This document is scheduled to be published in the
Federal Register on 2026-07-16 and available online at
https://www.federalregister.gov/d/2026-14327, and on
https://govinfo.gov

ode 4169-69-P]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 400, 405, 406, 407, 410, 414, 415, 417, 422, 423, 424, 425, 427, 428, 512

[CMS-1848-P]

RIN 0938-AV82

Medicare and Medicaid Programs; CY 2027 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Proposed rule.

SUMMARY: This proposed rule addresses: changes to the physician fee schedule (PFS); other changes to Medicare Part B payment policies to ensure that payment systems are updated to reflect changes in medical practice, relative value of services, and changes in the statute; codification of establishment of new policies for: the Medicare Prescription Drug Inflation Rebate Program under the Inflation Reduction Act of 2022; the Ambulatory Specialty Model; updates to drugs and biological products paid under Part B; Medicare Shared Savings Program requirements; updates to the Quality Payment Program; updates to policies for Rural Health Clinics and Federally Qualified Health Centers; update to the Ambulance Fee Schedule regulations; codification of the Inflation Reduction Act and Consolidated Appropriations Act, 2026 provisions; updates to Clinical Laboratory Fee Schedule regulations; updates to the Medicare Promoting Interoperability Program.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, by September 14, 2026.

ADDRESSES: In commenting, please refer to file code CMS-1848-P.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically*. You may submit electronic comments on this regulation to https://www.regulations.gov/docket/CMS-2026-2377. Follow the "Submit a comment" instructions.

2. *By regular mail*. You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-1848-P,

P.O. Box 8016,

Baltimore, MD 21244-8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail*. You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-1848-P,

Mail Stop C4-26-05,

7500 Security Boulevard,

Baltimore, MD 21244-1850.

For information on viewing public comments, see the beginning of the "SUPPLEMENTARY INFORMATION" section.

FOR FURTHER INFORMATION CONTACT:

MedicarePhysicianFeeSchedule@cms.hhs.gov, for any issues not identified below. Please

indicate the specific issue in the subject line of the email. For all questions related to reporting a service on a claim, please contact your Medicare Administrative Contractor.

Michael Soracoe, Morgan Kitzmiller, or *MedicarePhysicianFeeSchedule@cms.hhs.gov,* for issues related to practice expense, work RVUs, conversion factor, and PFS specialty-specific impacts.

Hannah Ahn, Allison Bramlett, or *MedicarePhysicianFeeSchedule@cms.hhs.gov*, for issues related to potentially misvalued services under the PFS.

Mikayla Murphy, or *MedicarePhysicianFeeSchedule@cms.hhs.gov*, for issues related to direct supervision using two-way audio/video communication technology, telehealth, and other services involving communications technology.

Maya Peterson or *MedicarePhysicianFeeSchedule@cms.hhs.gov*, for issues related to E/M overlap between stand-alone visits and global periods, and E/M visit complexity add-on code (MOD1 and MOD2).

Terry Simananda, or *MedicarePhysicianFeeSchedule@cms.hhs.gov*, for issues related to smoking and tobacco use cessation, screening, brief intervention, and referral to treatment, psychiatric collaborative care model, and shared medical appointments.

Sarah Leipnik, or *MedicarePhysicianFeeSchedule@cms.hhs.gov*, for issues related to global surgery payment accuracy.

Pamela West, or *MedicarePhysicianFeeSchedule@cms.hhs.gov*, for issues related to comprehensive outpatient rehabilitation facility (CORF) services and KX modifier thresholds.

Zehra Hussain, or *MedicarePhysicianFeeSchedule@cms.hhs.gov*, for issues related to payment of skin substitutes.

Laura Kennedy, (410) 786-3377, Rebecca Ray, (667) 414-0879, and Jae Ryu, (667) 414-0765 for issues related to Drugs and Biological Products Paid Under Medicare Part B.

Lisa Parker, (410) 786–4949, or FQHC–PPS@cms.hhs.gov, Michele Franklin, (410) 786–9226, or RHC@cms.hhs.gov, and Patrick Sartini, (410) 786-9252 for issues related to FQHC and RHC payments.

Patrick Sartini, (410) 786-9252, or *CLFS_Inquiries@cms.hhs.gov* for issues related to Clinical Laboratory Fee Schedule.

Sabrina Ahmed, (410) 786-7499, or *SharedSavingsProgram@cms.hhs.gov*, for issues related to the Medicare Shared Savings Program (Shared Savings Program) quality performance standard and other quality reporting requirements.

Kimberly Spalding Bush, (410) 786-3232, or *SharedSavingsProgram@cms.hhs.gov*, for issues related to the Shared Savings Program certified electronic health record technology (CEHRT) use requirements.

Janae James, (410) 786-0801, or *SharedSavingsProgram@cms.hhs.gov*, for issues related to Shared Savings Program beneficiary assignment and financial methodology.

Lucy Bertocci, (443) 681-0762, or *SharedSavingsProgram@cms.hhs.gov*, for issues related to reducing or eliminating Part B cost sharing, prepaid shared savings, beneficiary notifications, advance investment payments or identifying ACOs experienced with performance-based risk.

Elisabeth Daniel, (667) 290-8793, for issues related to the Medicare Prescription Drug Inflation Rebate Program.

Benjamin Picillo or Genevieve Kehoe, *AmbulatorySpecialtyModel@cms.hhs.gov,* or 1-844-711-2664 (Option 4) for issues related to the Ambulatory Specialty Model.

Amy Gruber, (410) 786-1542, for issues related to Ambulance Fee Schedule.

Kati Moore, (410) 786-5471, for inquiries related to the Merit-based Incentive Payment System (MIPS) track of the Quality Payment Program (QPP).

Trevey Davis, (410) 786-6600, for inquiries related to the Advanced Alternative Payment Models (APMs) track of QPP.

Jessica Warren, (410) 786-7519, and Lisa Marie Gomez, (410) 786-1175, for inquiries related to the Medicare Promoting Interoperability Program.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: https://www.regulations.gov. Follow the search instructions on that website to view public comments. CMS will not post on Regulations.gov public comments that make threats to individuals or institutions or suggest that the commenter will take actions to harm an individual. CMS continues to encourage individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

Plain Language Summary: In accordance with 5 U.S.C. 553(b)(4), a plain language summary of this rule may be found at https://www.regulations.gov/.

Addenda Available Only Through the Internet on the CMS Website: The PFS Addenda along with other supporting documents and tables referenced in this proposed rule are available on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html*. Click on the link on the left side of the screen titled, "PFS Federal Regulations Notices" for a chronological list of PFS **Federal Register** and other related documents. For the CY 2027 PFS final rule, refer to item CMS-1848-P. Readers with questions related to accessing any of the Addenda or other supporting documents referenced in this proposed rule and posted on the CMS website identified above should contact *MedicarePhysicianFeeSchedule@cms.hhs.gov*.

CPT (Current Procedural Terminology) Copyright Notice: Throughout this proposed rule, we use CPT codes and descriptions to refer to a variety of services. We note that CPT

codes and descriptions are copyright 2020 American Medical Association. All Rights Reserved. CPT is a registered trademark of the American Medical Association (AMA). Applicable Federal Acquisition Regulations (FAR) and Defense Federal Acquisition Regulations (DFAR) apply.

I. Executive Summary

A. Purpose

This major annual rule proposes to revise payment policies under the Medicare PFS and makes other policy changes, including proposals to implement certain provisions of the Full-Year Continuing Appropriations and Extensions Act, 2025 (Pub. L. 119-4, March 15, 2025), Further Continuing Appropriations and Other Extensions Act of 2024 (Pub. L. 118-22, November 17, 2023), Consolidated Appropriations Act, 2023 (Pub. L. 117-328, December 29, 2022), Inflation Reduction Act of 2022 (IRA) (Pub. L. 117-169, August 16, 2022), Consolidated Appropriations Act, 2022 (Pub. L. 117-103, March 15, 2022), Consolidated Appropriations Act, 2021 (CAA, 2021) (Pub. L. 116-260, December 27, 2020), Bipartisan Budget Act of 2018 (BBA of 2018) (Pub. L. 115-123, February 9, 2018), the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) (Pub. L. 115-271, October 24, 2018) and Consolidated Appropriations Act, 2026 (Pub. L. 119-75, February 3, 2026), related to Medicare Part B payment. In addition, this proposed rule includes provisions regarding other Medicare payment provisions described in sections III. and IV. of this proposed rule.

This proposed rule updates policies for the Medicare Prescription Drug Inflation Rebate Program codified at 42 CFR parts 427 and 428 consistent with sections 1847A(i) and 1860D-14B of the Social Security Act (the Act). For the Medicare Part B Drug Inflation Rebate Program, this rule describes the identification of the Consumer Price Index for all Urban Consumers (CPI-U) for the payment amount benchmark quarter and the rebate period in certain instances when CPI-U survey data are unavailable and the calculation of the Part B rebate amount in such instances; proposes to clarify the definition of “first marketed date”; and

proposes to clarify that certain skin substitutes would not be excluded from the definition of a Part B rebatable drug. For the Medicare Part D Drug Inflation Rebate Program, this rule describes the identification of the CPI-U for the payment amount benchmark period and applicable period in certain instances when CPI-U survey data are unavailable and the calculation of the Part D rebate amount in such instances; proposes a modification to the methodology finalized in the CY 2026 PFS final rule to account for 340B-eligible units for AIDS Drug Assistance Program (ADAP) enrollees for the applicable period beginning October 1, 2025; and proposes to require Medicare providers and suppliers that are 340B covered entities to submit Part D 340B claims data to the Medicare Part D Claims Data 340B Repository beginning in 2027.

This proposed rule proposes to modify policies for the Shared Savings Program, which is a voluntary program that started in 2012. The program allows groups of providers and suppliers to form or participate in Accountable Care Organizations (ACOs), and to be held accountable for the quality and total cost of care for an assigned population of Medicare fee-for-service (FFS) beneficiaries.

B. Summary of the Key Provisions

Section 1848 of the Act requires us to establish payments under the PFS, based on national uniform relative value units (RVUs) that account for the relative resources used in furnishing a service. The statute requires that RVUs be established for three categories of resources: work, practice expense (PE), and malpractice (MP) expense. In addition, the statute requires that each year we establish, by regulation, the payment amounts for physicians' services paid under the PFS, including geographic adjustments to reflect the variations in the costs of furnishing services in different geographic areas.

In this major proposed rule, we are proposing RVUs for CY 2027 for the PFS to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services, as well as changes in the statute. This proposed rule also includes discussions

and provisions regarding several other Medicare Part B payment policies, and other policies regarding programs administered by CMS.

Specifically, this proposed rule addresses:

- Background (section II.A.)
- Determination of PE RVUs (section II.B.)
- Payment for Medicare Telehealth Services (section II.C.)
- Valuation of Specific Codes, Including Potentially Misvalued Codes (PMVC) (section II.D.)
- Redesigning Primary Care to Make America Healthy Again (section II.E.)
- Comprehensive Outpatient Rehabilitation Facility (CORF) Services and KX Modifier Thresholds (section II.F.)
- Supporting Beneficiaries Planning for Future Medical Decisions (section II.G.)
- Current Procedural Terminology (CPT) Request for Information (RFI) (section II.H.)
- Drugs and Biological Products Paid Under Medicare Part B: Discarded Drugs (section III.A.)
- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) (section III.B.)
- Clinical Laboratory Fee Schedule (CLFS): CAA, 2026 (section III.C.)
- Proposed Changes to the Ambulatory Specialty Model (ASM) (section III.D.)
- Limiting Medicare Coverage of Certain Individuals (section III.E.)
- Medicare Prescription Drug Inflation Rebate Program (section III.F.)
- Medicare Shared Savings Program (section III.G.)
- Changes to the Regulations Associated with the Ambulance Fee Schedule (section III.H.)
- Request for Information (RFI) on Duplicate Laboratory Testing, Imaging, and Result Sharing and Interoperability (section III.I.)

- CY2027 Modifications to the Quality Payment Program Reporting and Data Submission (section IV.)
- Collection of Information Requirements (section V.)
- Response to Comments (section VI.)
- Regulatory Impact Analysis (section VII.)

C. Summary of Costs and Benefits

Based on our estimates, the Office of Information and Regulatory Affairs in the Office of Management and Budget has determined that this proposed rule is economically significant under section 3(f)(1) of Executive Order 12866. As required by section 1848(d)(1)(A) of the Act, beginning in 2026, there are two separate conversion factors (CFs): one for items and services furnished by a qualifying APM participant (QP) as defined in section 1833(z)(2) of the Act and 42 CFR 414.1305 (referred to as the qualifying APM conversion factor) and another for items and services furnished by clinicians who are not QPs (referred to as the nonqualifying APM conversion factor), equal to the respective conversion factor for the previous year multiplied by the update established under section 1848(d)(20) of the Act for such respective conversion factor for such year. Under these provisions, the 2027 qualifying APM conversion factor represents a projected decrease of $0.40 (-1.19 percent) from the current conversion factor of $33.4009. Similarly, the 2027 nonqualifying APM conversion factor represents a projected decrease of $0.56 (-1.68 percent) from the current conversion factor of $33.5875.

For a detailed discussion of the economic impacts, see section VII., Regulatory Impact Analysis, of this proposed rule.

II. Provisions of the Rule for the PFS

A. Background

In accordance with section 1848 of the Social Security Act (the Act), CMS has paid for physicians' services under the Medicare physician fee schedule (PFS) since January 1, 1992. The PFS relies on national relative values that are established for work, practice expense (PE), and malpractice (MP), which are adjusted for geographic cost variations. These values are multiplied by a conversion factor (CF) to convert the relative value units (RVUs) into payment rates. The concepts and methodology underlying the PFS were enacted as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) (Pub. L. 101-239, December 19, 1989), and the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) (Pub. L. 101-508, November 5, 1990). The final rule published in the November 25, 1991 **Federal Register** (56 FR 59502) set forth the first fee schedule used for Medicare payment for physicians' services.

We note that throughout this proposed rule, unless otherwise noted, the term "practitioner" is used to describe both physicians and nonphysician practitioners (NPPs) who are permitted to bill Medicare under the PFS for the services they furnish to Medicare beneficiaries.

B. Determination of PE RVUs

1. Overview

Practice expense (PE) is the portion of the resources used in furnishing a service that reflects the general categories of physician and practitioner expenses, such as office rent and personnel wages, but excluding malpractice (MP) expenses, as specified in section 1848(c)(1)(B) of the Act. As required by section 1848(c)(2)(C)(ii) of the Act, we use a resource-based system for determining PE RVUs for each physicians' service. We develop PE RVUs by considering the direct and indirect practice resources involved in furnishing each service. Direct expense categories include clinical labor, medical supplies, and medical equipment. Indirect expenses include administrative labor, office expenses, and all other expenses. The sections that follow provide more detailed information about the methodology for translating the resources involved

in furnishing each service into service specific PE RVUs. We refer readers to the CY 2010 Physician Fee Schedule (PFS) final rule with comment period (74 FR 61743 through 61748) for a more detailed explanation of the PE methodology.

2. Practice Expense Methodology

a. Direct Practice Expense

We determine the direct PE for a specific service by adding the costs of the direct resources (that is, the clinical staff, medical supplies, and medical equipment) typically involved with furnishing that service. The costs of the resources are calculated using the refined direct PE inputs assigned to each CPT code in our PE database, which are generally based on our review of recommendations received from the American Medical Association (AMA)/Specialty Society Relative Value Scale (RVS) Update Committee (referred to as the RUC) and those provided in response to public comment periods. For a detailed explanation of the direct PE methodology, including examples, we refer readers to the 5-year review of work RVUs under the PFS and proposed changes to the PE methodology in the CY 2007 PFS proposed rule (71 FR 37242) and the CY 2007 PFS final rule with comment period (71 FR 69629).

b. Indirect Practice Expense per Hour Data

We use survey data on indirect PEs incurred per hour (PE/HR) worked to develop the indirect portion of the PE RVUs. Prior to CY 2010, we primarily used the PE/HR by specialty obtained from the AMA's Socioeconomic Monitoring System (SMS). The AMA administered a new survey in CY 2007 and CY 2008, the Physician Practice Information Survey (PPIS). The PPIS is a multispecialty, nationally representative, PE survey of physicians and NPPs paid under the PFS using a survey instrument and methods highly consistent with those used for the SMS and the supplemental surveys. The PPIS gathered information from 3,656 respondents across 51 physician specialty and health care professional groups. We have stated that we believe the PPIS is the most comprehensive source of PE survey information available. We used the PPIS data to

update the PE/HR data for the CY 2010 PFS for almost all of the Medicare-recognized specialties that participated in the survey.

When we began using the PPIS data in CY 2010, we did not change the PE RVU methodology or how the PE/HR data are used. We only updated the PE/HR data based on the new survey. Furthermore, as we explained in the CY 2010 PFS final rule with comment period (74 FR 61751), because of the magnitude of payment reductions for some specialties resulting from the use of the PPIS data, we transitioned its use over a 4-year period from the previous PE RVUs to the PE RVUs developed using the new PPIS data. As provided in the CY 2010 PFS final rule with comment period (74 FR 61751), the transition to the PPIS data was complete for CY 2013. Therefore, PE RVUs from CY 2013 forward are developed based entirely on the PPIS data, except as noted in this section.

Section 1848(c)(2)(H)(i) of the Act requires us to use the medical oncology supplemental survey data submitted in 2003 for oncology drug administration services. Therefore, the PE/HR for medical oncology, hematology, and hematology/oncology reflects the continued use of these supplemental survey data.

Supplemental survey data on independent labs from the College of American Pathologists were implemented for payments beginning in CY 2005. Supplemental survey data from the National Coalition of Quality Diagnostic Imaging Services (NCQDIS), representing independent diagnostic testing facilities (IDTFs), were blended with supplementary survey data from the American College of Radiology (ACR) and implemented for payments beginning in CY 2007. Neither IDTFs nor independent labs participated in the PPIS. Therefore, we continue to use the PE/HR that was developed from their supplemental survey data.

Consistent with our past practice, the previous indirect PE/HR values from the supplemental surveys for these specialties were updated to CY 2006 using the Medicare Economic Index (MEI) to put them on a comparable basis with the PPIS data.

We also do not use the PPIS data for reproductive endocrinology and spine surgery since these specialties are not separately recognized by Medicare, nor do we have a method to blend the PPIS data with Medicare-recognized specialty data.

Previously, we established PE/HR values for various specialties without SMS or supplemental survey data by crosswalking them to other similar specialties to estimate a proxy PE/HR. For specialties that were part of the PPIS for which we previously used a crosswalked PE/HR, we instead used the PPIS based PE/HR. We use crosswalks for specialties that did not participate in the PPIS. These crosswalks have been generally established through notice and comment rulemaking and are available in the file titled "CY 2027 PFS proposed rule PE/HR" on the CMS website under downloads for the CY 2027 PFS proposed rule at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html*.

c. Allocation of PE to Services

To establish PE RVUs for specific services, it is necessary to establish the direct and indirect PE associated with each service.

(1) Direct Costs

The relative relationship between the direct cost portions of the PE RVUs for any two services is determined by the relative relationship between the sum of the direct cost resources (that is, the clinical staff, medical supplies, and medical equipment) typically involved with furnishing each of the services. The costs of these resources are calculated from the refined direct PE inputs in our PE database. For example, if one service has a direct cost sum of $400 from our PE database and another service has a direct cost sum of $200, the direct portion of the PE RVUs of the first service would be twice as much as the direct portion of the PE RVUs for the second service.

(2) Indirect Costs

Under current policy, we allocate the indirect costs at the code level based on the direct costs specifically associated with a code and the greater of either the clinical labor costs or the work RVUs. We also incorporate the survey data described earlier in the PE/HR discussion. The general approach to developing the indirect portion of the PE RVUs is as follows:

- For a given service, we use the direct portion of the PE RVUs calculated as previously described and the average percentage that direct costs represent of total costs (based on survey data) across the specialties that furnish the service to determine an initial indirect allocator. That is, the initial indirect allocator is calculated so that the direct costs equal the average percentage of direct costs of those specialties furnishing the service. For example, if the direct portion of the PE RVUs for a given service is 2.00 and direct costs, on average, represent 25 percent of total costs for the specialties that furnish the service, the initial indirect allocator would be calculated so that it equals 75 percent of the total PE RVUs. Thus, in this example, the initial indirect allocator would equal 6.00, resulting in a total PE RVU of 8.00 (2.00 is 25 percent of 8.00 and 6.00 is 75 percent of 8.00).

- Next, under current policy, we add the greater of the work RVUs or clinical labor portion of the direct portion of the PE RVUs to this initial indirect allocator. In our example, if this service had a work RVU of 4.00 and the clinical labor portion of the direct PE RVU was 1.50, we would add 4.00 (since the 4.00 work RVUs are greater than the 1.50 clinical labor portion) to the initial indirect allocator of 6.00 to get an indirect allocator of 10.00. In the absence of any further use of the survey data, the relative relationship between the indirect cost portions of the PE RVUs for any two services would be determined by the relative relationship between these indirect cost allocators. For example, if one service had an indirect cost allocator of 10.00 and another service had an indirect cost allocator of 5.00, the indirect portion of the PE RVUs of the first service would be twice as great as the indirect portion of the PE RVUs for the second service.

- Then, we incorporate the specialty specific indirect PE/HR data into the calculation. In our example, if, based on the survey data, the average indirect cost of the specialties furnishing the first service with an allocator of 10.00 was half of the average indirect cost of the specialties furnishing the second service with an indirect allocator of 5.00, the indirect portion of the PE RVUs of the first service would be equal to that of the second service.

In the CY 2007 PFS final rule with comment period, we implemented the "bottom up" methodology for the development of PE RVUs (71 FR 69630-69643). We finalized the use of the work RVU or the clinical labor portion of the direct PE RVU, whichever is greater, to allocate indirect costs. We also finalized a modified formula for a global service (that is, a service with a professional component (PC) and a technical component (TC)) to utilize both the work RVU and the clinical labor PE RVU to allocate indirect costs. As noted in the CY 2007 PFS final rule with comment period, we do this to recognize that, for the PC service, indirect PEs will be allocated using the work RVUs, and for the TC service, indirect PEs will be allocated using the direct PE RVU and the clinical labor PE RVU. This also allows the global component RVUs to equal the sum of the PC and TC RVUs.

In recent years, as we have conducted analyses aimed at improving the accuracy of payment under the PFS, we have re-examined this longstanding policy that effectively allocates a larger share of indirect PE RVUs to services that can be reported using technical, professional, and global components than to those that cannot. We refer the reader to a report by RAND Corporation, under contract with CMS, which addresses several approaches to improving the accuracy of other PFS services relative to services that have a professional and technical component. This report is available at *https://www.rand.org/pubs/research_reports/RRA4720-2.html*.

This longstanding policy inadvertently advantages services that can be reported using technical, professional, and global components, referred to as “triplet services” in the report by RAND Corporation, because indirect PE RVUs are allocated on the sum, whereas services that

can only be reported as a global service, referred to as "non-triplet services" in the report, depend on the maximum (rather than sum) of clinical labor PE RVUs and physician work RVUs. This is an unintended advantage of the arithmetic required for the global component RVUs to equal the sum of the PC and TC RVUs. We believe it would be more accurate than the current PE methodology to use the same allocation methodology for all PFS services. Therefore, we are proposing to allocate indirect PE using both the work RVU and the clinical labor RVU for all services, with the exception of codes with 010- and 090-day global periods, instead of just applying that methodology to those services that can be reported using technical, professional, and global components (typically diagnostic and imaging services). In the description of the calculation of the PE methodology below, we indicate the portion of the methodology that would be calculated differently under this proposal.

(3) Facility and Non-facility Costs

For procedures that can be furnished in a physician's office, as well as in a facility setting, where Medicare makes a separate payment to the facility for its costs in furnishing a service, we establish two PE RVUs: facility and non-facility. The methodology for calculating PE RVUs is generally the same for both the facility and non-facility RVUs but is applied independently to yield two separate PE RVUs. In calculating the PE RVUs for services furnished in a facility, we do not include resources that would generally not be provided by physicians when furnishing the service. For this reason, the facility PE RVUs are generally lower than the non-facility PE RVUs. In the CY 2026 PFS final rule (90 FR 49292-49296), we finalized a modification in the allocation of indirect PE to reduce the portion of the facility PE RVUs allocated based on work RVUs to half the amount allocated to non-facility PE RVUs beginning in CY 2026.

(4) Services with Technical Components and Professional Components

Diagnostic services are generally comprised of two components: a professional component (PC); and a technical component (TC). The PC and TC may be furnished

independently or by different healthcare providers, or they may be furnished together as a global service. When services have separately billable PC and TC components, the payment for the global service equals the sum of the payment for the TC and PC. To achieve this, we use a weighted average of the ratio of indirect to direct costs across all the specialties that furnish the global service, TCs, and PCs; that is, we apply the same weighted average indirect percentage factor to allocate indirect expenses to the global service, PCs, and TCs for a service. (The direct PE RVUs for the TC and PC sum to the global direct PE RVUs.)

(5) PE RVU Methodology

For a more detailed description of the PE RVU methodology, we direct readers to the CY 2010 PFS final rule with comment period (74 FR 61745 through 61746). We also direct readers to the file titled "Calculation of PE RVUs under Methodology for Selected Codes" which is available on our website under downloads for the CY 2027 PFS proposed rule at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html.* This file contains a table that illustrates the calculation of PE RVUs as described in this proposed rule for individual codes.

(a) Setup File

First, we create a setup file for the PE methodology. The setup file contains the direct cost inputs, the utilization for each procedure code at the specialty and facility/non-facility place of service level, and the specialty specific PE/HR data calculated from the surveys.

(b) Calculate the Direct Cost PE RVUs

Sum the costs of each direct input.

Step 1: Sum the direct costs of the inputs for each service.

Step 2: Calculate the aggregate pool of direct PE costs for the current year. We set the aggregate pool of PE costs equal to the product of the ratio of the current aggregate PE RVUs to current aggregate work RVUs and the projected aggregate work RVUs.

Step 3: Calculate the aggregate pool of direct PE costs for use in ratesetting. This is the product of the aggregate direct costs for all services from Step 1 and the utilization data for that service.

Step 4: Using the results of Step 2 and Step 3, use the CF to calculate a direct PE scaling adjustment to ensure that the aggregate pool of direct PE costs calculated in Step 3 does not vary from the aggregate pool of direct PE costs for the current year. Apply the scaling adjustment to the direct costs for each service (as calculated in Step 1).

Step 5: Convert the results of Step 4 to an RVU scale for each service. To do this, divide the results of Step 4 by the CF. Note that the actual value of the CF used in this calculation does not influence the final direct cost PE RVUs as long as the same CF is used in Step 4 and Step 5. Different CFs would result in different direct PE scaling adjustments, but this has no effect on the final direct cost PE RVUs since changes in the CFs and the associated direct scaling adjustments offset one another.

(c) Create the Indirect Cost PE RVUs

Create indirect allocators.

Step 6: Based on the survey data, calculate direct and indirect PE percentages for each physician specialty.

Step 7: Calculate direct and indirect PE percentages at the service level by taking a weighted average of the results of Step 6 for the specialties that furnish the service. Note that for services with TCs and PCs, the direct and indirect percentages for a given service do not vary by the PC, TC, and global service.

