to see some repetition with those participants. The way that you can qualify for ASM, it is an individual person who has had at least one ASM performance year, satisfies the ASM eligibility criteria and has been selected for participation.

So what that means is they bill under the Medicare physician fees schedule. They meet the specialty requirements, which I'll go over in a minute. They have a minimum 20 episodes annually based on the episode based cost measures and they are located in a selected geographic area. 25% of CBSCBSAS randomly selected. This is what they did for team. They break the country into CBS as and then they randomly select 25%. They haven't told you what that 25% is in the proposed rule.

That's what this is going to do in the final rule, tell you what they select and then furthermore give you the the list of participants. So the way they're going to do that selection 25%, it's going to be based on the zip code on claims from two years prior. So if your zip code gets selected and you meet the criteria, then you'll be in this program. And there's no, So the two cohorts are heart failure and low back pain. And the way they're going to do with a specialty type of cardiologist whose plurality of Medicare billing is cardiology in the majority, it means that of all the groups that are being billed the most are for the heart failure specialty, the cardiology.

Then for low back pain, it's clinicians with a specialty type of anesthesiology, interventional pain management, neurosurgery, orthopedic surgery, pain management and physical medicine and rehabilitation. And again, it's that plurality of Medicare billing is for low back pain and it's based on those episode based cost measures which take into account the the cost for the entire episode associated with either heart failure or low back pain. And that's how they're going to identify the participants. But again list at the end of this year finalist middle. So same to the difference is quality and cost are worth 50%.

Promoting interoperability and improvement activities still got to do stuff but it's penalty only so it can only hurt you. And what they said was basically everyone was doing well on promoting interoperability and improvement activities and so it was just evening out all the scores. So they really want to base it on quality and cost which is what they are saying will actually produce larger swings as well as changing the methodology for calculation. So Pi and IA can only hurt you if you don't do them or you don't do them well. To quality, there is a required measure set that is specific to the specialty unlike with MVP where you can select for from a list all measures that they've identified for that cohort are required.

2026 Proposed Changes to the Quality Payment Program (QPP)

Recorded 08/20/25

And that's got some ramifications I'll talk about a little later. It is a performance. You do still have the data completeness requirement. And one thing I'll say here is that there's a call out, unlike in MIPS or MVP that if you do not submit at least one ECQM or CQM that meets the data compliant completeness requirement, you get a -9% penalty in that. So you have to, you have to report all of them. But they're saying if you don't submit one ECQM that doesn't have the data completeness done ECAM or CQM, you get the full -9% penalty.

So super that data completeness is super important and worth 50% of your total score. For cost, there are required cost measures. It is cohort based, one for each. It's that same episode based cost measure for heart failure and a low back pain. So for promoting interoperability, it's mostly all the same required Pi measures. That same 100 day performance period. A couple of different minor tweaks to what Pi is, but a negative score for poor performance. I see a couple of typos in here, my apologies. I'll get those fixed up.

It's a negative score for poor performance within Pi improvement activities. It's two. It's the same for both. It is a 90 day performance period. You must attest yes to have done these in order to get credit. If you don't, you'll get negative points on those ones, again, added to your score. OK, so here are the measures for heart failure. What I want to point out is that these are measures that you're familiar with. They all have measure IDs.

You may have already done some of these, like controlling high blood pressure. So immediately we're like, oh great, we have all these measures. We have them done. But the thing I also want to point to is that remember all these are required and that there's now an ECQM that's required to be submitted. So if you're a group that has only ever done MIPS CQMS and you have somebody that qualifies for the heart failure cohort, you're going to need to figure out these CQMS because you've got one that's required to keep that in mind.

These are the measures for your heart failure cohort. So now the low back pain, same thing. Some of these, you know, right, screening for depression, EMI screening. Last one there, functional status change for patients with low back impairments, that is a MIPS CQM. So if you've only ever done ECQMS, you're going to have to get this MIPS CQM going. It's just like such a mash up of these measure types. And that's back to what I was saying earlier in this presentation. It is super important that you have an understanding of data from your practices in all the places that it lives because you're going to have to bring it together and be able to create measurement on both types of measures.