We generally use an average of the 3 most recent years of available Medicare claims data to determine the specialty mix assigned to each code. Codes with low Medicare service volume require special attention since billing or enrollment irregularities for a given year can result in significant changes in specialty mix assignment. We finalized a policy in the CY 2018 PFS final rule (82 FR 52982 through 52983) to use the most recent year of claims data to determine which

codes are low volume for the coming year (those that have fewer than 100 allowed services in the Medicare claims data). For codes that fall into this category, instead of assigning a specialty mix based on the specialties of the practitioners reporting the services in the claims data, we use the expected specialty that we identify on a list developed based on medical review and input from expert interested parties. We display this list of expected specialty assignments as part of the annual set of data files we make available as part of notice and comment rulemaking and consider recommendations from the RUC and other interested parties on changes to this list annually. Services for which the specialty is automatically assigned based on previously finalized policies under our established methodology (for example, "always therapy" services) are unaffected by the list of expected specialty assignments. We also finalized in the CY 2018 PFS final rule (82 FR 52982 through 52983) a policy to apply these service-level overrides for both PE and MP, rather than one or the other category.

In prior years, we reviewed information submitted during the proposed rule comment period regarding potential additions to the list of expected specialty assignments, to determine whether the specialty assignments commenters recommended were appropriate for the services in question. Our review process has been based on determining if the recommended specialty matched the dominant specialty in the claims data. However, we have long held reservations on whether this was the most accurate method for implementing updates to the expected specialty assignments list. Since these updates to the list were never formally proposed in the proposed rule of each calendar year, there was never an opportunity for interested parties to comment and provide feedback before the assignments were finalized in the final rule. We believe that it would provide greater transparency and more opportunities for public comment if additions to the expected specialty assignments list were instead proposed in each year's proposed rule.

Therefore, we did not finalize any additions to the expected specialty assignments list in the CY 2026 PFS final rule (90 FR 49270). We stated that we would instead review the list of approximately 75 low volume HCPCS codes submitted by commenters and propose additions to

the list in this year's CY 2027 PFS proposed rule. We will also review any submissions for inclusion to the expected specialty assignments list by the same February 10th deadline that we have finalized in the past for consideration of RUC recommendations and invoice-based updates to supply and equipment pricing. We believe that synchronizing submissions to the expected specialty assignments list for low volume services with the same annual date used for RUC recommendations and invoice submissions will help standardize the process, while also providing more opportunities for feedback from interested parties by going through the annual comment process.

During the comment period for the CY 2026 PFS rule, several commenters stated that they had performed an analysis to identify all codes that meet the criteria to receive a specialty override under this CMS policy and drafted updated recommendations for codes that meet these criteria. Commenters stated that the purpose of assigning a specialty to these codes was to avoid the significant adverse impact on MP RVUs that results from errors in specialty utilization data magnified in representation (percentage) by small sample size. These commenters submitted a list of approximately 75 low volume HCPCS codes with recommended expected specialty assignments.

After reviewing the information provided by the commenters to determine whether the specialty assignments they recommended were appropriate for the services in question, based on determining if the recommended specialty matches the dominant specialty in the claims data, we are proposing the additions to the list of expected specialty assignments for low volume services identified in Table A-B1. We agree with the commenters that, based on claims data, CPT codes 33277 through 33281 and 33287 through 33288 should be crosswalked to the Cardiac Electrophysiology specialty and that CPT codes 93584 through 93588 should be crosswalked to the Interventional Cardiology specialty. We also agree with commenters that CPT code 23077 should be crosswalked to the Surgical Oncology specialty. However, we do not have PE/HR data for these specialties as they were not part of the PPIS when it was conducted in 2007; therefore,

we are crosswalking these CPT codes to the closest available specialties (Cardiology for the first two groups of codes and All Physicians for CPT code 23077), as listed on Table A-B1.

We disagree with the commenters on a series of additional suggested assigned specialties. In each case, there was another specialty which was reported more than twice as often in the claims data as the specialty suggested by commenters and in some cases reported as much as five times as often. Therefore, we are crosswalking CPT codes 15135 and 41000 to the Otolaryngology specialty, CPT codes 26118 and 26650 to the Orthopedic Surgery specialty, CPT codes 93025 and 93150 to the Cardiology specialty, and CPT codes 93152 and 93153 to the Pulmonary Disease specialty as these were the dominant specialties in the claims data. These crosswalks are included in Table A-B1.

TABLE A-B1: PROPOSED NEW ADDITIONS TO THE EXPECTED SPECIALTY ASSIGNMENT LIST

HCPCS	Short Descriptor	Expected Specialty Assignment
0596T	Temp fml iu vlv-pmp 1st insj	UROLOGY
0597T	Temp fml iu valve-pmp rplcmt	UROLOGY
11463	Exc skn hdrdnt ing complex	PLASTIC AND RECONSTRUCTIVE SURGERY
15135*	Drm agrft f/s/n/h/f/g/m 1st	OTOLARYNGOLOGY
20979	Us bone stimulation	PODIATRY
21407	Opn tx orbit fx w/implant	PLASTIC AND RECONSTRUCTIVE SURGERY
22836	Ant thrc vrt body tethrg <7	ORTHOPEDIC SURGERY
22837	Ant thrc vrt body tethrg 8+	ORTHOPEDIC SURGERY
22838	Rev rplc/rmv thrc vrt tethrg	ORTHOPEDIC SURGERY
22860	Tot disc arthrp 2ntrspc lmbr	NEUROSURGERY
23077*	Resect shoulder tumor < 5 cm	ALL PHYSICIANS
23675	Cltx sho dislc neck fx mnpj	ORTHOPEDIC SURGERY
25440	Repair nonu scphd carpl b1	HAND SURGERY
26118*	Rad resect hand tumor 3 cm/>	ORTHOPEDIC SURGERY
26650*	Treat thumb fracture	ORTHOPEDIC SURGERY
27087	Remove hip foreign body	ORTHOPEDIC SURGERY
27393	Lengthening of thigh tendon	ORTHOPEDIC SURGERY
28055	Neurectomy foot	PODIATRY
31032	Explore sinus remove polyps	OTOLARYNGOLOGY
31292	Nsl/sins ndsc med/inf dcmprn	OTOLARYNGOLOGY
32096	Open wedge/bx lung infiltr	THORACIC SURGERY
32141	Remove/treat lung lesions	THORACIC SURGERY
33277*	Insj phrnc nrv stim transvns	CARDIOLOGY
33278*	Rmvl phrnc nrv stim sys	CARDIOLOGY
33279*	Rmvl phrnc nrv stim transvns	CARDIOLOGY
33280*	Rmvl phrnc nrv stim pg only	CARDIOLOGY
33281*	Reposg phrnc nrv stim trnsvn	CARDIOLOGY
33287*	Rmv&rplcmt phrnc nrv stim pg	CARDIOLOGY
33288*	Rmv&rplcmt phrnc nrv stim ld	CARDIOLOGY

HCPCS	Short Descriptor	Expected Specialty Assignment
33875	Thoracic aortic graft	THORACIC SURGERY
34813	Femoral endovas graft add-on	VASCULAR SURGERY
35682	Composite byp grft 2 veins	VASCULAR SURGERY
35881	Revise graft w/vein	VASCULAR SURGERY
36474	Endovenous mchnchem add-on	VASCULAR SURGERY
41000*	Drainage of mouth lesion	OTOLARYNGOLOGY
41530	Tongue base vol reduction	OTOLARYNGOLOGY
42815	Excision of neck cyst	OTOLARYNGOLOGY
43501	Surgical repair of stomach	GENERAL SURGERY
44850	Repair of mesentery	GENERAL SURGERY
45550	Repair rectum/remove sigmoid	COLORECTAL SURGERY
50542	Laparo ablate renal mass	UROLOGY
50951	Endoscopy of ureter	UROLOGY
51570	Removal of bladder	UROLOGY
51880	Repair of bladder opening	UROLOGY
53260	Treatment of urethra lesion	UROLOGY
58580	Transcrv abltj utrn fibrd rf	OBSTETRICS/GYNECOLOGY
61055	Injection into brain canal	DIAGNOSTIC RADIOLOGY
61516	Crnec treph exc cyst sttl	NEUROSURGERY
61889	Ins sk-mnt crnl nstm pg/rcvr	NEUROSURGERY
61891	Rev/rplcmt sk-mnt crnl nstm	NEUROSURGERY
61892	Rmv sk-mnt crnl nstm pg/rcvr	NEUROSURGERY
62281	Treat spinal cord lesion	PHYSICAL MEDICINE AND REHABILITATION
63200	Release spinal cord lumbar	NEUROSURGERY
67550	Insert eye socket implant	OPHTHALMOLOGY
74415	Urography nfs drip&/bls w/nf	DIAGNOSTIC RADIOLOGY
76145	Med physic dos eval rad exps	INTERVENTIONAL RADIOLOGY
76812	Ob us detailed addl fetus	OBSTETRICS/GYNECOLOGY
92583	Select picture audiometry	AUDIOLOGIST
93025*	Microvolt t-wave assess	CARDIOLOGY
93150*	Therapy activation ipnss	CARDIOLOGY
93152*	Interrog&prgrmg ipnss polysm	PULMONARY DISEASE
93153*	Interrog w/o prgrmg ipnss	PULMONARY DISEASE
93584*	Vngrph chd anom/persist svc	CARDIOLOGY
93585*	Vngrph chd azygs/hemiazygs	CARDIOLOGY
93586*	Vngrph chd coronary sinus	CARDIOLOGY
93587*	Vngrph chd vnvn cltrl at/abv	CARDIOLOGY
93588*	Vngrph chd vnvn cltrl below	CARDIOLOGY
95866	Needle emg hemidiaphragm	NEUROLOGY
96203	Mlt fam grp bhv train ea add	PSYCHIATRY
96933	Rcm celulr subcelulr img skn	DERMATOLOGY
G0017	Crisis psychotherapy 60m	PSYCHIATRY
G0018	Crisis psychotherapy add 30m	PSYCHIATRY

* Recommended specialty assignment crosswalked.

The full list of expected specialty assignments is included in the CY 2027 public use files, which are available on the CMS website under downloads for the CY 2027 PFS proposed rule at *http://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html.*

Step 8: Calculate the service level allocators for the indirect PEs based on the percentages calculated in Step 7. The indirect PEs are allocated based on the three components: the direct PE RVUs; the clinical labor PE RVUs; and the work RVUs.

Under current policy, for most services the indirect allocator is: indirect PE percentage * (direct PE RVUs/direct percentage) + work RVUs.

There are two situations where this formula is modified:

- If the service is a global service (that is, a service with global, professional, and technical components), then the indirect PE allocator is: indirect percentage (direct PE RVUs/direct percentage) + clinical labor PE RVUs + work RVUs.
- If the clinical labor PE RVUs exceed the work RVUs (and the service is not a global service), then the indirect allocator is: indirect PE percentage (direct PE RVUs/direct percentage) + clinical labor PE RVUs.

(*Note*: Under current policy, for global services, the indirect PE allocator is based on both the work RVUs and the clinical labor PE RVUs. We do this to recognize that, for the PC service, indirect PEs would be allocated using the work RVUs, and for the TC service, indirect PEs would be allocated using the direct PE RVUs and the clinical labor PE RVUs. This also allows the global component RVUs to equal the sum of the PC and TC RVUs.)

For presentation purposes, in the examples in the download file titled "Calculation of PE RVUs under Methodology for Selected Codes", the formulas were divided into two parts for each service.

- The first part does not vary by service and is the indirect percentage (direct PE RVUs/direct percentage).
- Under current policy, the second part is either the work RVU, clinical labor PE RVU, or both depending on whether the service is a global service and whether the clinical PE RVUs exceed the work RVUs (as described earlier in this step).

We note that for CY 2026, we finalized a change to the methodology so that when work RVUs are used to allocate indirect PE to the facility RVUs, they are assigned at one-half the amount allocated to the non-facility PE RVUs for that same service. These PE methodology changes are discussed in greater detail in the CY 2026 PFS final rule (90 FR 49292 through 49296).

Proposed Step 8: Calculate the service level allocators for the indirect PEs based on the percentages calculated in Step 7. The indirect PEs are allocated based on the three components: the direct PE RVUs; the clinical labor PE RVUs; and the work RVUs.

The proposed indirect allocator is: indirect PE percentage *(direct PE RVUs/direct percentage) + work RVUs + clinical labor RVUs. The proposed change is to include both the work RVUs and clinical labor RVUs in the indirect allocator for all services, except for codes with 010- and 090-day global periods, as opposed to including the work RVUs and clinical labor RVUs only for global services as detailed above.

If this proposed policy were to be finalized, this Proposed Step 8 would replace the Step 8 listed earlier. For presentation purposes, in the examples in the download file titled ''Calculation of PE RVUs under Methodology for Selected Codes,'' the formulas were divided into two parts for each service.

- The first part is the indirect percentage (direct PE RVUs/direct percentage).
- The second part is the sum of the work RVU and the clinical labor PE RVU, including the methodology change finalized in CY 2026 for services performed in the facility setting (when work RVUs are used to allocate indirect PE to the facility RVUs, they are assigned at one-half the amount allocated to the non-facility PE RVUs for that same service).

Apply a scaling adjustment to the indirect allocators.

Step 9: Calculate the current aggregate pool of indirect PE RVUs by multiplying the result of step 8 by the average indirect PE percentage from the survey data.

Step 10: Calculate an aggregate pool of indirect PE RVUs for all PFS services by adding the product of the indirect PE allocators for a service from Step 8 and the utilization data for that service.

Step 11: Using the results of Step 9 and Step 10, calculate an indirect PE adjustment so that the aggregate indirect allocation does not exceed the available aggregate indirect PE RVUs and apply it to indirect allocators calculated in Step 8.

Under current policy, calculate the indirect practice cost index (IPCI). We refer readers to the CY 2007 PFS final rule with comment period (71 FR 69633) for more information about the establishment of the IPCI.

Step 12: Using the results of Step 11, calculate aggregate pools of specialty specific adjusted indirect PE allocators for all PFS services for a specialty by adding the product of the adjusted indirect PE allocator for each service and the utilization data for that service.

Step 13: Using the specialty specific indirect PE/HR data, calculate specialty specific aggregate pools of indirect PE for all PFS services for that specialty by adding the product of the indirect PE/HR for the specialty, the work time for the service, and the specialty's utilization for the service across all services furnished by the specialty.

Step 14: Using the results of Step 12 as the denominator and Step 13 as the numerator, calculate the specialty specific indirect PE scaling factors.

Step 15: Using the results of Step 14, calculate an indirect practice cost index at the specialty level by dividing each specialty specific indirect scaling factor by the average indirect scaling factor for the entire PFS.

Step 16: Calculate the indirect practice cost index at the service level to ensure the capture of all indirect costs. Calculate a weighted average of the practice cost index values for the specialties that furnish the service. (Note: For services with TCs and PCs, we calculate the indirect practice cost index across the global service, PCs, and TCs. Under this method, the

indirect practice cost index for a given service (for example, echocardiogram) does not vary by the PC, TC, and global service.)

Step 17: Apply the service level indirect practice cost index calculated in Step 16 to the service level adjusted indirect allocators calculated in Step 11 to get the indirect PE RVUs.

Proposal regarding Steps 12 through 17: We develop the indirect practice expense (PE) RVUs under the PFS to reflect the relative resources involved in furnishing the services. Since the implementation of the resource-based PE RVUs, we have assumed that aggregate specialty level practice costs derived primarily from the 2007 PE/HR survey data are a reasonable way to help establish the resource-based indirect PE RVUs. We have historically used that data both to allocate indirect costs to each code and to re-scale the resulting PE RVUs for each code at the end of the established methodology to ensure that the overall allocation of PE RVUs for each specialty across the PFS approximates those expected based on the index derived from the PE/HR survey data. Over time, however, we have identified various limitations of the survey data, especially as the data we use has become increasingly dated and are intrinsically limited to small, selective samples based on pre-determined assumptions about where costs are likely to differ, and, as we addressed in CY 2026 PFS rulemaking, have not been adequately updated. (We refer readers to an extended discussion of our concerns with and decision not to update this data in the CY 2026 PFS final rule at 90 FR 49286 through 49292.) This has resulted in a PE methodology that privileges the historic survey data over incorporation of more recent data about specific services and produces unpredictable and counterintuitive results that are not transparent to the public.

Because we have taken various steps to improve the data used in the pricing inputs and the indirect allocation methodologies, we are proposing to remove the steps of the current methodology that rely on the indirect practice cost index (IPCI) from the calculation of the PE RVUs. We propose this change, because the steps of the current methodology that rely on the IPCI calculation effectively favor the aggregate specialty-level survey data over the code level

inputs and allocators and consequently limit the influence of improvements to inputs and allocation methodologies. We are proposing to implement this change over a 2-year transition period. Specifically, in the first year, only half of the measured variation in the IPCI will be applied to the indirect allocator. In the second year, the IPCI will no longer be applied.

The steps of the current methodology that rely on the IPCI calculation are steps 12 through 17. Thus, under this proposal, steps 12 through 17 would no longer be a part of the calculation, and the total PE RVU, prior to the calculation of final PE RVUs described below at Step 18, would be the sum of step 5 (Direct Cost PE RVUs) and step 11 (Indirect Cost PE RVUs).

(d) Calculate the Final PE RVUs

Step 18: Under current policy, add the direct PE RVUs from Step 5 to the indirect PE RVUs from Step 17 and apply the final PE budget neutrality (BN) adjustment. The final PE BN adjustment is calculated by comparing the sum of steps 5 and 17 to the aggregate work RVUs scaled by the ratio of current aggregate PE and work RVUs. This adjustment ensures that all PE RVUs in the PFS account for the fact that certain specialties are excluded from the calculation of PE RVUs but included in maintaining overall PFS BN. (See "Specialties excluded from ratesetting calculation" later in this proposed rule). Under the proposed policy, add the direct cost PE RVUs from Step 5 to the indirect cost PE RVUs from Step 11 and apply the final PE BN adjustment.

Proposed Step 19: Calculate and apply the PE stabilization factor for each PE RVU by comparing the result of step 18 with the results of the prior year's PE RVUs from step 18. As described previously in this section, we are proposing to remove the IPCI from the PE methodology, which we believe will improve the transparency and stability of PE RVUs over time. However, we recognize that the IPCI, because it is rooted in static PE/HR data, effectively resulted in stabilizing year-to-year changes in PE RVUs, especially due to changes in input valuations and changes to allocation methodologies. We have long noted that extreme volatility

in PE RVUs can have unintended consequences and distortions. To mitigate volatility that could otherwise occur, we are proposing a PE stabilization adjustment to further improve predictability and reduce volatility within the PE RVUs. Specifically, we are proposing that the PE RVU calculated after the application of the cognitive services floor and any adjustments that occur outside of the PE methodology will be subject to a cap and will not increase or decrease by more than 5 percent each year. In the proposed Step 19 we would compare the PE RVU after the application of the cognitive services floor and any code-level adjustments in the current ratesetting year to the allocation methodology from the prior year and then apply the 5 percent cap. We note that the proposed stabilization adjustment in Proposed Step 19 will be applied prior to the statutory phase-in of significant RVU reductions required by Section 1848(c)(7) of the Act, discussed in more detail later in this section, which limits all codes that are not new or revised to a 19 percent decrease in total RVU in an individual calendar year. Therefore, a code may be impacted by both the PE stabilization adjustment and the statutory phase-in, meaning a code's PE RVU may ultimately differ by greater than the PE stabilization adjustment detailed in proposed Step 19.

This proposed adjustment would not apply to new and revised codes or codes formerly contractor priced that are newly nationally priced, because it is not clear what the comparison PE RVU would be for those codes. Because we believe the benefits of the PE stabilization adjustment would ideally apply to new and revised codes and newly nationally priced codes, we are seeking comment on an approach that would allow us to expand the PE stabilization adjustment to these categories of codes. Additionally, the proposed PE stabilization adjustment would not apply to revalued codes because we believe the statutory phase-in sufficiently limits large reductions to individual codes undergoing review and/or revaluation, and limits the amount of time a revalued code would remain overvalued by being significantly constrained from reductions found to be appropriate through revaluation.

Step 19 (*under our proposal, step 19 would be renumbered as step 20*): Apply the phase-in of significant RVU reductions and its associated adjustment. Section 1848(c)(7) of the Act specifies that for services that are not new or revised codes, if the total RVUs for a service for a year would otherwise be decreased by an estimated 20 percent or more as compared to the total RVUs for the previous year, the applicable adjustments in work, PE, and MP RVUs must be phased in over a 2-year period. In implementing the phase-in, we consider a 19 percent reduction as the maximum 1-year reduction for any service not described by a new or revised code. This approach limits the year 1 reduction for the service to the maximum allowed amount (that is, 19 percent), and then phases in the remainder of the reduction. To comply with section 1848(c)(7) of the Act, we adjust the PE RVUs to ensure that the total RVUs for all services that are not new or revised codes decrease by no more than 19 percent, and then apply a relativity adjustment to ensure that the total pool of aggregate PE RVUs remains relative to the pool of work and MP RVUs. For a more detailed description of the methodology for the phase-in of significant RVU changes, we refer readers to the CY 2016 PFS final rule with comment period (80 FR 70927 through 70931).

In summary, for CY 2027, we are proposing to:

- Modify step 8 to calculate indirect PE based on both work RVUs and clinical labor RVUs for all services except 010- and 090-day global period codes;
- Remove steps 12 through 17 that rely on the IPCI from the calculation of the PE RVUs over a 2-year transition period, and;
- Add a new step to apply a stabilization adjustment to the PE RVUs (proposed step 19).

(e) Setup File Information

- Specialties excluded from ratesetting calculation: To calculate the PE and MP RVUs, we exclude certain specialties, such as NPPs paid at a percentage of the PFS and low volume specialties, from the calculation. These specialties are included to calculate the BN adjustment. They are displayed in Table A-B2.

TABLE A-B2: SPECIALTIES EXCLUDED FROM RATESETTING CALCULATION

Specialty Code	Specialty Description
49	Ambulatory surgical center
50	Nurse practitioner
51	Medical supply company with certified orthotist
52	Medical supply company with certified prosthetist
53	Medical supply company with certified prosthetist-orthotist
54	Medical supply company not included in 51, 52, or 53.
55	Individual certified orthotist
56	Individual certified prosthetist
57	Individual certified prosthetist-orthotist
58	Medical supply company with registered pharmacist
59	Ambulance service supplier, for example, private ambulance companies, funeral homes, etc.
60	Public health or welfare agencies
61	Voluntary health or charitable agencies
73	Mass immunization roster biller
74	Radiation therapy centers
87	All other suppliers (for example, drug and department stores)
88	Unknown supplier/provider specialty
89	Certified clinical nurse specialist
96	Optician
97	Physician assistant
A0	Hospital
A1	Skilled nursing facility
A2	Intermediate care nursing facility
A3	Nursing facility, other
A4	HHA
A5	Pharmacy
A6	Medical supply company with respiratory therapist
A7	Department store
A8	Grocery store
B1	Supplier of oxygen and/or oxygen related equipment (eff. 10/2/2007)
B2	Pedorthic personnel
B3	Medical supply company with pedorthic personnel
B4	Rehabilitation Agency
B5	Ocularist
C1	Centralized Flu
C2	Indirect Payment Procedure
C5	Dentistry

- *Crosswalk certain low volume physician specialties*: Crosswalk the utilization of certain specialties with relatively low PFS utilization to the associated specialties.

- *Physical therapy utilization*: Crosswalk the utilization associated with all physical therapy services to the specialty of physical therapy.

- *Identify professional and technical services not identified under the usual technical component (TC) and professional component (PC or 26) modifiers*: Flag the services that are PC and TC services but do not use TC and PC/26 modifiers (for example, electrocardiograms). This flag associates the PC and TC with the associated global code for use in creating the indirect PE

RVUs. For example, the professional service, CPT code 93010 (Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only), is associated with the global service, CPT code 93000 (Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report).

- *Payment modifiers*: In the CY 2013 PFS proposed rule (77 FR 68901), we introduced a more detailed methodology for adjusting volume and time to account for payment modifiers and other special payment rules, such as multiple procedure payment reductions, in the utilization data. We are proposing that, beginning in CY 2027, we would utilize a new approach to account for payment modifiers and other special payment rules. For each paid claim line, we would calculate the ratio of allowed charges to the national PFS payment amount. This would account for differences resulting from payment modifiers and other special payment rules, as well as differences in geography. We are proposing to use the same ratio to adjust time, rather than a separate calculation under our current methodology, with the exception of anesthesia, for which we calculate time using only procedures with modifiers indicating they are personally performed. These proposed changes will allow us to more accurately capture any combination of modifiers and special payment rules and automatically account for updates in modifiers and/or special payment rules in future years. These proposed changes have a very minimal impact on the resulting PE RVUs but will produce a more accurate result. As under our current methodology, the adjusted volume will be displayed in the utilization file that is posted in conjunction with each PFS rule.

- *Work RVUs*: The setup file contains the work RVUs from this proposed rule.

(6) Equipment Cost per Minute

The equipment cost per minute is calculated as:

(1/ (minutes per year * usage)) * price * ((interest rate/(1 (1/((1 + interest rate)^ life of equipment)))) + maintenance)

Where:

minutes per year = maximum minutes per year if usage were continuous (that is, usage=1); generally, 150,000 minutes.

usage = variable, see discussion later in this proposed rule.

price = price of the particular piece of equipment.

life of equipment = useful life of the particular piece of equipment.

maintenance = factor for maintenance; 0.05.

interest rate = variable, see discussion later in this proposed rule.

Usage: We currently use an equipment utilization rate assumption of 50 percent for most equipment, with the exception of expensive diagnostic imaging equipment, for which we use a 90 percent assumption as required by section 1848(b)(4)(C) of the Act.

Useful Life: In the CY 2005 PFS final rule we stated that we updated the useful life for equipment items primarily based on the AHA's "Estimated Useful Lives of Depreciable Hospital Assets" guidelines (69 FR 66246). The most recent edition of these guidelines was published in 2018. This reference material provides an estimated useful life for hundreds of different types of equipment, the vast majority of which fall in the range of 5 to 10 years, and none of which are lower than 2 years in duration. We believe that the updated editions of this reference material remain the most accurate source for estimating the useful life of depreciable medical equipment.

In the CY 2021 PFS final rule, (85 FR 84482 through 84483) we finalized a proposal to treat equipment life durations of less than 1 year as having a duration of 1 year for the purpose of our equipment price per minute formula. In the rare cases where items are replaced every few months, we noted that we believe it is more accurate to treat these items as disposable supplies with a fractional supply quantity as opposed to equipment items with very short equipment life durations. For a more detailed discussion of the methodology associated with very short equipment life durations, we refer readers to the CY 2021 PFS final rule (85 FR 84482 through 84483).

- *Maintenance*: We finalized the 5 percent factor for annual maintenance in the CY 1998 PFS final rule with comment period (62 FR 33164). As we previously stated in the CY 2016 PFS final rule with comment period (80 FR 70897), we do not believe the annual maintenance factor for all equipment is precisely 5 percent, and we concur that the current rate likely understates the true cost of maintaining some equipment. We also noted that we believe it likely overstates the maintenance costs for other equipment. When we solicited comments regarding data sources containing equipment maintenance rates, commenters could not identify an auditable, robust data source that CMS could use on a wide scale. We noted that we did not believe voluntary submissions regarding the maintenance costs of individual equipment items would be an appropriate methodology for determining costs. As a result, in the absence of publicly available datasets regarding equipment maintenance costs or another systematic data collection methodology for determining a different maintenance factor, in the proposed rule, we did not propose a variable maintenance factor for equipment cost per minute pricing as we did not believe that we have sufficient information at present. We noted in the CY 2026 PFS proposed rule (90 FR 32593) that we would continue to investigate potential avenues for determining equipment maintenance costs across a broad range of equipment items.

- *Interest Rate*: In the CY 2013 PFS final rule with comment period (77 FR 68902), we updated the interest rates used in developing an equipment cost per minute calculation (see 77 FR 68902 for a thorough discussion of this issue). The interest rate was based on the Small Business Administration (SBA) maximum interest rates for different categories of loan size (equipment cost) and maturity (useful life). The interest rates are listed in Table A-B3.

TABLE A-B3: SBA MAXIMUM INTEREST RATES

Price	Useful Life	Interest Rate
<$25K	<7 Years	7.50%
$25K to $50K	<7 Years	6.50%
>$50K	<7 Years	5.50%
<$25K	7+ Years	8.00%
$25K to $50K	7+ Years	7.00%
>$50K	7+ Years	6.00%

We are not proposing any changes to the equipment interest rates for CY 2027.

3. Adjusting RVUs To Match the PE Share of the Medicare Economic Index (MEI)

We have long stated that we believe that the MEI is the best measure available to determine the relative weights of the three components in payments under the PFS—work, practice expense (PE), and malpractice (MP). Accordingly, we believe that to ensure that the PFS payments reflect the relative resources in each of these PFS components as required by section 1848(c)(3) of the Act, the RVUs used in developing rates should reflect the same weights in each component as the cost share weights in the Medicare Economic Index (MEI). Accordingly, we have finalized to accomplish this (78 FR 74241 through 74242) by holding the work RVUs constant and adjusting the PE RVUs, MP RVUs, and conversion factor (CF) to produce the appropriate balance in RVUs among the three PFS components and payment rates for individual services, that is, that the total RVUs on the PFS are proportioned to approximately 51 percent work RVUs, 45 percent PE RVUs, and 4 percent MP RVUs. Historically, as the MEI cost shares are updated, we have proposed to modify steps 3 and 10 to adjust the aggregate pools of PE costs (direct PE in step 3 and indirect PE in step 10) in proportion to the change in the PE share in the MEI cost share weights, and to recalibrate the relativity adjustment that we apply in step 18 as described in the CY 2023 PFS final rule (87 FR 69414 and 69415) and CY 2014 PFS final rule (78 FR 74236 and 74237). The most recent recalibration was done for the CY 2014 RVUs.

However, due to overarching concerns with the data as described in the CY 2026 PFS final rule (90 FR 49287 through 49293) and our previously described policy goal to balance PFS payment stability and predictability with incorporating new data through routine updates to the MEI, we finalized our proposal to maintain the current PE/HR and 2006-based MEI cost shares (rather than transitioning to the 2017-based MEI cost shares), for CY 2026 PFS ratesetting due to the concerns about data quality and payment stability. Additionally, for CY 2027, we are

proposing to continue to use the current PE/HR and 2006-based MEI cost shares for CY 2027 PFS ratesetting.

4. Changes to Direct PE Inputs for Specific Services

This section focuses on specific PE inputs. The direct PE inputs are included in the CY 2027 direct PE input public use files, which are available on the CMS website under downloads for the CY 2027 PFS proposed rule at *https://www.cms.gov/Medicare/Medicare-Fee-fafor-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html.*

a. Standardization of Clinical Labor Tasks

As we noted in the CY 2015 PFS final rule with comment period (79 FR 67640 through 67641), we continue to make improvements to the direct PE input database to provide the number of clinical labor minutes assigned for each task for every code in the database instead of only including the number of clinical labor minutes for the preservice, service, and post service periods for each code. In addition to increasing the transparency of the information used to set PE RVUs, this level of detail would allow us to compare clinical labor times for activities associated with services across the PFS, which we believe is important to maintaining the relativity of the direct PE inputs. This information would facilitate the identification of the usual numbers of minutes for clinical labor tasks and the identification of exceptions to the usual values. It would also allow for greater transparency and consistency in the assignment of equipment minutes based on clinical labor times. Finally, we believe that the detailed information can be useful in maintaining standard times for particular clinical labor tasks that can be applied consistently to many codes as they are valued over several years, similar in principle to physician preservice time packages. We believe that setting and maintaining such standards would provide greater consistency among codes that share the same clinical labor tasks and could improve the relativity of values among codes. For example, as medical practice and technologies change over time, standards could be updated simultaneously for all codes with the applicable clinical labor tasks instead of waiting for individual codes to be reviewed.

In the CY 2016 PFS final rule with comment period (80 FR 70901), we solicited comments on the appropriate standard minutes for the clinical labor tasks associated with services that use digital technology. After consideration of comments received, we finalized standard times for clinical labor tasks associated with digital imaging at 2 minutes for "Availability of prior images confirmed", 2 minutes for "Patient clinical information and questionnaire reviewed by technologist, order from physician confirmed and exam protocoled by radiologist", 2 minutes for "Review examination with interpreting MD", and 1 minute for "Exam documents scanned into PACS" and "Exam completed in RIS system to generate billing process and to populate images into Radiologist work queue." In the CY 2017 PFS final rule (81 FR 80184 through 80186), we finalized a policy to establish a range of appropriate standard minutes for the clinical labor activity, "Technologist QCs images in PACS, checking for all images, reformats, and dose page." These standard minutes will be applied to new and revised codes that make use of this clinical labor activity when they are reviewed by us for valuation. We finalized a policy to establish 2 minutes as the standard for the simple case, 3 minutes as the standard for the intermediate case, 4 minutes as the standard for the complex case, and 5 minutes as the standard for the highly complex case. These values were based upon a review of the existing minutes assigned for this clinical labor activity; we determined that 2 minutes is the duration for most services and a small number of codes with more complex forms of digital imaging have higher values. We also finalized standard times for a series of clinical labor tasks associated with pathology services in the CY 2016 PFS final rule with comment period (80 FR 70902). We do not believe these activities would be dependent on the number of blocks or batch size, and we believe that the finalized standard values accurately reflect the typical time it takes to perform these clinical labor tasks.

In reviewing the RUC-recommended direct PE inputs for CY 2019, we noticed that the 3 minutes of clinical labor time traditionally assigned to the "Prepare room, equipment and supplies" (CA013) clinical labor activity were split into 2 minutes for the "Prepare room,

equipment and supplies" activity and 1 minute for the "Confirm order, protocol exam" (CA014) activity. We proposed to maintain the 3 minutes of clinical labor time for the "Prepare room, equipment and supplies" activity and remove the clinical labor time for the "Confirm order, protocol exam" activity wherever we observed this pattern in the RUC-recommended direct PE inputs. Commenters explained in response that when the new version of the PE worksheet introduced the activity codes for clinical labor, there was a need to translate old clinical labor tasks into the new activity codes, and that a prior clinical labor task was split into two of the new clinical labor activity codes: CA007 (*Review patient clinical extant information and questionnaire*) in the preservice period, and CA014 (*Confirm order, protocol exam*) in the service period. Commenters stated that the same clinical labor from the old PE worksheet was now divided into the CA007 and CA014 activity codes, with a standard of 1 minute for each activity. We agreed with commenters that we would finalize the RUC-recommended 2 minutes of clinical labor time for the CA007 activity code and 1 minute for the CA014 activity code in situations where this was the case. However, when reviewing the clinical labor for the reviewed codes affected by this issue, we found that several of the codes did not include this old clinical labor task, and we also noted that several of the reviewed codes that contained the CA014 clinical labor activity code did not contain any clinical labor for the CA007 activity. In these situations, we believe that the three total minutes of clinical staff time would be more accurately described by the CA013 "Prepare room, equipment and supplies" activity code, and we finalized these clinical labor refinements. We direct readers to the discussion in the CY 2019 PFS final rule (83 FR 59463 through 59464) for additional details.

Following the publication of the CY 2020 PFS proposed rule, a commenter expressed concern with the published list of common refinements to equipment time. The commenter stated that these refinements were the formulaic result of applying refinements to the clinical labor time and did not constitute separate refinements; the commenter requested that CMS no longer include these refinements in the table published each year. In the CY 2020 PFS final rule, we

agreed with the commenter that these equipment time refinements did not reflect errors in the equipment recommendations or policy discrepancies with the RUC's equipment time recommendations. However, we believed it was important to publish the specific equipment times that we were proposing (or finalizing in the case of the final rule) when they differed from the recommended values due to the effect these changes can have on the direct costs associated with equipment time. Therefore, we finalized the separation of the equipment time refinements associated with changes in clinical labor into a separate table of refinements. We direct readers to the discussion in the CY 2020 PFS final rule (84 FR 62584) for additional details.

Historically, the RUC has submitted a "PE worksheet" that details the recommended direct PE inputs for our use in developing PE RVUs. The format of the PE worksheet has varied over time, and among the medical specialties developing the recommendations. These variations have made it difficult for the RUC's development and our review of code values for individual codes. Beginning with its recommendations for CY 2019, the RUC mandated the use of a new PE worksheet for its recommendation development process that standardizes the clinical labor tasks and assigns them a clinical labor activity code. We believe the RUC's use of the new PE worksheet in developing and submitting recommendations helps us simplify and standardize the hundreds of clinical labor tasks currently listed in our direct PE database. To facilitate rulemaking for CY 2027, we are displaying the Labor Task Detail public use file that contains the current listing of clinical labor activity codes. This file is available on the CMS website under downloads for the CY 2027 PFS proposed rule at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html.*

b. Updates to Prices for Existing Direct PE Inputs

In the CY 2011 PFS final rule with comment period (75 FR 73205), we finalized a process to act on public requests to update equipment and supply price and equipment useful life inputs through annual rulemaking, beginning with the CY 2012 PFS proposed rule. Beginning in CY 2019 and continuing through CY 2022, we conducted a market-based supply and equipment

pricing update using information developed by our contractor which updated pricing recommendations for approximately 1300 supplies and 750 equipment items currently used as direct PE inputs. Given the potentially significant changes in payment that would occur, in the CY 2019 PFS final rule, we finalized a policy to phase in our use of the new direct PE input pricing over a 4-year period using a 25/75 percent (CY PFS 2019), 50/50 percent (CY PFS 2020), 75/25 percent (CY PFS 2021), and 100/0 percent (CY PFS 2022) split between new and old pricing. We believe that implementing the proposed updated prices with a 4-year phase-in would improve payment accuracy while maintaining stability and allowing interested parties to address potential concerns about changes in payment for particular items. This 4-year transition period to update supply and equipment pricing concluded in CY 2022; for a more detailed discussion, we refer readers to the CY 2019 PFS final rule with comment period (83 FR 59473 through 59480).

For CY 2027, we are proposing to update the price of nine supplies and two equipment items in response to the public submission of invoices following the publication of the CY 2026 PFS final rule. These supply and equipment items with updated prices are listed in the valuation of specific codes section of the rule under Table A-D9, CY 2027 Invoices Received for Existing Direct PE Inputs.

These proposed pricing updates include a request from the RUC to update the pricing of the moderate sedation pack (SA044) to more accurately reflect its components. The RUC determined that a sterile gown is not needed as part of the moderate sedation pack, however, a regular staff gown should be included to protect the sedation provider from all body fluids, substance, and excretions. The RUC also requested that a mask would be an appropriate addition in the sedation pack, resulting in a price change from the current $19.20, minus the $5.13 sterile gown, plus the $1.19 staff gown and $0.43 mask, for a new total price of $15.69. We are proposing this $15.69 price for the SA044 moderate sedation pack which is reflected in Table A-E, CY 2027 Invoices Received for Existing Direct PE Inputs.

Additionally, we received a potentially misvalued code (PMVC) nomination for SA119 kit, low frequency ultrasound wound therapy (MIST) and are proposing an updated supply cost from $320.18 to $100 for SA119. We refer readers to section II.D. of this proposed rule for more information about this proposal.

(1) Invoice Submission

We remind readers that we routinely accept public submissions of invoices as part of our process for developing payment rates for new, revised, and potentially misvalued codes. Often, these invoices are submitted in conjunction with the RUC-recommended values for the codes. To be included in a given year's proposed rule, we generally need to receive invoices by the same February 10th deadline we noted for consideration of RUC recommendations. However, we will consider invoices submitted as public comments during the comment period following the publication of the CY 2027 PFS proposed rule and will consider any invoices received after February 10th or outside of the public comment process as part of our established annual process for requests to update supply and equipment prices. Interested parties are encouraged to submit invoices with their public comments or, if outside the notice and comment rulemaking process, via email at *PE_Price_Input_Update@cms.hhs.gov*.

(2) Supply Pack Pricing Update

Interested parties previously notified CMS that they identified numerous discrepancies between the aggregated cost of some supply packs and the individual item components contained within. The interested parties indicated that CMS should rectify these mathematical errors as soon as possible to ensure that the sum correctly matches the totals from the individual items, and they recommended that we resolve these pricing discrepancies in the supply packs during CY 2024 rule. The AMA RUC convened a workgroup on this subject and submitted recommendations to update pricing for a series of supply packs along with the RUC's comment letter for the CY 2024 rule cycle.

We appreciated the additional information and RUC workgroup recommendations regarding discrepancies in the aggregated cost of some supply packs. However, due to the projected significant cost revisions in the pricing of supply packs and because we did not propose to address supply pack pricing in the CY 2024 proposed rule, we stated in the CY 2024 final rule that this issue would be better addressed in future rulemaking. For example, the cleaning and disinfecting endoscope pack (SA042) is included as a supply input in more than 300 HCPCS codes, which could have a sizable impact on the overall valuation of these services, and which was not incorporated into the proposed RVUs published for the CY 2024 proposed rule. We stated that interested parties would be better served if we comprehensively addressed this topic during future rulemaking in which commenters could provide feedback in response to proposed pricing updates (88 FR 78833 through 78834).

For CY 2025, we proposed implementing the supply pack pricing update and associated revisions as recommended by the RUC's workgroup (89 FR 97726 through 97727). We proposed to update the pricing of the "pack, cleaning and disinfecting, endoscope" (SA042) supply from $19.43 to $31.29, to update the pricing of the "pack, drapes, cystoscopy" (SA045) supply from $17.33 to $14.99, to update the pricing of the "pack, ocular photodynamic therapy" (SA049) supply from $16.35 to $26.35, to update the pricing of the "pack, urology cystoscopy visit" (SA058) supply from $113.70 to $37.63, and to update the pricing of the "pack, ophthalmology visit (w-dilation)" (SA082) supply from $3.91 to $2.33. As recommended by the RUC workgroup, we also proposed to delete the "pack, drapes, laparotomy (chest-abdomen)" (SA046) supply entirely. The updated prices for these supply packs were listed in the valuation of specific codes section of this rule under Table A-B5, CY 2025 Invoices Received for Existing Direct PE Inputs (89 FR 97852).

In accordance with the RUC workgroup's recommendations, we also proposed to create eight new supply codes, including components contained within previously existing supply packs. Aside from the SB056 supply, which is a replacement in several HCPCS codes for the

deleted SA046 supply pack, all of these new supplies are not included as standalone direct PE inputs in any current HCPCS codes, as they are, again, components contained within previously existing supply packs. We proposed to add:

- The kit, ocular photodynamic therapy (PDT) (SA137) supply at a price of $26.00 as a component of the SA049 supply pack;
- The Abdominal Drape Laparotomy Drape Sterile (100 in x 72 in x 124 in) (SB056) supply at a price of $8.049 as a replacement for the SA046 supply pack;
- The drape, surgical, legging (SB057) supply at a price of $3.284 as a component of the SA045 supply pack;
- The drape, surgical, split, impervious, absorbent (SB058) supply at a price of $8.424 as a component of the SA045 supply pack;
- The post-mydriatic spectacles (SB059) supply at a price of $0.328 as a component of the SA082 supply pack;
- The y-adapter cap (SD367) supply at a price of $0.352 as a component of the SA049 supply pack;
- The ortho-phthalaldehyde 0.55 percent (for example, Cidex OPA) (SM030) supply at a price of $0.554 as a component of the SA042 supply pack; and
- The ortho-phthalaldehyde test strips (SM031) supply at a price of $1.556 as a component of the SA042 supply pack.

The new supply pack component items were listed in the valuation of specific codes section of the rule under Table A-B8, CY 2025 PFS (89 FR 97722) New Invoices (89 FR 97853).

We also proposed the following additional supply substitutions based on the recommendations of the RUC workgroup. We proposed to remove the deleted SA046 supply pack and replace it with the drape, sterile, fenestrated 16in x 29in (SB011) supply for CPT codes 19020, 19101, 19110, 19112, 20101, and 20102. We proposed to remove the deleted SA046

supply pack and replace it with two supplies – the drape, sterile, three-quarter sheet (SB014) and the drape, towel, sterile 18in x 26in (SB019) – for CPT codes 19000 and 60300. We proposed to remove the deleted SA046 supply pack and replace it with 2 supplies – the drape, towel, sterile 18in x 26in (SB019) and the newly created Abdominal Drape Laparotomy Drape Sterile (100 in x 72 in x 124 in) (SB056) supply – for CPT codes 22510, 22511, 22513, and 22514. We proposed to remove the deleted SA046 supply pack without replacing it with anything for CPT code 22526; the RUC workgroup did not make a recommendation on what to do with CPT code 27278, which also previously contained the SA046 supply pack. Therefore, we also proposed not to replace the SA046 supply pack with any supplies for this code. The RUC workgroup also recommended removing the SA046 supply pack from CPT code 64595 with no replacement; however, this code was recently reviewed at the April 2022 RUC meeting and it no longer includes the SA046 supply.

In the comments on the CY 2025 PFS proposed rule (89 FR 97727), several commenters supported the proposed supply pack pricing update as recommended by the RUC workgroup, however they indicated concern over the proposed decrease in the price of the urology cystoscopy visit pack (SA058) from $113.70 to $37.63. The commenters stated that the proposed pricing reduction in the SA058 supply could result in drastic payment rate cuts for physicians performing cystoscopy services in the office setting. The commenters requested that CMS either delay the pricing update or phase-in the supply pack changes over a 4-year period like it has done for other PE changes with significant redistributive effects, allowing independent urology practices to better prepare for the negative financial impact this change will have.

After considering these comments, we agreed that the use of a phased-in transition period would be appropriate to allow practitioners to adjust to the updated pricing of these supplies. During our previous supply and equipment pricing update in the CY 2019 PFS final rule (83 FR 59475), we finalized a policy to phase in any updated pricing that we established during the 4-year transition period for very commonly used supplies and equipment, such as sterile gloves

(SB024) or exam tables (EF023), even if invoices were provided as part of the formal review of a code family. Based on this previously established policy, we finalized the use of a pricing transition for three supply packs in Table A-B4.

TABLE A-B4: CY 2025 SUPPLY PACK PRICING TRANSITION

CMS_ CODE	HCPCS Codes	CMS_2024 Price	Recommended Price	Year 1 (CY 2025) Price	Year 2 (CY 2026) Price	Year 3 (CY 2027) Price	Final (CY 2028) Price
SA042	306	$19.43	$31.29	$22.40	$25.36	$28.33	$31.29
SA058	38	$113.70	$37.63	$94.68	$75.67	$56.65	$37.63
SA082	145	$3.91	$2.33	$3.52	$3.12	$2.73	$2.33

Following the same pattern as our previous supply/equipment and clinical labor pricing updates, we finalized the implementation of this pricing transition over 4 years such that one-quarter of the difference between the current price and the fully phased-in price is implemented for CY 2025 PFS (89 FR 97722), one-third of the difference between the CY 2025 PFS (89 FR 97722) price and the final price is implemented for CY 2026 PFS, and one-half of the difference between the CY 2026 price and the final price is implemented for CY 2027, with the new direct PE prices fully implemented for CY 2028. For the other proposed supply packs, the cystoscopy drapes pack (SA045) is only included in seven HCPCS codes and the ocular photodynamic therapy pack (SA049) is only included in a single HCPCS code which do not meet these criteria established in previous rulemaking and described previously in this section. Therefore, we finalized each of them at their updated pricing for CY 2025 PFS (89 FR 97722) as proposed in the proposed rule. We believe that the use of this pricing transition will minimize any potential disruptive effects during the 4-year transition period that could be caused by other sudden shifts in RVUs due to the high number of services that make use of these very common supply packs.

Several commenters also stated that although five incomplete packs would have their pricing updated in the proposed rule, mathematical errors still remained for a number of additional supply packs. Commenters stated that only 3 of the 18 affirmed packs were priced correctly to match their components and provided tables showing the pricing of an additional 15 packs that needed mathematical correction by deconstructing the packs to determine the correct

price through summing their individual components. Commenters requested that CMS initiate a correction of the packs pricing such that the sum of the individual components match the price of the corresponding pack as detailed in Table A-B5.

TABLE A-B5: SUPPLY PACK PRICING REQUESTED BY CY 2025 COMMENTERS

HCPCS Codes	Item Name	CMS Code	Current Price	New Price	% Change
111 codes	pack, basic injection	SA041	$10.45	$17.28	65%
560 codes	pack, cleaning, surgical instruments	SA043	$12.61	$11.09	-12%
3 codes	pack, moderate sedation	SA044	$18.55	$19.20	4%
4568 codes	pack, minimum multi-specialty visit	SA048	$5.02	$1.98	-61%
168 codes	pack, ophthalmology visit (no dilation)	SA050	$2.72	$1.35	-50%
239 codes	pack, pelvic exam	SA051	$20.16	$2.81	-86%
1079 codes	pack, post-op incision care (staple)	SA052	$4.80	$9.90	106%
469 codes	pack, post-op incision care (suture & staple)	SA053	$5.47	$11.54	111%
1708 codes	pack, post-op incision care (suture)	SA054	$4.62	$10.34	124%
12 codes	pack, post-op incision care, craniotomy	SA055	$7.30	$18.18	149%
24 codes	pack, post-op incision care, neurosurgical	SA056	$6.20	$16.05	159%
120 codes	pack, drapes, ortho, large	SA080	$37.30	$25.38	-32%
29 codes	pack, drapes, ortho, small	SA081	$2.25	$1.88	-16%
119 codes	pack, protective, ortho, large	SA083	$10.86	$14.75	36%
27 codes	pack, protective, ortho, small	SA084	$5.99	$8.15	36%

While we shared the concerns of the commenters regarding the need for accuracy in the pricing of these supply packs, we had reservations about their potential for pricing disruptions. Ten of these supply packs are included in the direct PE inputs for at least 100 HCPCS codes, and three of the packs are included in more than 1000 HCPCS codes. Many of these pricing updates would lead to drastic changes in pricing for these supply packs which are included in hundreds of HCPCS codes, such as the SA051 pelvic exam pack decreasing in price from $20.16 to $2.81 (-86 percent) and the SA048 minimum multi-specialty visit pack decreasing in price from $5.02 to $1.98 (-61 percent). We were particularly concerned that these changes in supply pack pricing could lead to significant shifts in the overall PE RVU for affected HCPCS codes, without these proposed rates appearing in the proposed rule or allowing any opportunity for public comment.

Therefore, we did not finalize pricing updates for these additional 15 supply packs as requested by commenters. We anticipated returning to this subject in future rulemaking to allow any changes in associated pricing for HCPCS codes to appear in the proposed rule and provide an opportunity for the public to comment. Should these supply pack pricing updates be proposed

in future rulemaking, we anticipated that we might propose the same pricing transition described above due to the number of potentially affected HCPCS codes. We finalized all of the other supply pack pricing changes as proposed, with the exception of the 4-year pricing transition for three supply packs as described previously in this section.

For CY 2026, we proposed to continue implementing the supply pack pricing update and associated revisions as previously recommended by the RUC's workgroup. We proposed to update the price of the 15 supply packs detailed in Table A-B5 which were received too late in CY 2025 PFS (89 FR 97722) to allow for proposed pricing or public comment. In the case of the surgical instruments cleaning pack (SA043), the moderate sedation pack (SA044) and the small ortho drapes pack (SA081), the proposed pricing update is modest enough that we proposed these supplies move immediately to their final prices for CY 2026.

For the 12 other supply packs, we proposed that they be incorporated into the muti-year supply pack pricing transition finalized in CY 2025 rulemaking. Rather than having two separate 4-year pricing transitions associated with supply packs, we proposed that these 12 additional supply packs fold into the previous pricing transition using the same methodology, such that one-third of the difference between the CY 2025 PFS (89 FR 97722) price and the final price is implemented for CY 2026, and one-half of the difference between the CY 2026 price and the final price is implemented for CY 2027, with the new direct PE prices fully implemented for CY 2028 (89 FR 97728). With the inclusion of the SA042, SA058, and SA082 supply packs which began their pricing transition for CY 2025, we proposed the total supply pack pricing update detailed in Table A-B6.

TABLE A-B6: SUPPLY PACK PRICING TRANSITION

CMS_ CODE	HCPCS Codes	CMS_2024 Price	Recommended Price	Year 1 (CY 2025) Price	Year 2 (CY 2026) Price	Year 3 (CY 2027) Price	Final (CY 2028) Price
SA042	306	$19.43	$31.29	$22.40	$25.36	$28.33	$31.29
SA058	38	$113.70	$37.63	$94.68	$75.67	$56.65	$37.63
SA082	145	$3.91	$2.33	$3.52	$3.12	$2.73	$2.33
SA041	111	$10.45	$17.28	-	$12.73	$15.00	$17.28
SA048	4568	$5.02	$1.98	-	$4.01	$2.99	$1.98
SA050	168	$2.72	$1.35	-	$2.26	$1.81	$1.35
SA051	239	$20.16	$2.81	-	$14.38	$8.59	$2.81

CMS_ CODE	HCPCS Codes	CMS_2024 Price	Recommended Price	Year 1 (CY 2025) Price	Year 2 (CY 2026) Price	Year 3 (CY 2027) Price	Final (CY 2028) Price
SA052	1079	$4.80	$9.90	-	$6.50	$8.20	$9.90
SA053	469	$5.47	$11.54	-	$7.49	$9.52	$11.54
SA054	1708	$4.62	$10.34	-	$6.53	$8.43	$10.34
SA055	12	$7.30	$18.18	-	$10.93	$14.55	$18.18
SA056	24	$6.20	$16.05	-	$9.48	$12.77	$16.05
SA080	120	$37.30	$25.38	-	$33.33	$29.35	$25.38
SA083	119	$10.86	$14.75	-	$12.16	$13.45	$14.75
SA084	27	$5.99	$8.15	-	$6.71	$7.43	$8.15
SD089	100	$20.56	$41.15	-	$27.42	$34.29	$41.15

Table A-B6 also includes the hydrophilic guidewire (SD089) supply which we proposed to transition in pricing over 3 years given its inclusion in approximately 100 HCPCS codes. We continue to believe that the use of this pricing transition will minimize any potential disruptive effects during the transition period that could be caused by other sudden shifts in RVUs due to the high number of services that make use of these very common supply items. After consideration of the public comments, we finalized our supply pack pricing policies as proposed in the CY 2026 PFS final rule (90 FR 49284).