So keep that in mind as well. Moving on to cost, so it uses the episode based cost measures as I talked about where it takes into account full cost of the for for the care of that particular episode. So for instance, heart failure. And then what it's going to do is it's going to compare the total Medicare spending per episode versus the other specialist. So it's comparing you compared to the standard deviation. So your cost and how far your cost is away from the median costs. They use median and standard deviation and they're going to benchmark, give you a benchmark based on how far away you are from the median.

2026 Proposed Changes to the Quality Payment Program (QPP)

Recorded 08/20/25

This is the benchmarking range. It's not it's not set in stone. This is basically figuring out what they said in the final and giving an estimation of how that looks. So don't, it's not, it's not perfect, don't take it away, but it's illustrative. That's why I put that there. So it's based on standard deviations from the cohorts medium, but in general, lower costs have some adjustments for patient complexity, other factors. And you must have greater than or equal to 20 episodes for scoring in this category. OK, improvement activities, penalty only.

There are two required proven activities and they are significant and here's why. So the first one, primary care connections and HRSN screening. So the clinician is required to help patients find a PCP if they need it. So they have to ask the patient if they have a PCP. If they don't have to help them find a PCP after every specialist visit, they have to communicate with the PCP. So there's got to be some type of flow of communication in this improvement activity. And then they have to ensure the patients get health related social needs screening.

And it is, yes, the S2H screening measure questions. So this was a little interesting to me because DMS spent the entire year pulling out the S2H measures from every single regulation. They pulled it out of the inpatient, the outpatient, the ambulatory, they actually pulled it out of the MIPS and MVPS and they pulled it out of missing one, but they pulled it out of everything and then they put it in here as an improvement activity. So what it says is that the specialist doesn't have to do the screening. They have to ensure the screening is done. So they have to communicate with the PC base basically saying did you screen them for health related social needs?

And if they don't encourage the PCP to screen them for health related social needs or ask if they can conduct the health related social needs screening, There was no words about equity in any of this. It was all health related social needs. So that might be an indication of how they might put this back into the program in the future through an improvement activities. And I thought it was also interesting and, and you know, I, I thought that was a good way of handling requiring the coordination with the PCP to have the PCP do the screening, which was a lot of the kind of pushback of who's responsible for screening for, for these PCP makes the most sense in this situation.

The second one for improvement activities is collaborative care arrangements. They must execute a formal agreement with a primary care practice and it must include three of the five elements. So could be data sharing, Co management, care transition, closed loop communication and care coordination integration. It's all sorts of details behind this one. So you have to get into a collaborative care arrangement or CCA. If you do not, and I have another slide on the CCA, if you attest to one yes to 1 only, you'll get -10 points. If you don't attest yes to both, you're going to get -20 points.

So basically, you have to do them. You have to attest yes. Now again, if you do not attest at all, if you attest no, you're going to get one of these penalties from a point standpoint. But if you don't want to test at all, you get -9% as well as your penalty. So it's, it's highly punitive if you don't at least do the attestation here. So a

2026 Proposed Changes to the Quality Payment Program (QPP)

Recorded 08/20/25

collaborative care arrangement, there's the whole section about collaborative care arrangements. Specialist must enter into a CCCA with APCP for ASM. Well, that sentence and it gives them some guidelines.

So I do suggest if this is something you have specialist that might be qualified, you start looking into what this collaborative care arrangement might mean. You know, specialist can pay, they give examples. Here's a couple like specialist can pay primary care practices for coordination services. Primary care can pay specialist for consulting training and it offers legal protection from anti kickback violations just as some. But you can absolutely give a lot of those a lot of examples within that that final role. So there's lots more there. You are required to have a written agreement, has to be fair market value, no conditioning on referrals and must advance the ASM clinical goals.

OK, promoting interoperability requirements. It is similar to MIPS Pi as I mentioned, but you do not need, the clinician does not need to attest the actions to limit or restrict compatibility or interoperability of cert attestations. That is not required as part of it, but basically all the other measures are required. You must report at the individual clinician level, not the TIN level. They've given some flexibility in some of the other programs like ACOs and MIPS and MVP and where that Pi submission happens. For this, they're saying it must be at the clinician level.