For CY 2027, these supply packs will continue with the third year of the previously finalized 4-year transition process as detailed in Table A-B6. As is the case with other supply and equipment pricing, we will consider invoices associated with these supply packs which are submitted as public comments during the comment period following the publication of the CY 2027 PFS proposed rule as part of our established annual process for requests to update supply and equipment prices. Interested parties are encouraged to submit invoices with their public comments or, if outside the notice and comment rulemaking process, via email at *PE_Price_Input_Update@cms.hhs.gov*.

c. Technical Corrections to Direct PE Input Database and Supporting Files

Following the publication of the CY 2026 PFS final rule, the RUC submitted a potential technical correction issue related to global period assignment for approximately three dozen codes. The RUC stated that these codes had long descriptors which indicated that they were add-on codes "(List separately in addition to code for primary procedure)"; however, these codes

were assigned the XXX global period instead of the ZZZ global period. The RUC requested that CMS consider assigning the ZZZ global period for these codes as a technical correction.

We reviewed the list of codes submitted by the RUC and we agree that there appears to be a technical error in the global period assignment for these codes. Most of the affected codes have non-payable status codes and no RVUs, while the handful of affected HCPCS codes that do have RVUs specifically state in their descriptors that they were intended to be add-on codes, such as CPT code 88332 (Pathology consultation during surgery; each additional tissue block with frozen section(s)). We are therefore proposing to change the following codes to the ZZZ global period:

TABLE A-B7: PROPOSED ZZZ GLOBAL PERIOD CODES

HCPCS	Short Descriptor
20930	Sp bone algrft morsel add-on
20936	Sp bone agrft local add-on
22841	Insert spine fixation device
81266	Str markers spec anal addl
81416	Exome sequence analysis
81426	Genome sequence analysis
81536	Oncology gynecologic
82952	Gtt-added samples
87187	Sc std microdil/agar mlc
87503	Influenza dna amp prob addl
87904	Phenotype dna hiv w/clt add
88314	Histochemical stains add-on
88332	Path consltj surg ea add blk
94645	Cont inhlj tx each addl hour
95940	Ionm in operatng room 15 min
95941	Ionm remote/>1 pt or per hr
99486	Suprv interfac trnsport addl
99602	Home nfs visit each addl hr
0054T	Bone srgry cmptr fluor image
0055T	Bone srgry cmptr ct/mri imag
0076T	S&i stent/chest vert art
0095T	Rmvl artific disc addl crvcl
0098T	Rev artific disc addl
0174T	Cad cxr with interp
0397T	Ercp w/optical endomicroscpy
G1028	Take home supply 8mg per 0.1
G2078	Take-home meth
G2079	Take-hom buprenorphine
G2080	Add 30 mins counsel
G2215	Home supply nasal naloxone
G2216	Home supply inject naloxon
S2351	Diskectomy, anterior, with d
S2900	Robotic surgical system

The RUC also requested assigning the ZZZ global period to three anesthesia codes: CPT

codes 01953, 01968, and 01969. However, currently all anesthesia codes use the XXX global period, and it is unclear whether the concept of an add-on global period would apply to anesthesia coding given that they are valued using base units and time units, unlike all other PFS services. For this reason, we are not proposing the ZZZ global period for these three codes at this time. We are soliciting comments from interested parties regarding the global period assignment for these three anesthesia codes, as well as the other codes listed in Table A-B7.

d. Updates to Practice Expense (PE) Methodology – Site of Service Payment Differential

We proposed a significant refinement to our PE methodology to better reflect trends in physician practice settings in the CY 2026 PFS final rule (90 FR 49292 through 49297). Under the finalized policy, we allocate half the amount of indirect PE RVUs per work RVU for services furnished in the facility setting compared to those allocated to services furnished in the non-facility setting. We noted in the CY 2026 PFS proposed rule (90 FR 32374) that this change to the indirect cost allocation methodology was intended to better recognize the relative resources involved in furnishing services paid under the PFS in facility and non-facility settings. We compared this change to our current methodology prior to CY 2026, which functionally presumed approximately equal indirect costs incurred by physicians across sites of service. This presumption was initially made in the context of most practitioners maintaining office practices independent of the facilities in which they provided care, and as we discussed in the CY 2026 PFS proposed and final rules, appears to be inconsistent with contemporary trends in physician practice where some significant portion of services furnished in facility settings are performed by medical practitioners who do not maintain fully independent practices and are less likely to incur a comparable amount of indirect costs.

Since finalizing the proposal in the CY 2026 PFS final rule, we have heard from interested parties that the implementation of this policy resulted in an unintended, but significant, site of service differential for physician visits in nursing facility settings based solely on whether the beneficiary's stay is covered under Part A. For purposes of PFS payment, a service furnished

to a patient in a skilled nursing facility during a Part A hospital stay (place of service 31) is considered to be in the "facility" setting, while a service furnished to a patient in a Part B stay (place of service 32) is considered to be in the "non-facility" setting, per the Medicare Claims Processing Manual (MCPM), Chapter 12, Section 20.4.2 at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf*. Prior to CY 2026, the payment rate for these E/M services furnished in a skilled nursing facility ("facility") and a nursing facility ("non-facility") were equal. As intended, the 50 percent reduction to the allocation of indirect PE based on work RVUs that we finalized for CY 2026 shifted PE RVUs from the facility setting to the non-facility setting. However, for nursing facility and skilled nursing facility visits, the current site of service differential is determined based on the status of the beneficiary (that is, a Part A versus Part B stay) in that setting, rather than in the setting of care itself. Given that the resource costs for the professional involved in furnishing an E/M service would not be expected to differ based on whether the patient is in a Part A stay or not, we believe it is more accurate for these E/M services to be paid the same amount without regard to the beneficiary's Part A status. Therefore, we are proposing to address this anomaly for CY 2027 by equalizing the rate for nursing facility visits without regard to the beneficiary's status by setting the facility PE RVU equal to the non-facility PE RVU for CPT codes 99304 (*Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.*), 99305 (*Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.*), 99306 (*Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making.*

When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded.), 99307 (*Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.*), 99308 (*Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.*), 99309 *(Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.*), 99310 *(Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.*), 99315 *(Nursing facility discharge management; 30 minutes or less total time on the date of the encounter*), and 99316 *(Nursing facility discharge management; more than 30 minutes total time on the date of the encounter*).

This particular situation illuminates ongoing concerns regarding the current site of service differential. For example, interested parties have suggested that the current binary of facility and non-facility does not account for the range of employment models associated with physician services that drive significant differences in actual practice expenses. Interested parties have encouraged us to refine our previously finalized policy to ensure it is more empirically grounded and narrowly tailored to independent physicians, consistent with the policy's original intent. Interested parties have also stated that the facility PE reductions have had a disparate effect on hospital medicine groups and hospitalists, particularly those that operate

independently from their hospital or health systems. Interested parties have stated that independent hospital medicine groups account for approximately one-third to one-half of the hospital medicine groups nationwide, and they are unable to cut administrative and overhead costs enough to absorb our CY 2026 facility PE reductions. As a result, some interested parties have stated that the reductions are accelerating the insolvency of independent physician practices and leading to an increase in hospital consolidation. We note that we have heard no general consensus among interested parties to this effect, and we have received feedback that this policy supports independent practices.

In the CY 2026 PFS proposed rule, we sought comments on whether our proposal to reduce the portion of the facility PE RVUs allocated based on work RVUs to half the amount allocated to non-facility PE RVUs was an appropriate reduction or whether we should consider a different percentage reduction for CY 2026 or in future years. In finalizing the proposal, we noted that, while our change to the methodology for CY 2026 represented a starting point to correcting historic distortions in the allocation of indirect PE costs across settings of care, we intended to further examine our methodology and consider additional refinements based upon feedback received and any studies or data sources identified.

For CY 2027, we remain open to more specific data that addresses the variability, as well as feedback on how to update the valuation and payment methodologies to better reflect the relative resources involved in furnishing the services, both across settings of care, and within the context of an evolving ecosystem of care models and business arrangements. Historically, we have relied extensively on specialty-specific PE/HR survey data and the binary site of service differential to best reflect variable PE costs.

To better inform our consideration of how to account for practice expenses under the PFS methodologies, including the current differentials that are effectuated based on the binary facility/non-facility settings of care, we are seeking comment on how PE costs vary for physicians and other professionals, not only based on whether they practice in part or exclusively

in a facility setting but also based on how their costs vary when they are employed by health systems, hospitals, or other entities. We noted in the CY 2026 PFS final rule that (90 FR 49292) that the AMA has stated that physician practices maintain some indirect PE costs for physicians who are solely facility-based such as coding, billing, and scheduling. That being said, we generally agree with the concerns presented by MedPAC on the growth of exclusively facility-based physicians and agree that potential overpayments for indirect practice expense costs could be a driver of clinician movement to higher cost settings without creating commensurate clinical value. This is why we lowered indirect PE for facility-based physician to 50 percent in the CY 2026 PFS final rule.

Moving forward, we remain interested in ensuring indirect PE RVUs are appropriately accounting for indirect PE costs. As such, we are seeking information that will help illuminate to what extent these costs are truly incurred when the professionals are employed by the hospital and/or practice primarily in the hospital and are not already accounted for in the existing OPPS payments. For example, when a physician is employed by and practicing in a hospital, what portion of the indirect PE is associated with the PFS service, versus costs that are associated with the payment to the hospital, such as those paid under the OPPS?

We are seeking comment on the amount of indirect PE hospital-employed physicians incur when they furnish care within a facility. For these physicians, is the 50 percent indirect PE allocation accurate or could it possibly be less than 50 percent, such as 0 percent? In the case that there are little to no indirect costs incurred by the physician or other professionals, and these costs are borne by the hospital, we believe that these costs are not appropriately accounted for under the PFS and we may well be overestimating the relative resource costs compared to other PFS services. In consideration of the accuracy of the current 50 percent indirect PE allocation for services furnished in the facility setting, we are also seeking comment on whether and how we might, alternatively or additionally, define and identify physicians and professionals who are employed by hospitals, health systems, or other entities to ensure the services they furnish are

not inappropriately consuming PE RVUs that would be more appropriately assigned to services furnished by professionals incurring comparatively greater practice expenses. Specifically, we are seeking comment on whether a new HCPCS modifier for employed physicians would be a reasonable way to identify and reduce facility PE from the services they perform in the facility setting, or whether there are other methods we could consider.

We are seeking comment on what are the primary variables we should consider to continue to improve our data sources, allocation methodologies, and payment rates across settings of care, to best reflect the resources involved in furnishing PFS services by professionals and suppliers operating in a complex marketplace, across settings of care. We remain interested in objective data regarding payment arrangements between hospitals, health systems, other employers and physicians, including which costs are incurred and whether the full range of costs are truly incurred by physicians and other professionals in these kinds of employment relationships. This would help us understand and improve how PE is allocated across settings of care, both in general and for specific kinds of services.

6. Strategies to Improve Payment Transparency, Accuracy, and Congruency Across Payment Systems

a. Professional and Technical Components

Because PFS services are paid across settings of care, and are the primary way that Medicare pays medical professionals, understanding the structure of PFS payment is a critical part of price transparency for Medicare, other payers, and consumers. Likewise, misunderstanding or confusion about what relative resources are incorporated in specific PFS payment rates can be a significant obstacle for payers and consumers navigating the health care market. For example, approximately 4,100 services paid as "global surgical packages," (herein 'globals') are valued as bundled payments that aggregate multiple components of care into a single payment amount, including post-operative visits that are presumed to occur in particular settings (for example, inpatient hospital, outpatient hospital, office) regardless of where the

services actually take place. Most PFS services are valued with a site of service binary, where the non-facility setting is the aggregation of all relative resources involved in furnishing the professional and technical aspects of the service, and the facility setting, where the rate generally excludes the facility costs involved in the service since those costs are addressed through separately reported facility fees. In contrast to these two constructs, there are other codes (mainly describing diagnostic and imaging services) that may be billed with professional component (PC, or modifier 26) and technical component (TC) modifiers, or without modifiers (global codes) that are paid for the complete global service. These differences in how payments are constructed and displayed can make it difficult for interested parties and CMS to evaluate relative payment rates, underlying resource costs, and value across settings of care.

These challenges are further compounded by differences across Medicare payment systems in how similar services are defined, bundled, and paid. For example, some payment systems incorporate technical inputs and facility resources into a single payment. This variation can obscure meaningful comparisons across sites of care and may complicate efforts to advance site-neutral payment policies aimed at reducing incentives for hospitals to acquire physician practices and limit site-of-care decisions based on financial considerations. As CMS continues to consider approaches that remove obstacles from market competition across settings of care, especially by improving transparency, comparability of PFS payments is an important foundational step.

To facilitate more consistent comparisons across services and settings, we have developed a public use file that displays, for services that are not currently billable with TC/26 modifiers, RVUs amounts that reflect the relative resources involved in furnishing professional and technical aspects of the services, which is available on the CMS website under downloads for the CY 2027 PFS proposed rule at *http://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html.* This file is intended to improve transparency regarding how PFS payments may be conceptually divided between

physician professional and technical components of the services, especially to illuminate the differences in fees between technical aspects of PFS services compared to facility fees across settings of care. We believe that making these components more visible, where feasible, may help interested parties better understand the structure of PFS payments and support more informed comparisons across settings of care. We note that we have excluded 010- and 090-day global surgery services from display in this public use file since there are numerous ways to consider how the structure of payment for those codes may be best understood. The use of bundled payments for the 010- and 090-day global surgery services results in aggregated valuation for all pre-operative, intra-operative, and post-operative services furnished over a defined period (0-, 10-, or 90-day global periods), including services by both physician and clinical staff and practice expense without clear visibility into how each component contributes to the total bundled valuation. While we note that the current structure of global surgery services has effectively obscured how the components of care are individually valued and limited our ability to disaggregate them for purposes of this public use file, we seek comment on how to address this problem, either in possible improvements to the global surgery packages or, at least, in the best way to make their component pieces transparent. Additionally, we note that there is a subset of additional exclusions from this public use file, such as codes subject to the cognitive services floor and the statutory phase-in of significant RVU reductions, due to technical challenges with how these policies are implemented that hinder the disaggregation of their component parts.

We emphasize that we are not proposing any changes to existing payment or billing policies, including the use of the 010- and 090-day globals. Rather, this effort is intended to improve transparency and provide a foundation for future rulemaking. We believe that greater visibility into how the professional and technical aspects of PFS services are valued and paid, where feasible, may enhance the ability of consumers, and payers (including CMS) to assess relativity across services, may enhance CMS's efforts to improve valuation over time, and

support broader efforts to align payments across settings of care. We are seeking comment on several aspects of this approach. First, we seek comment on the utility of displaying RVUs associated with professional and technical aspects of services that are not currently billable with TC/26 modifiers, including how we may use this information to assess payment differences across settings. Again, we also seek comment on potential approaches CMS could consider in future rulemaking to improve transparency for services currently paid as globals. Specifically, we are interested in feedback on how CMS could develop methodologies to more clearly identify and, where appropriate, disaggregate the underlying components of these services. We are also interested in comments on how CMS could "right-size" payments for the globals over time to ensure they remain aligned with current clinical practice and resource costs, are more readily updated based on empirical data, and do not obscure differences in cost and value across settings of care.

b. Global Surgical Packages

We finalized a policy in the CY 2015 PFS final rule (79 FR 67582 through 67591) to transition all 10-day and 90-day globals to 0-day globals, allowing any post-operative visits furnished after the day of the procedure to be billed as a standalone visit. CMS was prohibited from implementing this policy through section 523(a) of the Medicare Access and CHIP Reauthorization Act (MACRA) and was required to collect data on how to best value globals. CMS did so through a research contract with RAND and a data-collection process over several years to develop data to improve the payment rates for these services. Data collection has been based on reporting of CPT code 99024 (*Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure*), which is limited to practices with 10 practitioners or more, limited to nine States, and is used solely for data collection so it has no associated payment with reporting the code. In the CY 2019 PFS final rule (83 FR 59503), we released findings that only 4 percent of reviewed 10-day globals and 67

percent of reviewed 90-day globals had one or more post-operative visit which occurred during the global period and sought comment on potential approaches for revaluing the globals based on these findings (83 FR 59504). In the CY 2023 PFS proposed rule (87 FR 45877 through 45880), CMS reviewed the prior work and conversations around global valuations, solicited feedback from the public, and has continued to explore ways over the years to address valuation of the globals that would be minimally disruptive to the PFS.

Over the past several years, CMS has taken several iterative steps to improve payment accuracy for the globals. In the CY 2025 PFS final rule (89 FR 97964 through 97968), CMS expanded the applicability of the transfer of care modifiers to address instances where separate practitioners are billing for standalone E/M visits during the global period more directly with mandatory reporting of payment modifiers in clinical cases when there is both a formal or informal transfer of care between practitioners furnishing distinct portions of a global service. CMS also created a post-operative care services add-on code to more appropriately reflect the time and resources involved for practitioners who were not involved in furnishing the surgical procedure. CMS is continuing to explore further steps to improve accountability and more accurate payment and what additional next steps CMS could take to improve the payment rates for global services.

In keeping with the administration priorities and aligning spending and value, we are proposing to pause the data collection required by MACRA based on RAND's findings over the past several years. We remain interested in how best to use and collect this data going forward and ways we might consider improving this data collection. We currently have several years of data that have continued to illustrate what we believe is the issue with the post-operative visits during the global period and how these visits are not occurring, yet providers are still being paid for these visits under the current global payment policy. Additionally, we believe that the current data collection may be causing undo burden to providers and we believe that pausing the data collection will aid in burden reduction for practitioners. We do however question whether a more

robust data collection would be appropriate and if we should have all providers report CPT code 99024.

We are also seeking comment on the question we mentioned earlier in this section, as to whether CMS should have all providers report CPT code 99024, and also other data sources we might consider to more accurately value the globals.

We are posting a public use file with this proposed rule to display the imputed RVUs associated with both the 10- and 90-day post-operative visits based on a purely arithmetic approach to understand the valuation of the services based on the data that was analyzed. This public use file shows the current work RVUs, the number of post-operative visits that are reported to CMS using no-pay HCPCS code 99024, and the work RVUs remaining if all post-operative visits are removed. This public use file is available on the CMS website under downloads for the CY 2027 PFS proposed rule at *http://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html.* We welcome comments on potential revaluation strategies that we may consider through future rulemaking.

C. Payment for Medicare Telehealth Services

As discussed in prior rulemaking, several conditions must be met for Medicare to make payment for telehealth services under the PFS. See further details and full discussion of the scope of Medicare telehealth services in the CY 2018 PFS final rule (82 FR 53006), the CY 2021 PFS final rule (85 FR 84502), the CY 2024 PFS final rule (88 FR 78861 through 78866), the CY 2026 PFS final rule (90 FR 49316 through 49320), and in 42 CFR 410.78 and 414.65. Our current 3-step review process reflects the stepwise method by which we consider requests to add services to or remove services from the Medicare Telehealth Services List, beginning with the CY 2026 Medicare Telehealth Services List:

Step 1. Determine whether the service is separately payable under the PFS.

Step 2. Determine whether the service is subject to the provisions of section 1834(m) of the Act.

Step 3. Review the elements of the service as described by the HCPCS code and determine whether each of them is capable of being furnished using an interactive telecommunications system as defined in § 410.78(a)(3).

1. Changes to the Medicare Telehealth Services List

a. Requests to Add Services to the Medicare Telehealth Services List for CY 2027

We did not receive any requests to add or remove services from the Medicare Telehealth Services List for CY 2027.

Consistent with the deadline for our receipt of code valuation recommendations from the American Medical Association's Relative Value Scale Update Committee (AMA RUC) and other interested parties established in the CY 2019 PFS final rule (83 FR 59491) and with the process set forth in prior calendar years, for CY 2027, requests to add services to the Medicare Telehealth Services List must have been submitted to and received by CMS by February 10, 2026. Consistent with the deadline for our receipt of code valuation recommendations from the AMA RUC and other interested parties established in the CY 2019

PFS final rule (83 FR 59491) and with the process set forth in prior calendar years, for CY 2028, requests to add services to the Medicare Telehealth Services List must be submitted to and received by CMS by February 10, 2027. Each request submitted by the deadline to add a service to the Medicare Telehealth Services List must include any supporting documentation the requester wishes CMS to consider. Because we use the annual PFS rulemaking process to make changes to the Medicare Telehealth Services List, requesters are advised that any information submitted as part of a request is subject to public disclosure for this purpose. For more information on submitting a request to add services to the Medicare Telehealth Services List, including where to send these requests, and to view the current Medicare Telehealth Service List, see our website at *https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html*.

b. CMS Proposal to Add New Codes to the List

We are proposing to add HCPCS G-codes GACP1 (*Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), first 20 minutes of clinical staff time with the patient, family member(s), directed by a treating physician or other treating qualified health care professional*), GACP2 (*Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), each additional 20 minutes with the patient, family member(s), directed by a treating physician or other treating qualified health care professional (List separately in addition to code for primary procedure*)), GSMAS (*Voluntary, group-based medical session involving multiple patients with common medical condition(s), receiving medical care in a group setting; billed and led by a physician or qualified nonphysician practitioner and may include services provided by other qualified healthcare professionals, clinical staff, or auxiliary personnel under the direction of the supervising physician or other practitioner. Session integrates group education, counseling, and peer support with individualized patient clinical assessment and care, 2-10 patients, billed once*

per patient, per session.), GSLPP (*Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual; for the pediatric population up to age 18 or 21*), and GADV1 (*Office or other outpatient evaluation and management service(s) for the diagnosis and treatment of vaccine adverse effects, new or established patient; each 15 minutes personally performed by the physician or qualified healthcare professional (list separately in addition to CPT codes 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350))* to the Medicare Telehealth Services List. If finalized, these services will be separately payable under the PFS. These services will be subject to the provisions of section 1834(m) of the Act, as they are inherently face-to-face services and would serve as a substitute for an in-person encounter. We also believe that the elements of these services as described by the HCPCS codes are capable of being furnished using an interactive telecommunications system as defined in § 410.78(a)(3). We refer readers to the relevant proposal in section II.D. of this proposed rule for further background on these proposed codes.

2. Telehealth Flexibilities and Modifiers

As discussed in the CY 2021 PFS final rule (85 FR 84506), legislation enacted to address the PHE for COVID-19 provided the Secretary with new authorities under section 1135(b)(8) of the Act, as added by section 102 of the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (Pub. L. 116-123, March 6, 2020) and subsequently amended by section 6010 of the Families First Coronavirus Response Act (Pub. L. 116-127, March 18, 2020) and section 3703 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) (Pub. L. 116-136, March 27, 2020), to waive or modify Medicare telehealth payment requirements during the PHE for COVID-19.

We used these authorities to establish several flexibilities to accommodate changes in the delivery of care during the PHE. Through waiver authority under section 1135(b)(8) of the Act, in response to the PHE for COVID-19, we removed the geographic and site of service originating site restrictions in section 1834(m)(4)(C) of the Act, as well as restrictions in section

1834(m)(4)(E) of the Act on the types of practitioners who may furnish telehealth services, for the duration of the PHE for COVID-19. We also used waiver authority to allow certain telehealth services to be furnished via audio-only communication technology. At the end of the PHE for COVID-19, these waivers and interim policies were set to expire, and payment for Medicare telehealth services would have once again been limited by the requirements of section 1834(m) of the Act. These flexibilities have been extended by Congress numerous times since, most recently in the Consolidated Appropriations Act, 2026 (CAA, 2026) (Pub. L. 119-75, February 3, 2026).

Section 6209(a) and (b) of the CAA, 2026 extends the flexibilities for Medicare telehealth services to remove the geographic restrictions, expand the list of acceptable originating sites, and expand the array of practitioners eligible to furnish telehealth services from January 30, 2026 to the extended date of December 31, 2027. Section 6209(d) of the CAA, 2026 delays the in-person visit requirements for mental health services furnished through telehealth from January 30, 2026 to the extended date of January 1, 2028. Section 6209(e) of the CAA, 2026 extends the flexibilities to allow audio-only Medicare telehealth services from January 30, 2026 to the extended date of January 1, 2028. To align with these extensions, § 410.78 has been revised, detailed later in this proposed rule.

Additionally, section 6209(g) of the CAA, 2026, requires CMS to establish modifiers for telehealth services in certain instances, effective January 1, 2027. These modifiers do not affect payment and are required for claims for telehealth services that are furnished through a virtual telehealth platform by a physician or practitioner that contracts with an entity that owns such virtual platform; or for which a physician or practitioner has a payment arrangement with an entity for use of such virtual platform; and for claims for telehealth services that are furnished incident to a physician's or practitioner's professional service.

In accordance with section 6209(g) of CAA, 2026, we are creating modifiers BB and BC. Guidance on use of these modifiers will be available on the CMS website. Any updates to this

policy will be issued via subregulatory guidance in accordance with section 6209(h) of the CAA, 2026, which authorizes the Secretary to implement section 6209 via program instruction or otherwise.

3. Telehealth Critical Care Consultations

In the CY 2017 PFS final rule (81 FR 80352 through 80353), we established HCPCS codes G0508 (*Telehealth consultation, critical care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth*) and G0509 (*Telehealth consultation, critical care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth*) to report telehealth consultations for a patient requiring critical care services. These services were modeled after CPT codes 99291 (*Critical care, evaluation and management of the critically ill or critically injured patient; first 30 to 74 minutes*) and 99292 (*Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (list separately in addition to code for primary service*)).

When adding some services to the Medicare Telehealth Services List in the past, we have included certain frequency restrictions on how often physicians and other practitioners may furnish the service via telehealth. These include a limitation of one critical care consultation service furnished via telehealth per day, added in the CY 2017 final rule (81 FR 80198). In the CY 2026 PFS final rule, we finalized permanently removing frequency limitations on furnishing these services via telehealth (90 FR 49324 through 49325).

We continue to believe that physicians and other practitioners, who have the greatest familiarity and insight into the needs of individual beneficiaries, can use their complex professional judgment to determine whether they can safely furnish a service via telehealth, given the entirety of the circumstances, including the clinical profile and needs of the beneficiary, to determine the appropriate service modality. We strive to balance the goals of increasing physician or practitioner and patient choice of service modality with consideration of

patient safety for all Medicare beneficiaries. As technology advances and more services may be safely furnished via telehealth and paid under the PFS, it is increasingly important for physicians and other practitioners to exercise their professional judgment in determining the generally appropriate service modality for their patients to receive a service.

Since the permanent removal of the frequency limitation of one critical care consultation service furnished via telehealth per day, we have received questions about language in the code descriptors for HCPCS codes G0508 *(Telehealth consultation, critical care, initial , physicians typically spend 60 minutes communicating with the patient and providers via telehealth*) and G0509 (*Telehealth consultation, critical care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth*) describing "initial" and "subsequent" consultations, as well as questions regarding the language about the typical time spent on the service. To clarify the requirements for billing these services, we are proposing the following revised code descriptors:

- G0508: *Telehealth consultation, critical care; first 30 to 74 minutes*.
- G0509: *Telehealth consultation, critical care; each additional 30 minutes (List separately in addition to code for primary service*).

We welcome comments on this proposal.

4. Changes to Teaching Physicians' Billing for Services Involving Residents or Teaching Physicians with Virtual Presence

In the CY 2021 PFS final rule (85 FR 84577 through 84585), we finalized a temporary policy that allowed the teaching physician to have a virtual presence in all teaching settings, but only in clinical instances when the service was furnished virtually (for example, a three-way telehealth visit, with all parties in separate locations). This permitted teaching physicians to have a virtual presence during the key portion of the Medicare telehealth service for which payment was sought, through audio/video real-time communications technology, in all residency training locations through December 31, 2024.

As summarized in the CY 2025 PFS final rule (89 FR 97764 through 97765), commenters encouraged CMS to establish this policy permanently and include in-person services to promote access to care, and stated that teaching physicians should be allowed to determine when their virtual presence would be clinically appropriate based on their assessment of the patient's needs and the competency level of the resident. In the CY 2026 PFS final rule, we finalized permanently allowing teaching physicians to have a virtual presence in all teaching settings, only in clinical instances when the service is a three-way telehealth visit, with the teaching physician, resident, and patient in different locations.

We have received feedback from interested parties that indicates that our current policy for teaching physicians and residents can, in somewhat rare cases, cause logistical complexities in scenarios where either the teaching physician or resident is already in the same physical location as the beneficiary. For CY 2027, we are proposing a modification to our previously finalized policy. Rather than requiring the teaching physician, resident, and patient to each be in a different location, we are proposing to allow teaching physicians to bill for services involving residents when either the teaching physician or resident is in the same physical location as the beneficiary. We would generally interpret physical presence to be defined as either the teaching physician or resident in the same room as the beneficiary, but we are seeking comment on other scenarios in which this may be appropriate. This would only be applicable to services that are on the Medicare Telehealth Services List. As always, documentation in the medical record must continue to demonstrate whether the teaching physician was physically present or present through audio/video real-time communications technology at the time of the Medicare telehealth service, which includes documenting the specific portion of the service for which the teaching physician was present through audio/video real-time communications technology. In accordance with section 1842(b)(7)(A)(i)(I) of the Act, the teaching physician must have personal oversight and involvement over the management of the portion of the case for which the payment is sought. We are seeking comments on this proposal.

5. Telehealth Originating Site Facility Fee Payment Amount Proposed Update

Section 1834(m)(2)(B) of the Act established the Medicare telehealth originating site facility fee for telehealth services furnished from October 1, 2001 through December 31, 2002 at $20.00, and specifies that, for telehealth services furnished on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased by the percentage increase in the Medicare Economic Index (MEI) as defined in section 1842(i)(3) of the Act. The proposed percentage increase in the MEI for CY 2027 is 2.5 percent and is based on the expected historical percentage increase of the 2017-based MEI. For the final rule, we propose to update the MEI increase for CY 2027 based on historical data through the second quarter of 2026. Therefore, for CY 2027, the proposed payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is $32.65. Table A-C1 shows the Medicare telehealth originating site facility fee and the corresponding MEI percentage increase for each applicable time period.

TABLE A-C1: THE MEDICARE TELEHEALTH ORIGINATING SITE FACILITY FEE

Time Period	MEI (%)	Facility Fee for Q3014
Oct. 1, 2001 to Dec. 31, 2002	n/a	$20.00
2003	3.0	$20.60
2004	2.9	$21.20
2005	3.1	$21.86
2006	2.8	$22.47
2007	2.1	$22.94
2008	1.8	$23.35
2009	1.6	$23.72
2010	1.2	$24.00
2011	0.4	$24.10
2012	0.6	$24.24
2013	0.8	$24.43
2014	0.8	$24.63
2015	0.8	$24.83
2016	1.1	$25.10
2017	1.2	$25.40
2018	1.4	$25.76
2019	1.5	$26.15
2020	1.9	$26.65
2021	1.4	$27.02
2022	2.1	$27.59
2023	3.8	$28.64
2024	4.6	$29.96
2025	3.5	$31.01
2026	2.7	$31.85
2027*	2.5	$32.65

*Reflects the most recent estimate of the CY 2027 MEI percentage increase and will be updated in the final rule based on historical data through the second quarter of 2026.

D. Valuation of Specific Codes Including Potentially Misvalued Services Under the PFS

1. Background: Process for Valuing New, Revised, and Potentially Misvalued Codes

Establishing valuations for newly created and revised CPT codes is a routine part of maintaining the PFS. Since the inception of the PFS, it has also been a priority to revalue services regularly to make sure that the payment rates reflect the changing trends in the practice of medicine and current prices for inputs used in the PE calculations. Initially, this was accomplished primarily through the 5-year review process, which resulted in revised work RVUs for CY 1997, CY 2002, CY 2007, and CY 2012, and revised PE RVUs in CY 2001, CY 2006, and CY 2011, and revised MP RVUs in CY 2010, CY 2015, and CY 2020. Under the 5-year review process, revisions in RVUs were proposed and finalized via rulemaking. In addition to the 5-year reviews, beginning with CY 2009, CMS and the AMA's Relative Value Unit Update Committee (RUC) identified a number of potentially misvalued codes each year using various identification screens, as outlined in section II.C. of this proposed rule, Potentially Misvalued Services under the PFS. Historically, when we received RUC recommendations, our process had been to establish interim final RVUs for the potentially misvalued codes, new codes, and any other codes for which there were coding changes in the final rule with comment period for a year. Then, during the 60-day period following the publication of the final rule with comment period, we accepted public comments about those valuations. For services furnished during the calendar year following the publication of interim final rates, we paid for services based upon the interim final values established in the final rule. In the final rule with comment period for the subsequent year, we considered and responded to public comments received on the interim final values and typically made any appropriate adjustments and finalized those values.

In the CY 2015 PFS final rule with comment period (79 FR 67547), we finalized a new process for establishing values for new, revised and potentially misvalued codes. Under the new process, we include proposed values for these services in the proposed rule, rather than establishing them as interim final in the final rule with comment period. Beginning with the CY

2017 PFS proposed rule (81 FR 46162), the new process was applicable to all codes, except for new codes that describe truly new services. For CY 2017, we proposed new values in the CY 2017 PFS proposed rule for the vast majority of new, revised, and potentially misvalued codes for which we received complete RUC recommendations by February 10, 2016. To complete the transition to this new process, for codes for which we established interim final values in the CY 2016 PFS final rule with comment period (81 FR 80170), we reviewed the comments received during the 60-day public comment period following release of the CY 2016 PFS final rule with comment period (80 FR 70886), and re-proposed values for those codes in the CY 2017 PFS proposed rule. We considered public comments received during the 60-day public comment period for the proposed rule before establishing final values in the CY 2017 PFS final rule. As part of our established process, we will adopt interim final values only in the case of wholly new services for which there are no predecessor codes or values and for which we do not receive recommendations in time to propose values.

As part of our obligation to establish RVUs for the PFS, we thoroughly review and consider available information including recommendations and supporting information from the RUC, the Health Care Professionals Advisory Committee (HCPAC), public commenters, medical literature, Medicare claims data, comparative databases, comparison with other codes within the PFS, as well as consultation with other physicians and healthcare professionals within CMS and the Federal Government as part of our process for establishing valuations. Where we concur that the RUC's recommendations, or recommendations from other commenters, are reasonable and appropriate and are consistent with the time and intensity paradigm of physician work, we proposed those values as recommended. Additionally, we continually engage with interested parties, including the RUC, regarding our approach for accurately valuing codes, and as we prioritize our obligation to value new, revised, and potentially misvalued codes. We continue to welcome feedback from all interested parties regarding valuation of services for consideration through our rulemaking process.

2. Methodology for Establishing Work RVUs

a. Background

For each code identified in this section, we conduct a review that includes the current work RVU (if any), RUC-recommended work RVU, intensity, time to furnish the preservice, intraservice, and postservice activities, as well as other components of the service that contribute to the value. Our reviews of recommended work RVUs and time inputs generally include, but have not been limited to, a review of information provided by the RUC, the HCPAC, and other public commenters, medical literature, and comparative databases, as well as a comparison with other codes within the PFS, consultation with other physicians and health care professionals within CMS and the Federal Government, as well as Medicare claims data. We also assess the methodology and data used to develop the recommendations submitted to us by the RUC and other public commenters and the rationale for the recommendations. In the CY 2011 PFS final rule with comment period (75 FR 73328 through 73329), we discussed a variety of methodologies and approaches used to develop work RVUs, including survey data, building blocks, crosswalks to key reference or similar codes, and magnitude estimation (see the CY 2011 PFS final rule with comment period (75 FR 73328 through 73329) for more information). When referring to a survey, unless otherwise noted, we mean the surveys conducted by specialty societies as part of the formal RUC process.

Components that we use in the building block approach may include preservice, intraservice, or postservice time and post-procedure visits. When referring to a bundled CPT code, the building block components could include the CPT codes that make up the bundled code and the inputs associated with those codes. We use the building block methodology to construct, or deconstruct, the work RVU for a CPT code based on component pieces of the code. Magnitude estimation refers to a methodology for valuing work that determines the appropriate work RVU for a service by gauging the total amount of work for that service relative to the work for a similar service across the PFS without explicitly valuing the components of that work. In

addition to these methodologies, we frequently utilize an incremental methodology in which we value a code based upon its incremental difference between another code and another family of codes. Section 1848(c)(1)(A) of the Act specifically defines the work component as the resources that reflect time and intensity in furnishing the service. Also, the published literature on valuing work has recognized the key role of time in overall work. For particular codes, we refine the work RVUs in direct proportion to the changes in the best information regarding the time resources involved in furnishing particular services, either considering the total time or the intraservice time.

Several years ago, to aid in the development of preservice time recommendations for new and revised CPT codes, the RUC created standardized preservice time packages. The packages include preservice evaluation time, preservice positioning time, and preservice scrub, dress and wait time. Currently, there are preservice time packages for services typically furnished in the facility setting (for example, preservice time packages reflecting the different combinations of straightforward or difficult procedure, and straightforward or difficult patient). Currently, there are three preservice time packages for services typically furnished in the non-facility setting.

We have developed several standard building block methodologies to value services appropriately when they have common billing patterns. For example, in cases where a service is typically furnished to a beneficiary on the same day as an E/M service, we believe that there is overlap between the two services in some of the activities furnished during the preservice evaluation and postservice time. Our longstanding adjustments have reflected a broad assumption that at least one-third of the work time in both the preservice evaluation and postservice period is duplicative of work furnished during the E/M visit.

Accordingly, in cases where we believe that the RUC has not adequately accounted for the overlapping activities in the recommended work RVU and/or times, we adjust the work RVU and/or times to account for the overlap. The work RVU for a service is the product of the time involved in furnishing the service multiplied by the intensity of the work. Preservice evaluation

time and postservice time both have a long-established intensity of work per unit of time (IWPUT) of 0.0224, which means that 1 minute of preservice evaluation or postservice time equates to 0.0224 of a work RVU.

Therefore, in many cases when we remove 2 minutes of preservice time and 2 minutes of postservice time from a procedure to account for the overlap with the same day E/M service, we also remove a work RVU of 0.09 (4 minutes × 0.0224 IWPUT) if we do not believe the overlap in time had already been accounted for in the work RVU. The RUC has recognized this valuation policy and, in many cases, now addresses the overlap in time and work when a service is typically furnished on the same day as an E/M service.

The following paragraphs discuss our approach to reviewing RUC recommendations and developing proposed values for specific codes. When they exist, we also include a summary of interested party reactions to our approach. We noted that many commenters and interested parties have expressed concern over the years with our ongoing adjustment of work RVUs based on changes in the best information we had regarding the time resources involved in furnishing individual services. We have been particularly concerned with the RUC's and various specialty societies' objections to our approach given the significance of their recommendations to our process for valuing services and since much of the information we use to make the adjustments is derived from their survey process. We note that we are obligated under the statute to consider both time and intensity in establishing work RVUs for PFS services. As explained in the CY 2016 PFS final rule with comment period (80 FR 70933), we recognize that adjusting work RVUs for changes in time is not always a straightforward process, so we have applied various methodologies to identify several potential work values for individual codes.

We observed that for many codes reviewed by the RUC, recommended work RVUs have appeared to be incongruous with recommended assumptions regarding the resource costs in time. This has been the case for a significant portion of codes for which we recently established or proposed work RVUs that are based on refinements to the RUC-recommended values. When we

adjusted work RVUs to account for significant changes in time, we started by looking at the change in the time in the context of the RUC-recommended work RVU. When the recommended work RVUs do not appear to account for significant changes in time, we employed different approaches (including survey data, building blocks, crosswalks to key reference or similar codes, and magnitude estimation) to identify potential values that reconcile the recommended work RVUs with the recommended time values. Many of these methodologies, such as survey data, building block, crosswalks to key reference or similar codes, and magnitude estimation have long been used in developing work RVUs under the PFS. In addition to these, we sometimes use the relationship between the old time values and the new time values for particular services to identify alternative work RVUs based on changes in time components.

In so doing, rather than ignoring the RUC-recommended value, we used the recommended values as a starting reference and then applied one of these several methodologies to account for the reductions in time that we believe were not otherwise reflected in the RUC-recommended value. If we believe that such changes in time are already accounted for in the RUC's recommendation, then we do not make such adjustments. Likewise, we do not arbitrarily apply time ratios to current work RVUs to calculate proposed work RVUs. We use the ratios to identify potential work RVUs and consider these work RVUs as potential options relative to the values developed through other options.

While we do not believe that the decrease in time as reflected in survey values should always equate to a one-to-one or linear decrease in newly valued work RVUs, we do believe that, since the two components of work are time and intensity, absent an obvious or explicitly stated rationale for why the relative intensity of a given procedure has increased, significant decreases in time should be reflected in decreases to work RVUs although not necessarily in a linear manner. If the RUC's recommendation has appeared to disregard or dismiss the changes in time, without a persuasive explanation of why such a change should not be accounted for in the overall

work of the service, then we generally used one of the aforementioned methodologies to identify potential work RVUs, including the methodologies intended to account for the changes in the resources involved in furnishing the procedure (such as building blocks or crosswalks to key reference or similar codes).

Several interested parties, including the RUC, have expressed general objections to our use of these methodologies and suggested that our actions in adjusting the recommended work RVUs are inappropriate; other interested parties have also expressed general concerns with CMS refinements to RUC-recommended values in general. In the CY 2017 PFS final rule (81 FR 80272 through 80277), we responded in detail to several comments that we received regarding this issue. In the CY 2017 PFS proposed rule (81 FR 46162), we requested comments regarding potential alternatives to making adjustments that would recognize overall estimates of work in the context of changes in the resource of time for particular services; however, we did not receive any specific potential alternatives. As described earlier in this section, crosswalks to key reference or similar codes are one of the many methodological approaches we employed to identify potential values that reconcile the RUC-recommended work RVUs with the recommended time values when the RUC-recommended work RVUs did not appear to account for significant changes in time.

We have historically relied on survey data provided by the American Medical Association (AMA)/Specialty Society Relative Value Scale (RVS) Update Committee (referred to as the RUC) to estimate practitioner time, work intensity, and practice expense for the purpose of establishing RVUs for the codes used for payment under the PFS. As described in section II.C. of this proposed rule, CMS regularly revalues codes as part of its potentially misvalued codes initiative, as required by section 1848(c)(2)(K) of the Act, using RUC survey data that shows clinicians' estimates of how long a particular service takes to complete. In the CY 2025 PFS final rule, we summarized public comments that we had received expressing concerns with using RUC data as a source of valuation and identifying a need for empirical data in the context

of valuing advanced primary care management services (89 FR 97898). In response to these comments, we indicated that we were open to alternative recommendations for how to price these and other services, and that we would consider all options presented to us with a preference for information with empirical evidence behind it. We also reminded commenters that we do not exclusively rely on RUC recommendations and can receive data and recommendations from other outside sources as well.

In the CY 2019 PFS final rule (83 FR 59515), in response to comments, we clarified that terms ‘‘reference services,’’ ‘‘key reference services,” and ‘‘crosswalks’’ as described by the commenters are part of the RUC’s process for code valuation. These are not terms that we created, and we do not agree that we necessarily must employ them in the identical fashion for the purpose of discussing our valuation of individual services that come up for review. However, in the interest of minimizing confusion and providing clear language to facilitate feedback from interested parties, we stated that we would seek to limit the use of the term, ‘‘crosswalk,’’ to those cases where we made a comparison to a CPT code with the identical work RVU (83 FR 59515). We noted that we also occasionally make use of a ‘‘bracket’’ for code valuation. A ‘‘bracket’’ refers to when a work RVU falls between the values of two CPT codes, one at a higher work RVU and one at a lower work RVU.

We look forward to continuing to engage with interested parties and commenters, including the RUC, as we prioritize our obligation to value new, revised, and potentially misvalued codes; and we will continue to welcome feedback from all interested parties regarding valuation of services for consideration through our rulemaking process. We refer readers to the detailed discussion in this section of the valuation considered for specific codes. Table A–DX contains a list of codes and descriptors for which we proposed work RVUs for CY 2027; this includes all codes for which we received RUC recommendations by February 10, 2026. The proposed work RVUs, work time and other payment information for all CY 2027 payable codes are available on the CMS website under downloads for the CY 2027 PFS proposed rule at

https://www.cms.gov/Medicare/Medicare-Feefor-ServicePayment/PhysicianFeeSched/index.html).

b. Efficiency Adjustment

In the CY 2026 final rule, we finalized the establishment of an efficiency adjustment to the work RVUs, as well as corresponding updates to the intraservice portion of physician time inputs for non-time-based services, with refinements (90 FR 49334 through 49345). We finalized a policy to apply this efficiency adjustment to the intraservice portion of physician time and work RVUs every 3 years. To calculate the efficiency adjustment, we finalized the use of the MEI productivity adjustment over a 5-year look back period from CY 2022 to CY 2026. We noted that using more recent historical data from the BLS yielded an efficiency adjustment of 3.6 percent. As we discussed in the CY 2026 PFS proposed rule, our approach in applying an efficiency adjustment was to take into account changes in medical practice and to better reflect resources involved, and it was designed to be conservative in nature, as we were concerned about making too many changes at once to the current methodology. Therefore, we finalized the proposed efficiency adjustment of 2.5 percent. We also exempted additional codes, specifically time-based codes, services on the CMS telehealth list, and new codes for CY 2026, as reflected in the Codes Subject to Efficiency Adjustment file. This file with efficiency adjustment exemptions is issued annually and can be found in the public use files for CY 2027; the file is available on the CMS website under downloads for the CY 2027 PFS proposed rule at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html*. For a full discussion of the efficiency adjustment, we direct readers to the CY 2026 PFS final rule (90 FR 49334 through 49345).

For CY 2027 rulemaking, the RUC made a number of work RVU recommendations prior to the finalization of the efficiency adjustment in the CY 2026 PFS final rule. In these cases, where the RUC's work RVU recommendation was based on a pre-adjusted work RVU, we have treated the recommendation as though the RUC had recommended the efficiency adjusted

valuation. For example, the RUC initially recommended a work RVU of 0.35 for CPT code 95XX4 based on a crosswalk to the pre-adjusted work RVU of CPT code 95885. The work RVU of this crosswalk code became 0.34 after applying the efficiency adjustment, which we have used as the recommended valuation for CPT code 95XX4. This policy affected a relatively small number of the codes reviewed for CY 2027, and we have noted in the preamble where the efficiency adjustment affected a work valuation.

3. Methodology for the Direct PE Inputs to Develop PE RVUs

a. Background

On an annual basis, the RUC provides us with recommendations regarding PE inputs for new, revised, and potentially misvalued codes. We review the RUC-recommended direct PE inputs on a code-by-code basis. Like our review of recommended work RVUs, our review of recommended direct PE inputs generally includes, but is not limited to, a review of information provided by the RUC, HCPAC, and other public commenters, medical literature, and comparative databases, as well as a comparison with other codes within the PFS, and consultation with physicians and health care professionals within CMS and the Federal Government, as well as Medicare claims data. We also assess the methodology and data used to develop the recommendations submitted to us by the RUC and other public commenters and the rationale for the recommendations. When we determine that the RUC's recommendations appropriately estimate the direct PE inputs (clinical labor, disposable supplies, and medical equipment) required for the typical service, are consistent with the principles of relativity, and reflect our payment policies, we use those direct PE inputs to value a service. If not, we refine the recommended PE inputs to better reflect our estimate of the PE resources required for the service. We also confirm whether CPT codes should have facility and/or non-facility direct PE inputs and refine the inputs accordingly.

Our review and refinement of the RUC-recommended direct PE inputs includes many refinements that are common across codes, as well as refinements that are specific to particular

services. Table A-D11 details our refinements of the RUC's direct PE recommendations at the code-specific level. In section II.B. of this proposed rule, Determination of Practice Expense Relative Value Units (PE RVUs), we address certain refinements that will be common across codes. Refinements to particular codes are addressed in the portions of that section that are dedicated to particular codes. We note that for each refinement, we indicate the impact on direct costs for that service. We note that, on average, in any case where the impact on the direct cost for a particular refinement is $0.35 or less, the refinement has no impact on the PE RVUs. This calculation considers both the impact on the direct portion of the PE RVU, as well as the impact on the indirect allocator for the average service. In this proposed rule, we also note that many of the refinements listed in Table A-D11 result in changes under the $0.35 threshold and would be unlikely to result in a change to the RVUs.

We note that the proposed direct PE inputs for CY 2027 are displayed in the CY 2027 direct PE input files, available on the CMS website under the downloads for the CY 2027 PFS proposed rule at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html*. The inputs displayed there have been used in developing the CY 2027 PE RVUs as displayed in Addendum B (see *https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/addendum-a-b-updates*).

b. Common Refinements

(1) Changes in Work Time

Some direct PE inputs are directly affected by revisions in work time. Specifically, changes in the intraservice portions of the work time and changes in the number or level of postoperative visits associated with the global periods result in corresponding changes to direct PE inputs. The direct PE input recommendations generally correspond to the work time values associated with services. We believe that inadvertent discrepancies between work time values

and direct PE inputs should be refined or adjusted in the establishment of proposed direct PE inputs to resolve the discrepancies.

(2) Equipment Time

Prior to CY 2010, the RUC did not generally provide CMS with recommendations regarding equipment time inputs. In CY 2010, in the interest of ensuring the greatest possible degree of accuracy in allocating equipment minutes, we requested that the RUC provide equipment times along with the other direct PE recommendations, and we provided the RUC with general guidelines regarding appropriate equipment time inputs. We appreciate the RUC's willingness to provide us with these additional inputs as part of its PE recommendations.

In general, the equipment time inputs correspond to the service period portion of the clinical labor times. We clarified this principle over several years of rulemaking, indicating that we consider equipment time as the time within the intraservice period when a clinician is using the piece of equipment plus any additional time that the piece of equipment is not available for use for another patient due to its use during the designated procedure. For those services for which we allocate cleaning time to portable equipment items, because the portable equipment does not need to be cleaned in the room where the service is furnished, we do not include that cleaning time for the remaining equipment items, as those items and the room are both available for use for other patients during that time. In addition, when a piece of equipment is typically used during follow-up postoperative visits included in the global period for a service, the equipment time will also reflect that use.

We believe that certain highly technical pieces of equipment and equipment rooms are less likely to be used during all of the preservice or postservice tasks performed by clinical labor staff on the day of the procedure (the clinical labor service period) and are typically available for other patients even when one member of the clinical staff may be occupied with a preservice or postservice task related to the procedure. We also noted that we believe these same assumptions will apply to inexpensive equipment items that are used in conjunction with and located in a

room with non-portable highly technical equipment items since any items in the room in question will be available if the room is not being occupied by a particular patient. For additional information, in that rule we referred readers to our discussion of these issues in the CY 2012 PFS final rule with comment period (76 FR 73182) and the CY 2015 PFS final rule with comment period (79 FR 67639).

(3) Standard Tasks and Minutes for Clinical Labor Tasks

In general, the preservice, intraservice, and postservice clinical labor minutes associated with clinical labor inputs in the direct PE input database reflect the sum of particular tasks described in the information that accompanies the RUC-recommended direct PE inputs, commonly called the "PE worksheets." For most of these described tasks, there is a standardized number of minutes, depending on the type of procedure, its typical setting, its global period, and the other procedures with which it is typically reported. The RUC sometimes recommends a number of minutes either greater than or less than the time typically allotted for certain tasks. In those cases, we review the deviations from the standards and any rationale provided for the deviations. When we do not accept the RUC-recommended exceptions, we refine the proposed direct PE inputs to conform to the standard times for those tasks. In addition, in cases when a service is typically billed with an E/M service, we remove the preservice clinical labor tasks to avoid duplicative inputs and to reflect the resource costs of furnishing the typical service.

We refer readers to section II.B. of this proposed rule, Determination of Practice Expense Relative Value Units (PE RVUs), for more information regarding the collaborative work of CMS and the RUC in improvements in standardizing clinical labor tasks.

(4) Recommended Items that are not Direct PE Inputs

In some cases, the PE worksheets included with the RUC's recommendations include items that are not clinical labor, disposable supplies, or medical equipment or that cannot be allocated to individual services or patients. We addressed these kinds of recommendations in

previous rulemaking (78 FR 74242), and we do not use items included in these recommendations as direct PE inputs in the calculation of PE RVUs.

(5) New Supply and Equipment Items

The RUC generally recommends the use of supply and equipment items that already exist in the direct PE input database for new, revised, and potentially misvalued codes. However, some recommendations include supply or equipment items that are not currently in the direct PE input database. In these cases, the RUC has historically recommended that a new item be created and has facilitated our pricing of that item by working with the specialty societies to provide us copies of sales invoices. For CY 2027 we received invoices for several new supply and equipment items. Tables A-D11 and A-D12 detail the invoices received for new and existing items in the direct PE database. As discussed in section II.B. of this proposed rule, Determination of Practice Expense Relative Value Units, we encourage interested parties to review the prices associated with these new and existing items to determine whether these prices appear to be accurate. Where prices appear inaccurate, we encourage interested parties to submit invoices or other information to improve the accuracy of pricing for these items in the direct PE database by February 10th of the following year for consideration in future rulemaking, similar to our process for consideration of RUC recommendations.

We remind interested parties that due to the relativity inherent in the development of RVUs, reductions in existing prices for any items in the direct PE database increase the pool of direct PE RVUs available to all other PFS services. Tables A-D11 and A-D12 also include the number of invoices received and the number of non-facility allowed services for procedures that use these equipment items. We provide the non-facility allowed services so that interested parties will note the impact the particular price may have on PE relativity, as well as to identify items that are used frequently, since we believe that interested parties are more likely to have better pricing information for items used more frequently. A single invoice may not be reflective

of typical costs, and we encourage interested parties to provide additional invoices so that we may identify and use accurate prices in the development of PE RVUs.

In some cases, we do not use the price listed on the invoice that accompanies the recommendation because we identify publicly available alternative prices or information that suggests a different price is more accurate. In these cases, we include this in the discussion of these codes. In other cases, we cannot adequately price a newly recommended item due to inadequate information. Sometimes, no supporting information regarding the price of the item has been included in the recommendation. In other cases, the supporting information does not demonstrate that the item has been purchased at the listed price (for example, vendor price quotes instead of paid invoices). In cases where the information provided on the item allows us to identify clinically appropriate proxy items, we may use existing items as proxies for the newly recommended items. In other cases, we include the item in the direct PE input database without any associated price. Although including the item without an associated price means that the item does not contribute to the calculation of the proposed PE RVU for particular services, it facilitates our ability to incorporate a price once we obtain information and are able to do so.