There are no bonus points available for those optional measures that Jen went over earlier. And the penalty calculation is basically your score times 100 -, $100 / 10$. So example there on the right step by step calculation, what they're going to do is let's say you earn 73 points, your score 7573% in Pi. Based on all those measures, you earn 73 points. You multiply the score by $173 * 173$. Then you subtract the result from a hundred $100 -$. 73 is 27 and then you divide it by the maximum negative adjustment, which is 10 points. $27 / 10 = 2.7$ and then it's a negative adjustment.

So if you scored 73 in this way, in this configuration example, you'd have a -2.7 points to your overall score. You can only have zero Pi penalty if your score is perfect. So if your historic Pi score has been perfect but for you, you're probably not going to get any penalty on this. Otherwise they're going to adjust it for not being pricked. There are still some additional bonus point opportunities even though the other ones weren't available on Pi. If you are a small practice 2 to 15 clinicians gets plus 10 points solo practitioners get.

They are also including that complex patient bonus, so up to 10 points for treating sicker more disadvantaged patients. It is same based on that HC school eligible percentages and then you must be above the cohort meeting on greater one or greater indicator to qualify. Final score calculation. I feel like I'm always doing math on these things. I did try and simplify it here. It's not. It's not too complicated. I've definitely seen worse. The final score complication calculation looks like this. It is your quality score plus your cost score times 100, then a any IA or Pi adjustments, and then any bonuses.

2026 Proposed Changes to the Quality Payment Program (QPP)

Recorded 08/20/25

So example Doctor Flower here. Let's say Doctor Flower got an 80% on quality and a 75% on cost. That gives him the base number of 77.5. You know basically like 80 in half. 75 1/2 added together is 77.5. Then let's say they only attested DS to one IA, so Doctor Flower then got a -10 and then they are had that same score. I just example for Pi had a 73, so they have a -2.7. They have a complex cohort so they get a + .5 point 5 and they're part of a small practice so they get plus 10.

That gives them a final score of 80 points. Pretty easy to follow along with that so far. Then they're going to transform the payment adjustment using something called a logistic function. This is where the difference in what you're trying to achieve, it might make a big swing. Essentially what it does is it rewards bigger in the median in the middle part of of the range and the outer ranges have less impact. So if you're, if you're on the higher end and you keep going higher and higher and higher, you're not going to have as much impact as somebody who's closer to the middle of the pack and then is able to inch away from the middle.

So they think this is going to be causing more swings. But first they have to transform it using this transformation example that I put on the right. So 80 points from Doctor Flower. Let's pretend that for the entire cohort, the median score or the middle score is 50 points. This becomes the midpoint. So they're going to calculate the difference $80 - 50$ is 30. They're going to multiply by steepness, whatever that is. That's the calculation $-.1 * 30$, so 3 point O. Then they're going to calculate this exponential.

I had to look that up. I forgot about it from like high school calculus class. And so they're going to take that E, whatever that is, the exponential minus that -3 and that gives you your score there. They're going to add 1 and take the reciprocal. So whatever, if you're math and you like this, that's how they're going to do it. But they're going to transform your score. In this case, Doctor Flowers 80 points becomes .95. Now here's the other thing that they took from team in the past. Remember the very beginning of this, we talked about this being a budget neutral program where CMS takes all the poor performers and then redistributes the funds to the top performers.

They're going to take all of those negative penalties, they're going to cut off 15%, say they're going to distribute the rest of you. So they're not going to give you all the bonus. They're going to redistribute those funds and take a 15% cut of it. So because of that, they have to give a scaling factor of 1.5. So the payment formula is your risk level, your transform score, that scaling factor to equally to redistribute those patient or those bonus funds and then -9%. So, and that's the calculation there. In this case for Doctor Flower, who scored 80 points and the median of the score was 50, they're going to get 3.85% bonus on their or their payments two years in the future.