(6) Service Period Clinical Labor Time in the Facility Setting

Generally speaking, our direct PE inputs do not include clinical labor minutes assigned to the service period because the cost of clinical labor during the service period for a procedure in the facility setting is not considered a resource cost to the practitioner since Medicare makes separate payment to the facility for these costs. We address code-specific refinements to clinical labor in the individual code sections.

(7) Procedures Subject to the Multiple Procedure Payment Reduction (MPPR) and the Outpatient Prospective Payment System (OPPS) Cap

We note that the list of services for the upcoming calendar year that are subject to the MPPR for diagnostic cardiovascular services, diagnostic imaging services, diagnostic ophthalmology services, and therapy services are displayed in the public use files for the PFS

proposed and final rules for each year. In addition, the list of procedures that meet the definition of imaging under section 1848(b)(4)(B) of the Act, and therefore, are subject to the OPPS cap, are also displayed in the public use files for the PFS proposed and final rules for each year. The public use files for CY 2027 are available on the CMS website under downloads for the CY 2027 PFS final rule at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html*. For more information regarding the history of the MPPR policy, we referred readers to the CY 2014 PFS final rule with comment period (78 FR 74261 through 74263).

Effective January 1, 2007, section 5102(b)(1) of the Deficit Reduction Act of 2005 (DRA) (Pub. L. 109–171, enacted on February 8, 2006) amended section 1848(b)(4) of the Act to require that, for imaging services, if— (i) The technical component (TC) (including the TC portion of a global fee) of the service established for a year under the fee schedule without application of the geographic adjustment factor, exceeds (ii) The Medicare outpatient department (OPD) fee schedule amount established under the prospective payment system (PPS) for hospital OPD services under section 1833(t)(3)(D) of the Act for such service for such year, determined without regard to geographic adjustment under section 1833(t)(2)(D) of the Act, the Secretary shall substitute the amount described in clause (ii), adjusted by the geographic adjustment factor under the PFS, for the fee schedule amount for such TC for such year. As required by section 1848(b)(4)(A) of the Act, for imaging services furnished on or after January 1, 2007, we cap the TC of the PFS payment amount for the year (prior to geographic adjustment) by the Outpatient Prospective Payment System (OPPS) payment amount for the service (prior to geographic adjustment). We then apply the PFS geographic adjustment to the capped payment amount. Section 1848(b)(4)(B) of the Act defines imaging services as "imaging and computer-assisted imaging services, including X-ray, ultrasound (including echocardiography), nuclear medicine (including PET), magnetic resonance imaging (MRI), computed tomography (CT), and fluoroscopy, but excluding diagnostic and screening mammography." For more information

regarding the history of the cap on the TC of the PFS payment amount under the DRA (the "OPPS cap"), we referred readers to the CY 2007 PFS final rule with comment period (71 FR 69659 through 69662).

For CY 2027, we identified new and revised codes to determine which services meet the definition of "imaging services" as defined at section 1848(b)(4)(B) of the Act for purposes of this cap. Beginning for CY 2027, we are proposing to include the following services in Table A-D1 on the list of codes to which the OPPS cap applies:

TABLE A-D1: CY 2027 PROPOSED CODE ADDITIONS TO THE OPPS CAP LIST

CPT Code	CPT Long Descriptor
70XX4	*Magnetic resonance angiography, head and neck, including image postprocessing; without contrast material(s)*
70XX5	*Magnetic resonance angiography, head and neck, including image postprocessing; with contrast material(s)*
70XX6	*Magnetic resonance angiography, head and neck; without contrast material(s) in one or both body regions, followed by contrast material(s) and further sequences in one or both body regions, including image postprocessing*
976XX	*Real-time fluorescence wound imaging with clinical darkness to identify presence, location, load of bacteria and measure wound size, per day*
92978	*Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel (List separately in addition to code for primary procedure)*
92979	*Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; each additional vessel (List separately in addition to code for primary procedure)*

We believe that these codes meet the definition of imaging services under section 1848(b)(4)(B) of the Act, and thus, should be subject to the OPPS cap.

c. Valuation of Specific Codes for CY 2027

(1) Fine Needle Aspiration (CPT codes 10005 and 10006)

The RUC received notification of interest from a specialty society to re-review CPT codes 10005 (*Fine needle aspiration biopsy, including ultrasound guidance; first lesion*) and 10006 (*Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion*) at the January 2026 meeting.

We are proposing the RUC-recommended work RVUs of 1.35 for CPT code 10005 and 1.00 for 10006.

We are proposing the RUC recommended direct PE inputs for CPT codes 10005 and 10006 with one modification. The RUC submitted an invoice associated with this code family

for an update in the price of the portable ultrasound (EQ250) equipment from its current price of $41,612.53 to $83,750.00. However, based on our review of current market pricing for portable ultrasounds, it appears that this type of equipment is becoming less expensive, not doubling in price over current . We also have reason to believe that the type of portable ultrasound listed on the submitted invoice represented the upper end of the market as opposed to the typical case. This invoice stated that the product in question constitutes "a high-performance diagnostic ultrasound system" including a 23-inch flat panel monitor. It is also not clear from the submitted invoice that the product in question is even a portable version of an ultrasound system. Given that the price on this invoice was significantly higher than other portable ultrasounds available for purchase, we are not proposing to update the price of the EQ250 portable ultrasound which is used in many other HCPCS codes. Instead, we are proposing to create a new equipment item that describes a "Fine Needle Aspiration portable ultrasound" (ER130) which we propose to price at the submitted $83,750.00 price. The ER130 equipment is proposed to replace the previous EQ250 portable ultrasound at the same 37 minutes for CPT code 10005 and 17 minutes for CPT code 10006 as recommended by the RUC.

(2) Skin Cell Suspension Autograft (CPT codes 15X19, 15X20, 15X21, and 15X22)

In September 2025, the CPT Editorial Panel created four codes to report skin cell suspension autograft (SCSA): CPT code 15X19 *(Skin cell suspension autograft (SCSA), trunk, arms, and/or legs; first 100 sq cm or less, or 1% of body area of infants and children),* CPT code 15X20 *(Skin cell suspension autograft (SCSA), trunk, arms, and/or legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)),* CPT code 15X21 *(Skin cell suspension autograft (SCSA), face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children),* and CPT code 15X22 *(Skin cell suspension autograft (SCSA), face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body*

area of infants and children, or part thereof (List separately in addition to code for primary procedure)). The existing eight skin cell suspension autograft CPT codes (CPT codes 15011-15018) were deleted, and the "Skin Cell Suspension Autograft" guidelines were revised. The four new codes were surveyed for the January 2026 RUC meeting.

For CY 2027, we are proposing the RUC-recommended work RVUs of 10.97 for CPT code 15X19, 0.59 for CPT code 15X20, 11.28 for CPT code 15X21, and 0.98 for CPT code 15X22. We are proposing the RUC-recommended direct PE inputs for CPT codes 15X19, 15X20, 15X21, and 15X22 without refinement.

(3) Computer Assisted Surgical Navigation (CPT code 20985)

CPT code 20985 *(Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (List separately in addition to code for primary procedure))* was first identified via the high-volume growth screen in April 2024.[1] The RUC's Relativity Assessment Workgroup (RAW) reviewed the action plan for 20985 and recommended that the RUC refer CPT code 20985 to the CPT Editorial Panel for revision, to modify the descriptor and address overlap with codes 0054T and 0055T. At the February 2025 CPT Editorial Panel meeting, CPT code 20985 was revised to remove "image-less" for reporting computer-assisted surgical navigational procedures for musculoskeletal procedures.

We are proposing the RUC-recommended work RVU of 2.44, which is the current work RVU of CPT code 20985 after the efficiency adjustment was applied at the start of CY 2026. The RUC did not recommend and we are not proposing direct PE inputs for CPT code 20985.

(4) Ablation Therapy – Bone Tumors (CPT code 209XX)

In February 2025, the CPT Editorial Panel approved new Category I add-on code 209XX (*Ablation therapy for reduction or eradication of bone tumor, including adjacent soft tissue when involved by tumor extension, cryoablation, open*) to describe and report cryoablation during an open surgical procedure where the bone is frozen after a tumor resection. CPT code 209XX was

[1] *https://www.ama-assn.org/system/files/raw-progress-report.pdf.*

surveyed for the April 2025 meeting where the specialty recommended an interim value; the code was resurveyed at the September 2025 RUC meeting and recommendations submitted to CMS.

We are proposing the RUC-recommended work RVU of 2.70 for CPT code 209XX. The RUC did not recommend and we are not proposing any direct PE inputs for this code.

(5) Intraosseous Fiducial Marker Placement (CPT codes 209X1 and 209X2)

At the May 2025 CPT Editorial Panel Meeting, CPT approved the addition of two codes and guidelines to report percutaneous intraosseous fiducial marker placement for the first target site and each additional target site, respectively: CPT codes 209X1 (*Placement of localization marker(s) (eg, fiducial marker[s]), intraosseous, percutaneous, including imaging guidance, when performed; first target site)* and 209X2 *(Placement of localization marker(s) (eg, fiducial marker[s]), intraosseous, percutaneous, including imaging guidance, when performed; each additional target site)* . The specialties clarified that these codes are not new technology but are new codes to more accurately describe existing technology. These codes were surveyed for the October 2025 RUC meeting

We are proposing the RUC-recommended work RVU of 3.00 for CPT code 209X1 and the RUC-recommended work RVU of 1.76 for CPT code 209X2.

We are proposing the RUC-recommended direct PE inputs for both codes in the family without refinement.

(6) Osteotomy – Spine (CPT codes 22210, 22212, 22214, and 22216)

In CY 2025 rulemaking, CPT codes 22210 (*Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; cervical*), 22212 (*Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; thoracic*), 22214 (*Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar*), and 22216 (*Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; each additional vertebral segment*

(List separately in addition to primary procedure)) were nominated as potentially misvalued services.

At the September 2025 CPT Editorial Panel Meeting, CPT revised the existing codes and guidelines to clarify that the codes include complete resection of the interspinous ligament and the entirety of the ligamentum flavum (ie, laminar and subarticular) to allow deformity correction through spinal column realignment. The osteotomy includes resection of the inferior portion of the lamina, the inferior facet of the cranial vertebra, the superior portion of the lamina, and the superior facet of the caudal vertebra. Following the revisions to the CPT guidelines and parentheticals for the code family, CPT codes 22210, 22212, 22214, and 22216 were surveyed for the January 2026 RUC meeting.

We disagree with the RUC's recommended work RVU for CPT codes 22210, 22212, and 22214 and we are proposing lower work RVUs in all three cases. We reviewed the RUC's recommended work valuations and found them to be high, relative to other codes with the same or similar times. We note that although the surveyed intraservice work time decreased substantially for all three of these codes, the RUC recommended either maintaining the current work RVU (for CPT code 22210) or increasing the work RVU (for CPT codes 22212 and 22214), stating that there was compelling evidence for increased work valuation based on a change in the patient population and a change in technology. However, these services maintained the same code descriptors, with only minor changes to their billing guidelines, indicating that despite the changes in technology and patient population the underlying procedure remains significantly similar. Therefore, we do not agree with the RUC that there has been an increase in intensity which would account for these recommended work RVUs. While we do not believe that the decrease in time as reflected in survey values should always equate to a one-to-one or linear decrease in newly valued work RVUs, we do believe that since the two components of work are time and intensity, absent an obvious or explicitly stated rationale why the relative intensity of a

given procedure has increased, significant decreases in time should be reflected in decreases to work RVUs although not necessarily in a linear manner.

In the case of CPT codes 22210, 22212, and 22214, we believe that the work RVUs should be reduced to account for the significant decreases in surveyed intraservice work time.

Additionally, the postoperative office visit levels in this code family are increasing from three level 2 evaluation and management visits to one level 4 and two level 3 office visits. The shifting of the post-operative visits in this code family to higher level office visit codes that require more time, maintains the total time and thus reflects a higher intensity and can contribute to a higher work RVU which highlights our overall concerns with visits during the global period and how we believe that all of these visits are not typically occurring. We refer readers to section II.B. of this proposed rule under "b. Global Surgical Packages" for that discussion.

We disagree with the RUC recommended value of 24.75 for CPT code 22210 and we are instead proposing a work RVU of 23.12 based on a crosswalk to CPT code 34701 (*Endovascular repair of infrarenal aorta by deployment of an aorto-aortic tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the aortic bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the aortic bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)*). This code has a lower intraservice time and a similar total time. We noticed that the surveyed intraservice time for CPT code 22210 is decreasing by nearly an hour, from 170 minutes to 120 minutes, indicating that the procedure typically takes much less time to perform than it did at the time of last review. Although the RUC has recommended significantly more postoperative time in the inpatient and outpatient visits, which has caused the total time of the procedure to increase slightly, we note that this postoperative care should take place at a significantly lower intensity than the 50 minutes of intraservice time being removed from the code. We are concerned that, while the intraservice

time for CPT code 22210 is decreasing from 170 to 120 minutes, this intraservice work time is being replaced with higher levels of post operative care to result in the total time being maintained similar to the current time. We believe that with the intraservice time going down, this reflects that the procedure has a lesser intensity than before and therefore it does not makes sense that the intensity of the post operative visit levels would increase. Separately, we continue to have concern with the post-operative visits in general and we do not believe the post-operative visits are happening and therefore would not justify the higher value.

We believe that it better serves relativity to propose a work RVU of 23.12, which maintains the current intensity of CPT code 22210, as opposed to proposing the RUC's recommended work RVU of 24.75 which results in an intensity increase for this code. We are supporting this proposed work RVU of 23.12 with a pair of other 90-day global codes with similar work time values: CPT code 34718 *(Endovascular repair of iliac artery, not associated with placement of an aorto-iliac artery endograft at the same session, by deployment of an iliac branched endograft, including pre-procedure sizing and device selection, all ipsilateral selective iliac artery catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally in the internal iliac, external iliac, and common femoral artery(ies), and treatment zone angioplasty/stenting, when performed, for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, penetrating ulcer), unilateral)*, valued at a work RVU of 23.40 with an intraservice time of 120 minutes, and CPT code 34707 *(Endovascular repair of iliac artery by deployment of an ilio-iliac tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally to the iliac bifurcation, and treatment zone angioplasty/stenting, when performed, unilateral; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation))*, valued at a work RVU of 21.72 with an intraservice time of 120 minutes.

We disagree with the RUC recommended value of 23.20 for CPT code 22212 and we are instead proposing a work RVU of 21.72 based on a crosswalk to CPT code 34707. This code has a lower intraservice time and a slightly lower total time. We noticed that the surveyed intraservice time for CPT code 22212 is also decreasing significantly, from 147 minutes to 120 minutes, which is offset by the RUC's recommendation of significantly more time in the postoperative visits. We do not agree with the RUC that the work RVU should be increasing by nearly 3.00 RVUs for a procedure where the intraservice time, which is likely to be the most difficult and dangerous part of the procedure, is going down by approximately half an hour. We believe that the RUC's recommended work RVU of 23.20 results in an intensity increase for this code and therefore it better serves relativity to propose a work RVU of 21.72, which maintains the current intensity of CPT code 22212. This proposed work RVU of 21.72 accounts for the decrease in intraservice time and change in the level of the postoperative office visits and is well bracketed by CPT code 34701, valued at a work RVU of 23.12 work with an intraservice time of 120 minutes, and CPT code 38115 *(Repair of ruptured spleen (splenorrhaphy) with or without partial splenectomy)*, valued at a work RVU of 21.33 with an intraservice time of 120 minutes.

We disagree with the RUC recommended value of 21.72 for CPT code 22214 and we are instead proposing a work RVU of 19.53 based on a crosswalk to CPT code 44125 (*Enterectomy, resection of small intestine; with enterostomy*). This code has a lower intraservice time and a higher total time and its use as a crosswalk code maintains the current intensity of CPT code 22214. As was the case with the first two codes, we noticed that the surveyed intraservice time for CPT code 22214 is decreasing significantly, from 163 minutes to 120 minutes, which is offset by the RUC's recommendation of significantly more time in the postoperative visits. We do not agree with the RUC that the work RVU should be increasing for a procedure where the intraservice time, the most difficult and dangerous part of the procedure, is going down by more than half an hour. We believe that it better serves relativity to propose a work RVU of 19.53, which maintains the current intensity of CPT code 22214, as opposed to proposing the RUC's

recommended work RVU of 21.72 which results in an intensity increase for this code. This proposed work RVU of 19.53 accounts for the decrease in intraservice time and change in the level of the postoperative office visits and is well bracketed by CPT code 38115, valued at a work RVU of 21.33 with an intraservice time of 120 minutes, and CPT code 42890 *(Limited pharyngectomy)*, valued at a work RVU of 18.65 with an intraservice time of 120 minutes.

We are proposing the RUC recommended work RVU of 3.00 for CPT code 22216, as this code maintains its current intensity at the RUC's recommended valuation and maintains relativity with other similar add-on codes.

We are proposing the RUC recommended direct PE inputs for all the codes in this family without refinement.

(7) Arthroplasty – Shoulder (CPT codes 23470 and 23472)

In April 2025, the RAW identified CPT code 23472 as having a site of service anomaly where Medicare data from 2021-2023 indicated it was performed less than 50 percent of the time in the inpatient setting yet included inpatient hospital E/M services within the global period. The RAW concluded that CPT code 23472 represented a site of service anomaly and identified CPT code 23470 as part of this family of services. The RUC therefore surveyed CPT codes 23470 (*Arthroplasty, glenohumeral joint; hemiarthroplasty*) and 23742 (*Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))*) for the September 2025 meeting.

We disagree with the RUC's recommended work RVU of 15.60 for CPT code 23470 and we are instead proposing a work RVU of 13.81 based on a crosswalk to CPT code 27416 (*Osteochondral autograft(s), knee, open (eg, mosaicplasty) (includes harvesting of autograft[s])*). The RUC recommended a work RVU of 15.60, which is the current work RVU of the RUC's crosswalk code 67107 (*Repair of retinal detachment; scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), including, when performed, implant, cryotherapy, photocoagulation, and drainage of subretinal fluid*) after the efficiency

adjustment was applied at the start of CY 2026. In reviewing CPT code 23470, we note that the recommended intraservice time is decreasing from 113 minutes to 90 minutes (20 percent reduction), and the recommended total time is decreasing from 390 minutes to 330 minutes (22 percent reduction); however, the RUC-recommended work RVU is only decreasing from 17.44 to 15.60, which is a reduction of just over 10 percent. While we do not believe that the decrease in time as reflected in survey values should always equate to a one-to-one or linear decrease in newly valued work RVUs we do believe that, since the two components of work are time and intensity, absent an obvious or explicitly stated rationale for why the relative intensity of a given procedure has increased, significant decreases in time should be reflected in decreases to work RVUs although not necessarily in a linear manner.

More specifically, CPT code 23470 was identified by the RAW as having a site of service anomaly in which the service was performed less than 50 percent of the time in the inpatient setting yet included inpatient hospital Evaluation and Management services within the global period. The RUC has recommended the removal of five inpatient hospital visits along with recommending a decrease of 23 minutes to the intraservice work time based on the survey. We do not believe that the RUC's recommended work decrease of fewer than two RVUs appropriately captures this decrease in procedure time and physician work for CPT code 23470. We also noticed that the RUC's recommended work RVU of 15.60 results in an intensity increase for CPT code 23470. We disagree that an increase in intensity for this code is warranted, particularly given that the typical case for the procedure is moving from the inpatient to outpatient setting. The code descriptor for CPT code 23470 also remains unchanged which suggests that there has been no significant change in the procedure's performance or intensity. Furthermore, we also found that the recommended work RVU of 15.60 was higher than nearly all of the other 90 day global codes with similar time values, and we do not believe that this type of shoulder arthroplasty procedure, which is typically done on a routine and elective basis, would warrant an intensity and work valuation at the very top of the scale relative to other 90 day

globals with similar time values. Because the PFS uses a relative value system, we believe it is important to highlight that these codes fail to maintain relativity with related surgical services. We are therefore proposing a work RVU of 13.81 based on a crosswalk to CPT code 27416 which preserves the current intensity of CPT code 23470 and better maintains relativity with the rest of the PFS.

We disagree with the RUC's recommended work RVU of 19.35 for CPT code 23472 and we are instead proposing a work RVU of 17.49 based on a crosswalk to CPT code 67414 (*Orbitotomy without bone flap (frontal or transconjunctival approach); with removal of bone for decompression*). The RUC recommended a work RVU of 19.35, which is the current work RVU of the RUC's crosswalk code 61798 (*Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 complex cranial lesion*) after the efficiency adjustment was applied at the start of CY 2026. In reviewing CPT code 23472, we note that the recommended intraservice time is decreasing from 140 minutes to 120 minutes (15 percent reduction), and the recommended total time is decreasing from 448 minutes to 348 minutes (24 percent reduction); however, the RUC-recommended work RVU is only decreasing from 21.58 to 19.35, which is a reduction of just over 10 percent. While we do not believe that the decrease in time as reflected in survey values should always equate to a one-to-one or linear decrease in newly valued work RVUs we do believe that, since the two components of work are time and intensity, absent an obvious or explicitly stated rationale for why the relative intensity of a given procedure has increased, significant decreases in time should be reflected in decreases to work RVUs although not necessarily in a linear manner.

More specifically, CPT code 23472 was identified by the RAW as having a site of service anomaly in which the service was performed less than 50 percent of the time in the inpatient setting yet included inpatient hospital Evaluation and Management services within the global period. The RUC has recommended the removal of 3 inpatient hospital visits, one outpatient E/M visit, a decrease from a full to a half discharge visit, along with recommending a decrease of 20

minutes to the intraservice work time based on the survey. We do not believe that the RUC's recommended work decrease of just over two RVUs appropriately captures this decrease in procedure time and practitioner work for CPT code 23472. We also noticed that the RUC's recommended work RVU of 19.35 results in an intensity increase for CPT code 23472. We disagree that an increase in intensity for this code is warranted, particularly given that the typical case for the procedure is moving from the inpatient to outpatient setting. The code descriptor for CPT code 23472 also remains unchanged which suggests that there has been no significant change in the procedure's performance or intensity. Furthermore, we also found that the recommended work RVU of 19.35 was higher than nearly all of the other 90 day global codes with similar time values, and we do not believe that this type of total shoulder arthroplasty procedure, which is typically done on a routine and elective basis, would warrant an intensity and work valuation at the very top of the scale relative to other 90 day globals with similar time values. We are therefore proposing a work RVU of 17.49 based on a crosswalk to CPT code 67414 which preserves the current intensity of CPT code 23472 and better maintains relativity with the rest of the PFS.

We are proposing the RUC-recommended direct PE inputs for CPT codes 23470 and 23472 without refinement.

(8) Arthroplasty – Hip (CPT code 27130)

In April 2025, the RAW identified CPT code 27130 as having a site of service anomaly where Medicare data from 2021-2023 indicated it was performed less than 50 percent of the time in the inpatient setting yet included inpatient hospital Evaluation and Management services within the global period. The RAW concluded that the code represented a site of service anomaly, and the RUC therefore surveyed CPT code 27130 (*Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft*) for the September 2025 meeting.

We disagree with the RUC's recommended work RVU of 16.70 for CPT code 27130 and we are instead proposing a work RVU of 15.37 based on a crosswalk to CPT code 43774 (*Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components*). The RUC recommended a work RVU of 16.70, which is the current work RVU of the RUC's crosswalk code 67108 (R*epair of retinal detachment; with vitrectomy, any method, including, when performed, air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique*) after the efficiency adjustment was applied at the start of CY 2026. In reviewing CPT code 27130, we noted that the recommended total time is decreasing from 377 minutes to 305 minutes (19 percent reduction); however, the RUC-recommended work RVU is only decreasing from 19.11 to 16.70, which is a reduction of 13 percent. While we do not believe that the decrease in time as reflected in survey values should always equate to a one-to-one or linear decrease in newly valued work RVUs we do believe that, since the two components of work are time and intensity, absent an obvious or explicitly stated rationale for why the relative intensity of a given procedure has increased, significant decreases in time should be reflected in decreases to work RVUs although not necessarily in a linear manner.

More specifically, CPT code 27130 was identified by the RAW as having a site of service anomaly in which the service was performed less than 50 percent of the time in the inpatient setting yet included inpatient hospital Evaluation and Management services within the global period. The RUC has recommended the removal of 2 inpatient hospital visits, a decrease from a full to a half discharge visit, along with recommending a decrease of 10 minutes to the intraservice work time based on the survey. We do not believe that the RUC's recommended work decrease of just over two RVUs appropriately captures this decrease in procedure time and practitioner work for CPT code 27130. We also noticed that the RUC's recommended work RVU of 16.70 results in an intensity increase for CPT code 27130. We disagree that an increase

in intensity for this code is warranted, particularly given that the typical case for the procedure is moving from the inpatient to outpatient setting. The code descriptor for CPT code 27130 also remains unchanged which suggests that there has been no significant change in the procedure's performance or intensity. Furthermore, we also found that the recommended work RVU of 16.70 was higher than nearly all of the other 90 day global codes with similar time values, and we do not believe that this type of total hip arthroplasty procedure, which is typically done on a routine and elective basis, would warrant an intensity and work valuation at the very top of the scale relative to other 90 day globals with similar time values. We are therefore proposing a work RVU of 15.37 based on a crosswalk to CPT code 43774 which preserves the current intensity of CPT code 27130 and better maintains relativity with the rest of the PFS.

We are proposing the RUC-recommended direct PE inputs for CPT code 27130 without refinement.

(9) Sacroiliac Joint Arthrodesis (CPT codes 27278 and 27279)

At the May 2025 CPT Editorial Panel meeting. CPT code 27278 (*Arthrodesis, sacroiliac joint, percutaneous or minimally invasive, including imaging guidance, unilateral; placement of intra-articular structural bone graft, metal and/or synthetic device(s) without cortical piercing, including use of osteopromotive material and/or obtaining bone graft, when performed*) was revised to include imaging guidance, placement of intra-articular structural bone graft, metal, and/or synthetic device(s) without cortical piercing and CPT code 27279 (*Arthrodesis, sacroiliac joint, percutaneous or minimally invasive, including imaging guidance, unilateral; placement of transarticular and/or intra-articular device(s) that engage bone with intrinsic fixation (eg, screw[s], flange[s], blade[s]) piercing the lateral cortex of the sacrum and the medial cortex of the ilium (with or without piercing the lateral cortex of the ilium), including use of osteopromotive material and/or obtaining bone graft, when performed*) was revised to include placement of transarticular and/or intra-articular device(s) that engage bone with intrinsic fixation (eg, screw(s), flange(s), blade(s)) piercing the lateral cortex of the sacrum and the medial

cortex of the ilium. CPT codes 27278 and 27279 were surveyed for the September 2025 RUC meeting.

We are proposing the RUC-recommended work RVUs of 7.66 for CPT code 27278 (which is the current work RVU of the code after the efficiency adjustment was applied at the start of CY 2026) and 11.00 for CPT code 27279. We are also proposing the RUC-recommended direct PE inputs for CPT codes 27278 and 27279 without refinement.

(10) Arthroplasty – Knee (CPT code 27447)

In April 2025, the RAW identified CPT code 27447 as having a site of service anomaly where Medicare data from 2021-2023 indicated it was performed less than 50 percent of the time in the inpatient setting yet included inpatient hospital Evaluation and Management services within the global period. The RAW concluded that the code represented a site of service anomaly, and the RUC therefore surveyed CPT code 27447 (*Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)*) for the September 2025 meeting.

We disagree with the RUC's recommended work RVU of 16.70 for CPT code 27447 and we are instead proposing a work RVU of 15.94 based on a crosswalk to CPT code 65730 (*Keratoplasty (corneal transplant); penetrating (except in aphakia or pseudophakia)*). The RUC recommended a work RVU of 16.70, which is the current work RVU of the RUC's crosswalk code 67108 (R*epair of retinal detachment; with vitrectomy, any method, including, when performed, air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique*) after the efficiency adjustment was applied at the start of CY 2026. In reviewing CPT code 27447, we noted that the recommended total time is decreasing from 374 minutes to 305 minutes (19 percent reduction); however, the RUC-recommended work RVU is only decreasing from 19.11 to 16.70, which is a reduction of 13 percent. While we do not believe that the decrease in time as reflected in survey values should always equate to a one-to-one or linear decrease in newly valued work RVUs we

do believe that, since the two components of work are time and intensity, absent an obvious or explicitly stated rationale for why the relative intensity of a given procedure has increased, significant decreases in time should be reflected in decreases to work RVUs although not necessarily in a linear manner.

More specifically, CPT code 27447 was identified by the RAW as having a site of service anomaly in which the service was performed less than 50 percent of the time in the inpatient setting yet included inpatient hospital Evaluation and Management services within the global period. The RUC has recommended the removal of two inpatient hospital visits, a decrease from a full to a half discharge visit, along with recommending a decrease of 7 minutes to the intraservice work time based on the survey. We do not believe that the RUC's recommended work decrease of just over two RVUs appropriately captures this decrease in procedure time and practitioner work for CPT code 27447. We also noticed that the RUC's recommended work RVU of 16.70 results in an intensity increase for CPT code 27447. We disagree that an increase in intensity for this code is warranted, particularly given that the typical case for the procedure is moving from the inpatient to outpatient setting. The code descriptor for CPT code 27447 also remains unchanged which suggests that there has been no significant change in the procedure's performance or intensity. Furthermore, we also found that the recommended work RVU of 16.70 was higher than nearly all of the other 90 day global codes with similar time values, and we do not believe that this type of total knee arthroplasty procedure, which is typically done on a routine and elective basis, would warrant an intensity and work valuation at the very top of the scale relative to other 90 day globals with similar time values. We are therefore proposing a work RVU of 15.94 based on a crosswalk to CPT code 65730 which preserves the current intensity of CPT code 27447 and better maintains relativity with the rest of the PFS.

We are proposing the RUC-recommended direct PE inputs for CPT code 27447 without refinement.

(11) Implantation of Extra-articular Shock Absorber – Medial Knee (CPT code 27X05)

At the September 2025 CPT Editorial Panel Meeting, CPT created a new Category I code to describe the implantation of a medial knee extra-articular shock absorber. CPT code 27X05 (*Implantation of medial knee extra-articular shock absorber, including fluoroscopic guidance)* was surveyed at the January 2026 RUC meeting.

We are proposing the RUC-recommended work RVU of 13.16 for CPT code 27X05. We are proposing the RUC-recommended direct PE inputs for CPT code 27X05 without refinement.

(12) Osteochondral Acellular Scaffold Implantation, Knee (CPT code 27XX8)

At the September 2025 CPT Editorial Panel Meeting, CPT created a new Category I CPT code 27XX8 (*Acellular scaffold(s) (eg, aragonite) implant(s), for osteochondral lesion(s), knee, open*), which describes open cartilage knee repair procedures with an acellular scaffold implant. Based on the inorganic nature of these implants, the CPT Editorial Panel included the term "acellular scaffold" in the code descriptor for 27XX8, as it is a more comprehensive term and further defines the types of regenerative implants being used that are neither autologous nor allogenic. The CPT Editorial Panel did not request deletion for existing Category III code 0737T, which is currently being reported for this procedure, since it may appropriately describe procedures with this type of implant joints other than the knee. CPT code 27XX8 was surveyed for the January 2026 RUC meeting.

We are proposing the RUC-recommended work RVU of 9.53 for CPT code 27XX8.We are proposing the RUC-recommended direct PE inputs for CPT code 27XX8 without refinement.

(13) Cardiac Contractility Modulation (CPT codes 33X01, 33X02, 33X03, 33X04, 33X05, 33X06, 33X07, 33X08, 33X09, 33X10, 33X11, 93X01, 93X02, 93X03, and 93X04)

In May 2025, the CPT Editorial Panel approved a new family of 11 Category I CPT codes for insertion, removal, and replacement of cardiac contractility modulation (CCM) systems, generators, and leads in several combinations. A separate set of four codes was created to describe the corresponding CCM programming, interrogation, and remote interrogation services. All 11 of the insertion, removal, and replacement/repositioning/revision CCM codes, as

well as three programming, interrogation, and remote interrogation CCM services that involve physician work, were surveyed for the September 2025 RUC meeting.

The specialty societies detailed the four code subsets within the CCM code family. These include CCM insertion services: CPT codes 33X01 (*Insertion of permanent cardiac contractility modulation system, including fluoroscopic guidance and programming of sensing and therapeutic parameters, with evaluation when performed; pulse generator and transvenous electrodes*), 33X02 (*Insertion of permanent cardiac contractility modulation system, including fluoroscopic guidance and programming of sensing and therapeutic parameters, with evaluation when performed; pulse generator only*), 33X03 (*Insertion of permanent cardiac contractility modulation system, including fluoroscopic guidance and programming of sensing and therapeutic parameters, with evaluation when performed; transvenous electrode, single*), and 33X04 (*Insertion of permanent cardiac contractility modulation system, including fluoroscopic guidance and programming of sensing and therapeutic parameters, with evaluation when performed; transvenous electrode, dual*); CCM removal services: CPT code 33X05 (*Removal of a permanent cardiac contractility modulation system; pulse generator and transvenous electrodes*), 33X06 (*Removal of a permanent cardiac contractility modulation system; pulse generator only*), 33X07 (*Removal of a permanent cardiac contractility modulation system; transvenous electrode, single*), and 33X08 (*Removal of a permanent cardiac contractility modulation system; transvenous electrode, dual*); CCM replacement, repositioning, and revision services: CPT code 33X09 (*Removal and replacement of permanent cardiac contractility modulation system, pulse generator only*), 33X10 (*Repositioning of previously implanted cardiac contractility modulation transvenous electrode(s), including fluoroscopic guidance and programming of sensing and therapeutic parameters*), and 33X11 (*Relocation or revision of skin pocket for implanted cardiac contractility modulation pulse generator*); and CCM programming, interrogation, and remote interrogation services: CPT code 93X01 (*Programming of the cardiac contractility modulation system (in person) with iterative adjustment of the implantable device to*

test the function of the device and select optimal permanent programmed values with analysis, including review and report by a physician or other qualified health care professional), 93X02 (*Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified healthcare professional, includes connection, recording and disconnection per patient encounter, implantable cardiac contractility modulation system*), 93X03 (*Interrogation device evaluation (remote), up to 90 days, cardiac contractility modulation system with interim analysis, review and report(s) by a physician or other qualified health care professional*), and 93X04 (*Interrogation device evaluation (remote), up to 90 days, cardiac contractility modulation system, remote data acquisition(s), receipt of transmissions, technician review, technical support, and distribution of results*).

We are proposing the RUC-recommended work RVU for all of the codes in this family. We are proposing a work RVU of 8.83 for CPT code 33X01, work RVU of 5.66 for CPT 33X02, work RVU of 6.00 for CPT 33X03, work RVU of 6.23 for CPT 33X04, work RVU of 9.90 for CPT 33X05, work RVU of 4.79 for CPT 33X06, work RVU of 7.30 for CPT 33X07, work RVU of 8.39 for CPT 33X08, work RVU of 6.00 for CPT 33X09, work RVU of 5.00 for CPT 33X10, work RVU of 5.12 for CPT 33X11, work RVU of 0.90 for CPT 93X01, work RVU of 0.80 for CPT 93X02, and work RVU of 0.59 for CPT 93X03. We note that several of these work RVUs were affected by the efficiency adjustment which was applied at the start of CY 2026, as the RUC recommendations were based on pre-adjustment work valuations. The RUC did not recommend, and we are not proposing, a work RVU for CPT code 93X04.

We are proposing the RUC-recommended direct PE inputs for CPT codes 33X01-33X11 as well as for CPT codes 93X01-93X04 without refinement.

(14) Insertion and Removal of Surgical Ventricular Assist Device (CPT codes 33X12, 33X13, and 33X15)

At the September 2025 CPT Editorial Panel meeting, the CPT Editorial Panel created three new category I CPT codes to describe the insertion and removal of a left heart ventricular

assist device (VAD), specifically using an open arterial with conduit surgical approach. These new category I CPT codes include the insertion CPT codes 33X15 *(Insertion of left heart ventricular assist device, including radiological supervision and interpretation, open; axillary, subclavian or innominate artery exposure with creation of conduit by infraclavicular or supraclavicular incision, unilateral)* and 33X12 *(Insertion of left heart ventricular assist device, including radiological supervision and interpretation, open; aorta exposure with creation of conduit by transthoracic (eg, median sternotomy, thoracotomy) incision)* as well as the removal CPT code 33X13 *(Removal of left heart ventricular assist device with resection and stapling of graft conduit and skin closure (eg, infraclavicular, supraclavicular).*

We are proposing the RUC-recommended work RVU of 13.65 for CPT code 33X15, work RVU of 17.52 for CPT 33X12, and work RVU of 6.58 for CPT 33X13.

We are proposing the RUC-recommended direct PE inputs for CPT codes 33X15, 33X12, and 33X13 without refinement.

(15) Transcatheter Tricuspid Valve Implant, Edge-to-Edge Repair (CPT codes 33X50, 33X51, and 33X52)

In September 2025, the CPT Editorial Panel approved the addition of CPT codes 33X50 *(Transcatheter tricuspid valve implantation (TTVI)/replacement with prosthetic valve, percutaneous approach, including right heart catheterization, temporary pacemaker insertion, and selective right ventricular or right atrial angiography, when performed)*, CPT code 33X51 *(Transcatheter tricuspid valve edge-to-edge repair (T-TEER), percutaneous approach; initial clip)*, and CPT code 33X52 *(Transcatheter tricuspid valve edge-to-edge repair (T-TEER), percutaneous approach; each additional clip during same session).* These codes were surveyed for the January 2026 RUC meeting.

The RUC recommended the inclusion of an inpatient hospital visit (CPT code 99233) within the global period of CPT codes 33X50 and 33X51, despite the fact that both codes were recommended with 0 day global periods. We disagree that this inpatient hospital visit should be

included within the valuation of these services, as 0 day global periods are specifically defined to include only postoperative care that takes place on the day of the procedure itself without incorporating any postoperative days. We are therefore proposing to remove the inpatient hospital visit (CPT code 99233) from both CPT codes 33X50 and 33X51, including the removal of 55 minutes of associated work time from each procedure.

We disagree with the RUC-recommended work RVU of 24.38 for CPT code 33X50 and we are instead proposing a work RVU of 17.52 based on a crosswalk to CPT code 95391 *(Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve)*. Our review of CPT code 33X50 found that the RUC's recommended work RVU of 24.38 placed it far higher than any other 0-day global code with similar time values on the PFS, especially after accounting for the removal of the work time associated with the inpatient hospital visit described earlier in this section. Most codes with 120 minutes of intraservice time and approximately 220 minutes of total time were valued around a work RVU of 13.00-15.00 and there were zero codes valued higher than a work RVU of 17.52. While we concur that CPT code 33X50 is a difficult and intensive procedure to perform, we do not believe it is accurately valued at 7 RVUs higher than any other code with comparable time values. We are instead proposing a work RVU of 17.52 based on a crosswalk to CPT code 95391, the highest 0-day global valuation with comparable work times, as this will avoid distorting relativity with other services on the PFS. We also note that CPT code 33X50 has comparable intensity at our proposed work RVU to the top reference code from the survey, CPT code 33477, which we believe better serves relativity than the RUC's recommended work RVU. The RUC's recommended work RVU of 24.38 would result in an intensity for CPT code 33X50 nearly 50 percent higher than the already complex and difficult transcatheter pulmonary valve implantation procedure described in the reference code, which we do not believe would be typical.

For CPT code 33X51, we disagree with the RUC's recommended work RVU of 23.92 and we are instead proposing a work RVU of 17.06. Although we disagree with the RUC-

recommended work RVU for CPT 33X51, we concurred that the relative difference in work between CPT codes 33X50 and 33X51 is equivalent to the recommended interval of 0.46 RVUs. Therefore, we are proposing a work RVU of 17.06 for CPT code 33X51, based on the recommended interval of 0.46 below our proposed work RVU of 17.52 for CPT code 33X50.

For CPT code 33X52, we disagree with the RUC-recommended work RVU of 8.00 and we are instead proposing a work RVU of 6.34 based on a crosswalk to CPT 22552 *(Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for primary procedure).* Our review of CPT code 33X52 found that the RUC's recommended work RVU of 8.00 placed it far higher than almost any other add-on code with similar time values on the PFS, with the sole exception of CPT code 61642 (Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in different vascular territory which is an outlier valuation at a work RVU of 8.66. Most add-on codes with approximately 50 minutes of total time were valued around a work RVU of 3.00-5.00 and there was only a single code valued higher than a work RVU of 6.34. While we concur that CPT code 33X52 is a difficult and intensive procedure to perform, we do not believe it is accurately valued at nearly two RVUs higher than other codes with comparable time values. We are instead proposing a work RVU of 6.34 based on a crosswalk to CPT code 22522, the highest non-outlier add-on code valuation with comparable work times, as this will avoid distorting relativity with other services on the PFS. We note that this valuation will also maintain relative intensity between CPT code 33X52 and the first two codes in the family at our proposed work RVUs.

The RUC did not recommend and we are not proposing any direct PE inputs for the three codes in this family.

(16) Percutaneous Transcatheter Closure (CPT code 33340)

In April 2025, the RAW identified CPT code 33340 (*Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal*

puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation) as a code that has Medicare utilization of 10,000 or more that has increased by at least 100 percent from 2018 through 2023. The specialty societies indicated and the RUC agreed that CPT code 33340 be surveyed for the January 2026 RUC meeting.

We disagree with the RUC's recommendation of the current work RVU of 9.99 for CPT code 33340 and we are instead proposing a work RVU of 9.00 based on crosswalk to CPT code 37271 *(Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel).* The RUC survey indicated that the typical time needed to perform CPT code 33340 has decreased, with the intraservice time decreasing from 70 minutes to 62 minutes and the total time decreasing from 165 minutes to 154 minutes. While we do not believe that the decrease in time as reflected in survey values should always equate to a one-to-one or linear decrease in newly valued work RVUs we do believe that, since the two components of work are time and intensity, absent an obvious or explicitly stated rationale for why the relative intensity of a given procedure has increased, significant decreases in time should be reflected in decreases to work RVUs although not necessarily in a linear manner. The RUC's recommendation to maintain the current work RVU of 9.99 for CPT code 33340 can only be justified if the intensity to perform the service has increased over time. However, there has been no change to the code descriptor for CPT code 33340 and no apparent change in clinical practice which would warrant the roughly 15 percent increase in intensity as recommended by the RUC. Since we do not believe that there is evidence indicating that CPT code 33340 has typically become more intense to perform, we are therefore proposing a work

RVU of 9.00 which maintains the current intensity of the service. This valuation is based on a crosswalk to CPT code 37271, a recently reviewed service from CY 2026 that has a higher intraservice time and nearly identical total time.

We are proposing the direct PE inputs for CPT code 33340 as recommended by the RUC without refinement.

(17) Treatment of Incompetent Veins (CPT codes 36470, 36471, 36465, 36466, 36473, and 36474)

In April 2025, the RAW identified CPT code 36465 (*Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein*), as a code that has Medicare utilization of 10,000 or more that has increased by at least 100 percent from 2018 through 2023. The RAW reviewed the action plan and the RUC recommended CPT code 36465 along with the family of services be surveyed for the January 2026 RUC meeting.

The RUC reviewed this family of services at the January 2026 meeting including all sclerosant treatment of incompetent veins. These services are: CPT code 36465; CPT code 36466 (*Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg*); CPT code 36470 (*Injection of sclerosant; single incompetent vein (other than telangiectasia)*); CPT code 36471 (*Injection of sclerosant; multiple incompetent veins (other than telangiectasia), same leg*);CPT code 36473 (*Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated*); and CPT code 36474 (*Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated*

in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)).

For CY 2027, we are proposing the RUC-recommended work RVUs for five of the six codes in this family. We are proposing the RUC-recommended work RVU of 2.29 for CPT code 36465, 0.73 for CPT code 36470, 1.18 for CPT code 36471, 3.41 for CPT code 36473, and 1.71 for CPT code 36474.

We disagree with the RUC recommended work RVU of 2.93 for CPT code 36466. Instead, we are proposing a work RVU of 2.62 based on a crosswalk to CPT code 57156 (*Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy*). In reviewing CPT code 36466, we noted that the recommended intraservice time is decreasing from 35 minutes to 30 minutes (14 percent reduction), and the recommended total time is decreasing from 76 minutes to 68 minutes (11 percent reduction); however, the RUC recommended maintaining the current work RVU of 2.93. While we do not believe that the decrease in time as reflected in survey values should always equate to a one-to-one or linear decrease in newly valued work RVUs we do believe that, since the two components of work are time and intensity, absent an obvious or explicitly stated rationale for why the relative intensity of a given procedure has increased, significant decreases in time should be reflected in decreases to work RVUs although not necessarily in a linear manner. The RUC's recommendation to maintain the current work RVU of 2.93 for CPT code 36466 can only be justified if the intensity to perform the service has increased over time. However, there has been no change to the code descriptor for CPT code 36466 and no apparent change in clinical practice which would warrant the roughly 17 percent increase in intensity as recommended by the RUC. Since we do not believe that there is evidence indicating that CPT code 36466 has typically become more intense to perform, we are therefore proposing a work RVU of 2.62 which maintains the current intensity of the service. This valuation is based on a crosswalk to CPT code 57156, which has the same intraservice work time of 30 minutes and higher total time.

We are proposing the RUC-recommended direct PE inputs for all CPT codes in this family without refinement.

(18) Microvascular Bypass, Lymphatic Vessels (CPT codes 38X03 and 38X04)

In September 2025, the CPT Editorial Panel approved two new Category I codes to describe microvascular bypass of lymphatic vessels, a microsurgical procedure. This newly created Category I CPT code family describes two services: a base code for the initial anastomosis, CPT code 38X03 (*Microvascular anastomosis between a single vein opening and any number of lymphatic vessels, per limb; initial anastomosis*), and the add-on code for each additional anastomosis, CPT code 38X04 (*Microvascular anastomosis between a single vein opening and any number of lymphatic vessels, per limb; initial anastomosis; each additional anastomosis (List separately in addition to code for primary procedure)*). CPT codes 38X03 and 38X04 were surveyed for the January 2026 RUC meeting.

We reviewed the RUC's recommended work valuations and found the RUC's recommended work RVU of 16.00 for CPT code 38X03 to be high, based on a search of similarly timed codes in the RUC database. For CY 2027 we are proposing a work RVU of 14.00, based on the RUC survey 25th percentile, for CPT code 38X03. We are proposing the RUC recommended work RVU of 6.00 for CPT code 38X04. We are proposing the RUC-recommended direct PE inputs for both CPT codes without refinement.

(19) Diaphragmatic Hernia Repair (CPT codes 39540, 39541, 39XX3, 39XX4, 39XX5, 39XX7, 39XX8, 39XX9, 39X11, 39X12, and 39X13)

At the September 2025 CPT Editorial Panel, the committee revised two existing CPT codes, CPT code 39540 *(Repair, diaphragmatic hernia (other than neonatal), via laparotomy; traumatic, acute)* and CPT code 39541 *(Repair, diaphragmatic hernia (other than neonatal), via laparotomy; traumatic, chronic)*, describing diaphragmatic hernia repair. They also created nine new Category I codes, CPT codes 39XX3 *(Repair, diaphragmatic hernia (other than neonatal), via laparotomy; nontraumatic (ie, Bochdalek, Morgagni*)), 39XX4 *(Repair, diaphragmatic*

hernia (other than neonatal), via thoracotomy; traumatic, chronic), 39XX5 *(Repair, diaphragmatic hernia (other than neonatal), via thoracotomy; nontraumatic (ie, Bochdalek, Morgagni))*, 39XX7 *(Laparoscopy, surgical, with repair of diaphragmatic hernia (other than neonatal); traumatic, acute)*, 39XX8 *(Laparoscopy, surgical, with repair of diaphragmatic hernia (other than neonatal); traumatic, chronic)*, 39XX9 *(Laparoscopy, surgical, with repair of diaphragmatic hernia (other than neonatal); nontraumatic (ie, Bochdalek, Morgagni))*, 39X11*(Thoracoscopy surgical, with repair of diaphragmatic hernia (other than neonatal); traumatic, chronic)*, 39X12 *(Thoracoscopy surgical, with repair of diaphragmatic hernia (other than neonatal); nontraumatic (ie, Bochdalek, Morgagni))*, and 39X13 *(Implantation of mesh or other prosthesis with open, laparoscopic, or thoracoscopic diaphragmatic hernia repair (List separately in addition to code for primary procedure))* that expanded the range of surgical interventions included in this code family. The RUC reviewed these services at the January 2026 meeting.

For CY 2027, we are proposing the RUC recommended work RVUs of 24.00 for CPT code 39540, 26.00 for CPT code 39541, 25.75 for CPT code 39XX3, 26.41 for CPT code 39XX4, 25.94 for CPT code 39XX5, 22.04 for CPT code 39XX7, 26.60 for CPT code 39XX8, 27.00 for CPT code 39XX9, 25.44 for CPT code 39X11, 25.94 for CPT code 39X12, and 3.00 for CPT code 39X13.

We are proposing the RUC-recommended direct PE inputs for all CPT codes in this family without refinement.

(20) Diaphragm Repair (CPT codes 39545 and 395X2)

In May 2025, the CPT Editorial Panel revised CPT code 39545 (*Plication of diaphragm for eventration or paralysis, via thoracotomy*) to specify plication of the diaphragm for eventration or paralysis, via thoracotomy, and created CPT code 395X2 (*Thoracoscopy, surgical, with plication of diaphragm for eventration or paralysis*) to report thoracoscopic plication of the diaphragm for eventration or paralysis.

For CY 2027, we are proposing the RUC recommended work RVUs of 18.45 for CPT code 39545 and 20.00 for CPT code 395X2. We are proposing the RUC-recommended direct PE inputs for both CPT codes without refinement.

(21) Division of Median Arcuate Ligament (CPT codes 39XX1 and 39XX2)

In February 2025, the CPT Editorial Panel created two new codes to report open and laparoscopic median arcuate ligament syndrome (MALS) treatment: CPT code 39XX1 (*Division of median arcuate ligament and release of celiac trunk, with ganglionectomy, when performed*) and CPT code 39XX2 (*Laparoscopy, surgical, with division of median arcuate ligament and release of celiac trunk, with ganglionectomy, when performed*). The two new codes were surveyed for the April 2025 RUC meeting.

We are proposing the RUC-recommended efficiency adjusted work RVUs of 26.41 for CPT code 39XX1 and 25.94 for CPT code 39XX2. We are proposing the RUC-recommended direct PE inputs for CPT codes 39XX1 and 39XX2 without refinement.

(22) Endoscopic Submucosal Dissection (CPT codes 4XX01 and 4XX02)

At the May 2025 CPT Editorial Panel Meeting, two new CPT codes were created for reporting endoscopic submucosal dissection (ESD) of both the upper and lower GI tract, including mucosal closure: CPT codes 4XX01 (*Endoscopic submucosal dissection (ESD) of upper gastrointestinal tract, including mucosal closure, when performed)* and 4XX02 *(Endoscopic submucosal dissection (ESD) of lower gastrointestinal tract, including mucosal closure, when performed)*. These new CPT codes were surveyed at the September 2025 AMA RUC meeting.

For CY 2027, we are proposing the RUC-recommended work RVUs of 15.00 for CPT code 4XX01 and 16.38 for CPT code 4XX02. We are proposing the RUC-recommended direct PE inputs for CPT codes 4XX01 and 4XX02 without refinement.

(23) Transoral Oropharyngeal Procedures (CPT codes 42808, 42XX1, and 42XX2)

In February 2025, the CPT Editorial Panel approved two new Category I codes that describe transoral endoscopic surgery under magnification for the removal of tumors in the oropharynx, including robotic assistance when performed: CPT code 42XX1 (*Transoral removal of oropharyngeal and/or pharyngeal neoplasm under magnification (eg, microscope or telescope), includes robotic assistance, when performed, tongue base*) and CPT code 42XX2 (*Transoral removal of oropharyngeal and/or pharyngeal neoplasm under magnification (eg, microscope or telescope), includes robotic assistance, when performed; tongue base; lateral pharyngeal wall, including tonsil*). CPT code 42808 (*Excision or destruction of lesion of pharynx, without magnification, any method*) was revised to clarify that it is done without magnification, and it was surveyed along with the two new codes at the April 2025 RUC meeting.

We are proposing the RUC-recommended work RVU for all three codes in this family. We are proposing a work RVU of 2.29 for CPT code 42808 (which is the current work RVU of the code after the efficiency adjustment was applied at the start of CY 2026), a work RVU of 20.00 for CPT code 42XX1, and a work RVU of 20.05 for CPT code 42XX2. We note that the RUC's recommended work RVU of 2.29 for CPT code 42808 assigns an intensity value of zero for this service; we are seeking comment from interested parties as to whether an alternate work valuation, such as the survey 25th percentile work RVU of 2.70, would be more appropriate.

We are proposing the RUC-recommended direct PE inputs for all three codes without refinement.

(24) Congenital Duodenal Obstruction Repair (CPT codes 44XX1 and 44XX2)

At the May 2025 CPT Editorial Panel Meeting, two new CPT codes were created for reporting surgical treatment for congenital duodenal obstruction via an open or laparoscopic approach, that were previously reported using unlisted codes: CPT codes 44XX1*(Duodenoduodenostomy or duodenojejunostomy for congenital duodenal obstruction)* and 44XX2 *(Laparoscopy, surgical; duodenoduodenostomy or duodenojejunostomy for*

congenital duodenal obstruction). These new CPT codes were surveyed at the September 2025 AMA RUC meeting.

For CY 2027, we are proposing the RUC-recommended work RVUs of 50.00 for CPT code 44XX1 and 52.60 for CPT code 44XX2. We are proposing the RUC-recommended direct PE inputs for CPT codes 44XX1 and 44XX2 without refinement.

(25) Irreversible Electroporation of Tumor, Pancreas (CPT code 48XXX)

In May 2025, the CPT Editorial Panel approved the addition of a new CPT code 48XXX (*Ablation, irreversible electroporation of tumor(s) of the pancreas, open, including imaging guidance)* to report open irreversible electroporation (IRE) ablation of tumors of the pancreas.

We are proposing the RUC-recommended work RVU of 25.19 for CPT code 48XXX, and the RUC-recommended direct PE inputs without refinement.