That's how they're going to hopefully make sense of that score. Couple other notes, final things, close it out, data sharing opportunities. This is what they're doing for team as well. And I don't think this has been done before. I could be wrong, but for the clinicians, you're going to get regular aggregate and patient level

2026 Proposed Changes to the Quality Payment Program (QPP)

Recorded 08/20/25

beneficiary files. So you're going to get these de identified performance trends, cost, utilization, quality data. You'll get them on regular intervals during the performance year. But you may also request patient level data with detailed Medicare Abd claims.

So these participants for ASM patients only, they can get a whole host of data from CMS directly and that can be used and shared with all these data sharing agreements so that you can actually understand where your costs are coming from. It does require this data sharing agreement signature and can be used for care coordination and quality improvement. All right, we're almost at the end here. Thanks for hanging in. Just wanted to zoom out real quick before we move on. Who's going to succeed in ASM? The winners will be special to embrace systematic quality improvement, build strong primary care partnerships, invest in care coordination capabilities and then obviously focus on evidence based cost effective care and adapt to data-driven practice management.

It's really what's going to be needed for these participants. And again, I emphasized this earlier, but like if it's successful, CMS is saying they're going to expand to other chronic conditions and specialties. So we're talking about two and it's a five year model that they may add other specialists as well. So if you are on this, great, you've learned a bit about it hopefully, but it is important to know that this is, this might be where they're heading in the future. And I talked about this too, CMS really wants that specialty data and it the future belongs to this collaborative accountable specialists.

All right, last thing, we're going to finish up with the final changes to the MSSPACOS proposed. There were a couple of highlights for ACS as we finish it out. Again, no change to the CMS web interface, still not an option. They did remove the estimate measure as a requirement. We talked about that too. They also are proposing to remove the HealthEquity benchmark adjustment for performance year 2025, so that affects 2025. They are going to allow you to keep the CQMNCOS 2025 and beyond, expand the caps to the Webmail phone administration and performance year 27.

They're expanding those exception policies for cyber attacks, and ACOs must make changes to their ACO participant list when an ACO participant experiences a change of ownership or a Chow, or if an ACO Skilled Nursing facility affiliate list has all as well. So something to find. They are talking about revising the definition of a beneficiary eligible for MIPS. So if your ACO is reporting Medicare CQMS, note that they are making a couple of proposed changes. They want to change the definition to had at least one primary care service with a date of service during the performance year and they're using primary care service and performance year instead of claims and measurement period.

So on the left hand side is the current statement of how they're identifying these beneficiaries as being eligible for Medicare CQMS in order to better align with how the AC OS are having their beneficiaries aligned to their AC OS is how they think they will fix that. Otherwise, all eligible rules bullets remain and they're going to say, they said that they will give you additional flag on that quarterly list of beneficiaries eligible for those

2026 Proposed Changes to the Quality Payment Program (QPP)

Recorded 08/20/25

Medicare CQMS. So they said they would actually start this in Q22025, even though it's not analyzed. They're going to give you those lists of Medicare CQM patients with the with the beneficiary flags.

Hopefully that will help you out a little bit. Last note, if you are an ACO and the ASM model, you have specialists in your ACO. They specifically talked about how this ASM was designed to overlap with other models and they called out MSSPACO. Unfortunately, they did not specifically say that AC OS who are reporting for this ASM requirements or participants don't have to report for them. So I would get clarification on that before I was feeling more confident in saying you don't need to report to them. All they said was that a clinician is not required for myths.

Did not say specifically about whether an AC OS still have to report for these under the APP framework. So we need to get that clarification. All right, we're right at time and we've just finished up. Thank you for your questions. We are going to answer these questions on Friday, September 5th at 12:30 PM. We're going to go through the Q&A from today's webinar. A link to add to the calendar will be sent in a webinar follow up e-mail today. Thank you so much for your time. Sorry I had to run through it at the end there.

Thanks, Jen for coming back in and for all your presentation today. We will answer those questions on 95, throw them in your question box if you want to get something answered, and we'll do some research for you. The slide deck should be in the document section for you and recording as well. This has been recorded, so you should be able to get that in the follow up e-mail, which will give you the recording access to the slides as well as a chance to check in with us again on Friday 95. Thanks so much for your time everyone.

You guys have a great day. Thanks so much, Jen. We'll see y'all next time.