(26) Prostate Biopsy Services (CPT codes 55705, 55707, 55708, 55709, 55710, 55711, 55712, 55714, and 55715)

This service was identified via the April 2022 RAW review of services performed by the same physician on the same date of service 75 percent of the time or more and was surveyed for the September 2024 RUC meeting. The data from the September 2024 survey indicated that the long descriptors did not adequately describe these services. While the codes were valued for the CPT 2026 cycle, the specialties and the RUC agreed that a new coding change application should be developed for the CPT Editorial Panel for restructuring in the CPT 2027 cycle. CPT revised the prostate biopsy code family in 2026 and it was surveyed for the January 2026 RUC meeting. The revisions to the family are as follows: CPT codes 55705 (*Biopsy, prostate, any approach, non-imaging guided*), 55707 (*Biopsy, prostate, transrectal, including imaging guidance, regional*), 55708 (*Biopsy, prostate, transrectal, including imaging guidance, regional and fusion-targeted lesion(s)*), 55709 *(Biopsy, prostate, transperineal, including imaging guidance, regional)*, 55710 *(Biopsy, prostate, transperineal, including imaging guidance, regional and of fusion-targeted lesion(s)*, 76872 *(ultrasound, transrectal)*, and 55714 *(Biopsy, prostate, including*

imaging guidance, in-bore-CT-or-MRI-guided; first targeted lesion) have work RVUs that were reaffirmed from CY 2026 by the RUC. CPT codes 55711 *(Biopsy, prostate, transrectal or transperineal, including imaging guidance, fusion),* 5XX14 *(Biopsy, prostate, transrectal or transperineal, including imaging guidance, fusion-targeted lesion(s) without regional; each additional targeted lesion (List separately in addition to code for primary procedure)* and 55715 *(Biopsy, prostate, including imaging guidance, in-bore CT- or MRI-guided; each additional targeted lesion (List separately in addition to code for primary procedure))* are new and/or revised codes for CY2027.

For CY 2027, we are proposing the RUC-recommended work RVU for eight of the nine codes in the family. We are proposing the RUC-recommended work RVUs of 1.88 for CPT code 55705, 2.63 for CPT code 55707, 3.39 for CPT code 55708, 3.23 for CPT code 55709, 3.81 for CPT code 55710, 2.37 for CPT code 55711, 3.62 for CPT code 55714, and 1.80 for CPT 55715.

For CPT code 5XX14, we disagree with the RUC-recommended work RVU of 0.80. In the interest of maintaining relativity with similarly timed codes, we are instead proposing a work RVU of 0.68 based on a crosswalk to CPT code 93567 (*Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for supravalvular aortography (List separately in addition to code for primary procedure)*). CPT code 55X14 was surveyed with only 6 minutes of intraservice and total work time, yet the RUC recommended a work RVU of 0.80. We compared this recommended valuation against CPT code 55715, another add-on code within this same family, which was surveyed at 35 minutes of intraservice and total work time but with a recommended work RVU of 1.80. This results in CPT code 55X14 having an intensity nearly triple that of CPT code 55715 which we do not believe would be typical. We also found that there were no other add-on codes in the RUC database with comparable time values to CPT code 55X14 which had a work RVU approaching 0.80. The closest was CPT code 77063 (*Screening digital breast tomosynthesis, bilateral*) at a work RVU of 0.59, with that code having 8 minutes of work time instead of 6 minutes, and all other comparable add-on codes had a

work RVU of 0.37 or lower. Although we agree that CPT code 55X14 is a difficult and intensive procedure, we believe that the RUC's recommended work RVU of 0.80 assigns too much work valuation and intensity to the service, and does not maintain relativity with other related codes on the PFS.

We are instead proposing a work RVU of 0.68 for CPT code 5XX14 based on a crosswalk to CPT code 93567. Our proposed work RVU of 0.68 is also supported with add-on CPT codes with similar work time values. CPT code 93566 (*Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective right ventricular or right atrial angiography (List separately in addition to code for primary procedure)*) is valued at a work RVU of 0.49 with an intraservice time of 10 minutes and CPT code 64484 (*Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)*) is valued at a work RVU of 0.98 with an intraservice time of 10 minutes.

We are proposing the RUC-recommended direct PE inputs for all CPT codes in this family without refinement.

(27) Maternity Care Services (CPT codes 59320, 59325, 59412, 59871, 59XX1, 59XX2, 59XX3, 59XX4, 59030, 59051, 59XX5, 59XX6, 59414, 59300, 59XX7, 59XX8, 59XX9, 59X10, 59X11, 59X12, and 59160)

a. Background and Proposal

At the January 2026 AMA RUC meeting, the maternity global codes were revised to delete 17 legacy CPT codes, create 12 new CPT codes, and revise 9 CPT codes describing maternity care services. See Table A-D2 for a summary of the codes and their long descriptors. These codes were restructured from the MMM global period to individual codes to reflect changes in practice. The previous MMM global period included 12 prenatal E/M visits bundled into CPT codes 59400, 59510, 59610, and 59618. In May 2025, the American College of

Obstetricians and Gynecologists (ACOG) published new clinical guidelines, recommending that obstetrician-gynecologists and other maternity care professionals tailor the visit frequency and monitoring schedule to the needs of the pregnant woman. These new clinical guidelines provide a sample schedule for prenatal care services and visit frequency, which describes 8 visits for average-risk pregnant women without medical or pregnancy complications, and 13 visits for pregnant women with greater-than-average risk. This sample schedule specifies that additional services may be offered as needed throughout the pregnancy.

When the RUC reviewed these codes, they included 12 prenatal E/M visits (two level 2 established patient office visits, eight level 3 established patient office visits, and two level 4 established patient office visits) in the calculations to make these changes budget-neutral despite the revisions to the clinical guidelines suggesting that 12 visits would no longer be typical. As the clinical guidelines have changed to reflect a revised assumption about the typical number of visits, estimating work neutrality based on the assumption that all 12 prenatal E/M visits in the base year would be reported in the predictive year overestimates the total utilization and as a result, undervalues the work RVUs as recommended by the RUC. To improve payment accuracy of the new codes, we are proposing to refine the RUC's recommended utilization crosswalk to remove four E/M visits (two level 2 established patient office visits and two level 4 established patient office visits) from the utilization estimate calculation and reallocate those RVUs within the code family to the new labor and delivery codes. This would mean reallocating 11,810 additional work RVUs to the new labor and delivery codes (CPT codes 59XX1-59XX8). Since the RUC provided a utilization estimate of 12,791 for CPT codes 59XX1-59XX8, this would result in a 15 percent increase in work RVUs for each labor and delivery code. We would like to emphasize that we are not endorsing a reduced number of prenatal visits for pregnant women. Our recalculation of the utilization estimates in the valuation of these services should not be used to determine the appropriate number of visits to provide reasonable and necessary care to

beneficiaries. As with all PFS services, maternity services should be furnished when medically reasonable and necessary.

There are no RUC-recommended direct PE inputs for these CPT codes. Table A-D2 also shows the RUC-recommended and CMS proposed work RVUs for the 21 CPT codes.

TABLE A-D2: CPT LONG DESCRIPTORS AND PROPOSED WORK RVUS FOR MATERNITY SERVICES

CPT Code	Long Descriptors	RUC Recommended Work RVUs	CMS Proposed Work RVUs
Antepartum Care			
59320	*Cerclage of cervix, during pregnancy; vaginal*	3.02	3.02
59325	*Cerclage of cervix, during pregnancy; abdominal*	6.34	6.34
59412	*External cephalic version*	2.63	2.63
59871	*Removal of cerclage suture under anesthesia (other than local)*	2.15	2.15
Labor Management and Delivery			
59XX1	*Initial day labor management; straightforward, per day*	3.50	4.03
59XX2	*Initial day labor management; complex, per day*	4.50	5.18
59XX3	*Subsequent day labor management; straightforward, per day*	3.00	3.45
59XX4	*Subsequent day labor management; complex, per day*	4.20	4.83
59XX5	*Vaginal delivery, with or without episiotomy;*	8.00	9.20
59XX6	*Vaginal delivery, with or without episiotomy; after previous cesarean delivery*	9.00	10.35
59XX7	*Cesarean delivery; primary*	12.00	13.80
59XX8	*Cesarean delivery; repeat*	14.66	16.86
Labor Procedures, Other Procedures, and Postpartum			
59030	*Fetal scalp blood sampling*	0.90	0.90
59051	*Fetal monitoring during labor by consulting physician (ie, non-attending physician) or other qualified health care professional, with interpretation and report*	0.93	0.93
59414	*Delivery of placenta only (separate procedure)*	1.61	1.61
59300	*Repair of first or second-degree episiotomy or laceration, by other than attending physician or other qualified health care professional performing vaginal delivery care (separate procedure)*	1.76	1.76
59X11	*Repair of episiotomy or laceration; third-degree laceration*	2.47	2.47
59X12	*Repair of episiotomy or laceration; fourth-degree laceration*	4.14	4.14
59XX9	*Subtotal or total hysterectomy after cesarean delivery*	15.56	15.56
59X10	*Uterine tamponade (eg, balloon, catheter, vacuum, packing material)*	2.15	2.15
59160	*Curettage, postpartum*	2.93	2.93

b. Comment Solicitation on Maintaining Current Coding Through Creation of HCPCS G-codes

We are interested in thinking about different approaches to how maternity care codes are valued and paid under the PFS. Although the RUC asserts that these proposed coding changes discussed above reflect clinical consensus, we have concerns that our adoption of the new codes would be disruptive based on how the longstanding existing code structure is currently accounted for in clinical practice patterns. We are seeking comment on whether CMS should create HCPCS G-codes that would maintain the current coding and payment for maternity services to ameliorate this concern, while we continue to consider the potential impact that changes in the maternity care code family have on clinical outcomes for maternal care. These codes would be used in lieu

of adoption of the new CPT codes for purposes of Medicare payment. We are specifically interested in additional information to support or oppose this concern, as well as additional information to support or oppose the use of the creation of HCPCS G-codes in lieu of adoption of the new CPT codes.

Specifically, for payment for maternity care services under the PFS, we are considering, and are seeking comment on, the creation of 15 new HCPCS G-Codes for CY 2027 that reflect the previous MMM global code structure, with the code descriptors and work RVUs detailed in Table A-D3, as an alternative to the revaluation of the codes as discussed in Section (a), of this preamble. We are seeking public comment on these HCPCS G-codes and, after consideration of public comment, could finalize payment for these codes. We are seeking comment on these HCPCS G-codes and are also seeking comment on any other HCPCS G-codes that may be needed to reflect the necessary service elements for this code family. These HCPCS G-codes would adopt all current conditions of payment for the MMM global codes, as well as maintain the MMM global period, if finalized.

TABLE A-D3: POTENTIAL G CODES TO MAINTAIN PREVIOUS CODE SET

HCPCS G-Code	Long Descriptors	G-Code Work RVUs
GMAT1	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care	37.00
GMAT2	Vaginal delivery only (with or without episiotomy and/or forceps);	14.37
GMAT3	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care	18.76
GMAT4	Antepartum care only; 4-6 visits	7.8
GMAT5	Antepartum care only; 7 or more visits	14.3
GMAT6	Postpartum care only (separate procedure)	3.22
GMAT7	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care	41.05
GMAT8	Cesarean delivery only;	16.13
GMAT9	Cesarean delivery only; including postpartum care	22.79
GMA10	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery	38.71
GMA11	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps);	16.09
GMA12	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care	20.48
GMA13	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery	41.57
GMA14	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery;	16.66
GMA15	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care	23.32

(28) Stereotactic Computer-Assisted Volumetric Navigation (CPT codes 61781, 61782, and 61783)

In April 2024, CPT code 61783 (*Stereotactic computer-assisted (navigational) procedure; spinal (List separately in addition to code for primary procedure)*) was identified via the high-volume growth screen. In January 2025, the RAW reviewed the action plan for CPT code 61783 and determined that this service should be surveyed with the appropriate family of codes. The RUC recommended that CPT code 61781 be surveyed with CPT codes 61782 (*Stereotactic computer-assisted (navigational) procedure; cranial, extradural (List separately in addition to code for primary procedure)*) and 61783 (*Stereotactic computer-assisted (navigational) procedure; spinal (List separately in addition to code for primary procedure)*) for September 2025.

We are proposing the RUC-recommended work RVU of 3.66 for CPT codes 61781 and 61783, and the RUC-recommended RVU of 2.06 for CPT code 61782. We note that all three of these RUC-recommended RVUs reflect the application of the CY 2026 efficiency adjustment described in the CY 2026 PFS final rule (90 FR 49334 through 49345).

We are proposing the RUC's recommended direct PE inputs for CPT code 61782. Since CPT codes 61781 and 61783 are performed in the facility setting only, the RUC did not recommend, and we are not proposing, any direct PE inputs for these two codes.

(29) Percutaneous Lumbar Decompression (CPT code 62287)

At the January 2025 RUC meeting, the surveying societies requested deletion of CPT code 62287 *(Decompression, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle-based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar)* due to declining Medicare utilization. At the May 2025 CPT Editorial Panel meeting, CPT reviewed additional utilization estimates, and requests from neurosurgery and radiology were received to resurvey and retain the code. CPT code 62287 was surveyed at the September 2025 AMA RUC meeting since it was not deleted in January 2025 with the other codes in the family.

We disagree with the RUC's recommended work RVU of 7.06 for CPT code 62287 and we are instead proposing a work RVU of 6.23 based on a crosswalk to CPT code 46707 *(Repair of anorectal fistula with plug (eg, porcine small intestine submucosa [SIS]))*. We believe that the RUC's recommended work RVU of 7.06 is an overestimation based on a comparison to other codes with similar time values, particularly the key reference code CPT code 22869 (*Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level*). There was a decrease in the surveyed work times, such as the intraservice time decreasing from 60 minutes to 37 minutes, which was not fully accounted for in the RUC's recommended work RVU of 7.06. We also note that the procedure does not seem to have become more intense, as the code descriptor did not change.

In the interest of maintaining relativity with similarly timed codes, we are instead proposing a work RVU of 6.23 based on a crosswalk to CPT code 46707. This code has an almost identical intraservice time and similar total time. The proposed work RVU accounts for the decrease in both intraservice time and total time and is well bracketed by CPT code 67912 *(Correction of lagophthalmos, with implantation of upper eyelid lid load (eg, gold weight))*, valued at a work RVU of 6.20 with an intraservice time of 40 minutes, and CPT code 24358 *(Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); debridement, soft tissue and/or bone, open)*, valued at a work RVU of 6.49 with an intraservice time of 40 minutes.

We are proposing the RUC-recommended direct PE inputs for all of the codes in this family.

(30) Laminectomy (CPT codes 63045, 63046, 63047, and 63048)

In April 2025, the RAW identified CPT code 63047 (*Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar*) as a site

of service anomaly where Medicare data from 2021 to 2023 indicated it was performed less than 50 percent of the time in the inpatient setting yet included inpatient hospital Evaluation and Management services within the global period with 2023 Medicare utilization over 10,000. The RAW also worked with the specialty societies and identified other codes 63045 (*Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; cervical*), 63046 (*Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; thoracic*) and 63048 (*Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional vertebral segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)*) as part of this family of services. These services were surveyed for September 2025.

We are proposing the RUC-recommended work RVUs for all four CPT codes in this family. We are proposing a work RVU of 17.25 for CPT code 63045, a work RVU of 16.71 for CPT code 63046, a work RVU of 14.99 for CPT code 63047, and a work RVU of 3.38 for CPT code 63048. We note that several of these work RVUs were affected by the efficiency adjustment which was applied at the start of CY 2026, as the RUC recommendations were based on pre-adjustment work valuations.

We are proposing the RUC recommended direct PE inputs for CPT codes 63045, 63046, 63047, and 63048 without refinement.

(31) Injection Anesthetic Agent (CPT codes 64400 and 64405)

The RUC identified CPT code 64400 *(Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular))* via their database flag, "Do not use to validate physician work", and recommended to survey this CPT code and the

related CPT code 64405 *(Injection(s), anesthetic agent(s) and/or steroid; greater occipital nerve)* for the September 2025 meeting.

For CY 2027, we are proposing the RUC-recommended work RVUs of 0.73 for CPT code 64400 (which is the current work RVU of the code after the efficiency adjustment was applied at the start of CY 2026) and 0.84 for CPT code 64405.

We are proposing the RUC-recommended direct PE inputs for both CPT codes without refinement.

(32) MRA – Head, Neck (CPT codes 70544, 70545, 70546, 70547, 70548, 70549, 70XX4, 70XX5, and 70XX6)

In April 2024, the RAW noted that the rate at which CPT codes 70547 (currently described as *Magnetic resonance angiography, neck; without contrast material(s)*) and 70544 (currently described as *Magnetic resonance angiography, head; without contrast material(s)*) are reported together continued to increase after the initial identification of the trend in April 2022 and a 2-year delay in review to allow practice patterns in the inpatient and outpatient setting go back to how they were prior to the COVID-19 pandemic. At the September 2025 CPT Editorial Panel, six CPT codes were revised to include "image postprocessing": CPT codes 70544 (*Magnetic resonance angiography, head, including image postprocessing; without contrast material(s)*), 70545 (*Magnetic resonance angiography, head, including image postprocessing; with contrast material(s)*), 70546 (*Magnetic resonance angiography, head, including image postprocessing; without contrast material(s), followed by contrast material(s) and further sequences*), 70547 (*Magnetic resonance angiography, neck, including image postprocessing; without contrast material(s)*), 70548 (*Magnetic resonance angiography, neck, including image postprocessing; with contrast material(s)*), and 70549 (*Magnetic resonance angiography, neck, including image postprocessing; without contrast material(s), followed by contrast material(s) and further sequences*). Three additional codes were created to bundle magnetic resonance angiography (MRA) head and neck with/without contrast: CPT codes 70XX4 (*Magnetic*

resonance angiography, head and neck, including image postprocessing; without contrast material(s)), 70XX5 (*Magnetic resonance angiography, head and neck, including image postprocessing; with contrast material(s)*), and 70XX6 (*Magnetic resonance angiography, head and neck; without contrastmaterial(s) in one or both body regions, followed by contrast material(s) and further sequences in one or both body regions, including image postprocessing*). The code family was surveyed for the January 2026 RUC meeting.

We are proposing the RUC-recommended work RVU for all nine codes in the family. We are proposing the RUC-recommended work RVUs of 1.17, 1.17, 1.44, 1.17, 1.46, 1.76, 1.77, 2.10, and 2.23 for CPT codes 70544, 70545, 70546, 70547, 70548, 70549, 70XX4, 70XX5, and 70XX6, respectively. We are proposing the RUC recommended direct PE inputs for CPT codes 70544, 70545, 70546, 70547, 70548, 70549, 70XX4, 70XX5, and 70XX6 without refinement.

(33) Computed Tomography-Upper Extremity with Contrast (CPT codes 73200, 73201, and 73202)

In April 2025, the RAW identified CPT code 73201 (*Computed tomography, upper extremity; with contrast material(s)*) via the CMS/Other source and 2023 Medicare utilization over 20,000 screen. The family of services was surveyed for the January 2026 RUC meeting, including CPT codes 73200 *(Computed tomography, upper extremity; without contrast material*) and 73202 *(Computed tomography, upper extremity; without contrast material, followed by contrast material(s) and further sections).*

We are proposing the RUC-recommended work RVUs of 1.00, 1.16, and 1.24 for CPT codes 73200, 73201, and 73202, respectively. We are proposing the RUC recommended direct PE inputs for CPT codes 73200, 73201, and 73202 without refinement.

(34) Biofeedback Training (CPT codes 90901, 90X03, 90912, and 90913)

CPT codes 90901 (*Biofeedback training by any modality (eg, EMG, EEG, ECG); initial 15 minutes of direct patient contact by physician or other qualified health care professional*), 90912 (*Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG*

and/or manometry, when performed; initial 15 minutes of one-on-one physician or other qualified health care professional contact with the patient) and 90913 (*Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; each additional 15 minutes of one-on-one physician or other qualified health care professional contact with the patient (List separately in addition to code for primary procedure)*) were surveyed at the January 2026 RUC meeting after having gone through revision at the September 2025 CPT Editorial Panel. CPT revised code 90901 to describe the initial 15 minutes of biofeedback training by a physician or other qualified health care professional with direct patient contact and created one new code, CPT code 90X03 (*Biofeedback training by any modality (eg, EMG, EEG, ECG); each additional 15 minutes of direct patient contact by physician or other qualified health care professional (List separately in addition to code for primary procedure)),* to describe each additional 15 minutes. CPT codes 90912 and 90913 were surveyed for the January 2026 RUC meeting since they are part of the same code family. CPT codes 90901 and new code 90X03 were surveyed for the January 2026 RUC HCPAC Review Board meeting.

We are proposing the HCPAC-recommended work RVUs of 0.61 for CPT code 90901 and 0.48 for CPT code 90X03. We are proposing the RUC-recommended work RVUs of 0.90 for CPT code 90912 and 0.50 for CPT code 90913.

We are proposing the direct PE inputs recommended by the HCPAC and the RUC for all four codes in the family without refinement.

CPT codes 90901, 90912, and 90913 are all designated as sometimes therapy services, as such we are proposing to designate 90X03 as a sometimes therapy service.

(35) Radiation Oncology Treatment Delivery (CPT codes 77402, 77407, and 77412)

In the CY 2026 PFS final rule (90 FR 49379 through 49383), we finalized our proposal to utilize the relationship between the Hospital Outpatient Prospective Payment System (OPPS) Ambulatory Payment Classifications (APC) relative weights for APCs 5621, 5622, and 5623 to inform the valuation of PE-only CPT codes 77402 (*Radiation treatment delivery; Level 1 (eg,*

single-electron field, multiple-electron fields, or 2D photons), including imaging guidance, when performed), 77407 (*Radiation treatment delivery; Level 2, single-isocenter (eg, 3D or IMRT), photons, including imaging guidance, when performed*), and 77412 (*Radiation treatment delivery; Level 3, multiple isocenters with photon therapy (eg, 2D, 3D, or IMRT) or a single-isocenter photon therapy (eg, 3D or IMRT) with active motion management, or total skin electrons, or mixed-electron/photon field(s), including imaging guidance, when performed*) when paid under the PFS. We also stated that we calculated the RVUs for these codes so that the overall PE and MP RVUs for these services represent the same share of total PE and MP RVUs in CY 2025 and CY 2026. To accomplish this, we developed PE and MP RVUs using the assumed distribution of services indicated in the utilization crosswalk.

We proposed to utilize the RUC-recommended crosswalk for these services, which assumed that 45 percent of the billed charges would be reported with CPT code 77412. Some commenters stated that CPT code 77412 would represent only 15 percent of the volume for these services. We stated in the CY 2026 PFS final rule that it is difficult to ascertain how services furnished in the past would be most accurately reported using a future code set (90 FR 49385). In response to comments and considering the disparate information we received, we finalized a modified crosswalk that adjusted downward the estimated portion that CPT code 77412 would be reported compared to CPT code 77407 based on commenters who represent those who provide care in the non-facility setting. Specifically, we modified the utilization crosswalk to crosswalk 35 percent of the utilization to CPT code 77412 and 55 percent of the utilization to CPT code 77407. Since the publication of the CY 2026 PFS final rule, interested parties have reported that the 35 percent utilization assumption for CPT code 77412 was still overstated despite our downward adjustment in the CY 2026 PFS final rule, and that the actual utilization for CPT code 77412 is approximately 18 percent. Given the importance of the assumed distribution of services in ensuring that we achieved our target of maintaining the same share of total PE and MP RVUs, we reviewed the claims data to evaluate the actual distribution of

utilization among CPT codes 77402, 77407, and 77412. We noted that during the first 3 months of 2026, CPT code 77412 comprised approximately 18 of the total volume of these services.

Given that we valued these services by utilizing the relative relationship between the OPPS APC relative weights rather than our standard PE methodology, shifts in utilization over time are not automatically incorporated into the annual development of PE RVUs for these services over time. Consequently, we are proposing to refine the relativity within this family of codes for CY 2027 based on available claim data that corroborates the information submitted to us by outside parties. We are not proposing to change the assumptions about the total number of services, but rather, to revalue the PE RVUs using the observed distribution of services, such that the PE and MP RVUs for these services represent the same share of total PE and MP RVUs as they did in CY 2025.

(36) Proton Beam Treatment Delivery (CPT Codes 77520, 77522, 77523, and 77525)

Payment amounts for proton beam treatment delivery services described by CPT codes 77520 (*Proton treatment delivery; simple, without compensation*), 77522 (*Proton treatment delivery; simple, with compensation*), 77523 (*Proton treatment delivery; intermediate*), and 77525 (*Proton treatment delivery; complex*) are currently determined by local Medicare Administrative Contractors (MACs). We have not previously established RVUs for these services due to the unique nature of the equipment costs associated with these services compared to other capital costs addressed by our usual PE methodology. In the CY 2026 PFS proposed rule, we sought comment on establishing national payment rates for proton beam treatment delivery services. In the CY 2026 final rule (90 FR 49390), we indicated our intent to establish national pricing for proton beam treatment delivery services in future rulemaking.

Interested parties have raised concerns about wide geographic payment disparities with the current contractor pricing that are unrelated to the cost of providing care and have requested that CMS nationally price proton beam treatment delivery services. For example, 2024 claims data for CPT code 77525, which has the second highest utilization of the code family, reflects

allowed charges that ranged from $122.15 to $1,374.26. Interested parties recommended that CMS establish identical payment rates for PFS and OPPS, calculating a weighted average of the payment rates to maintain budget neutrality across the PFS and OPPS. Other interested parties expressed concern about reliance on OPPS cost data to value proton beam treatment delivery services, as the substantial capital outlays required by freestanding centers could be greater than those faced by hospital systems and the freestanding centers lack the purchasing power or amortization flexibility that hospitals may have.

After considering the comments we received in response to the CY 2026 PFS rule regarding establishing national payment rates for proton beam treatment, similar to the policy we finalized for CY 2026 for radiation treatment delivery services, we are proposing to calculate the PE RVUs for these services as follows:

- Use the total allowed charges paid by the MACs for CPT codes 77520, 77522, 77523, and 77525 to establish the pool of PE RVUs to allocate to the services in this code family.
- Allocate PE RVUs to the individual services using the relationship between the APC relative weights for APCs 5625 (to which CPT codes 77522, 77523, and 77525 are assigned) and APC 5623 (to which CPT code 77520 is assigned) under the OPPS. We believe our proposal appropriately balances interested parties' requests to establish national payment rates with the difficulties we have faced when considering the capital-intensive and specialized resources for services like proton beam therapy services.

(37) Intracoronary Drug Delivery Balloon Services (CPT codes 9XX04 and 9XX07)

In May 2025, the CPT Editorial Panel created two new codes, CPT code 9XX04 (*Percutaneous transcatheter therapeutic drug delivery by intracoronary drug-delivery balloon (eg, drug-coated, drug-eluting), including mechanical dilation by nondrug-delivery balloon angioplasty, single major coronary artery and/or its branch(es)*) and CPT code 9XX07 (*Percutaneous transcatheter therapeutic drug-delivery by intracoronary drug-delivery balloon (eg, drug-coated, drug-eluting), single major artery and/or its branches (List separately in*

addition to code for primary procedure)) to describe percutaneous transcatheter therapeutic drug delivery by intracoronary drug-delivery balloons. The RUC reviewed these two new CPT codes at the September 2025 RUC meeting.

We reviewed the RUC's recommended work valuations and found the RUC's recommended work RVU of 10.00 for CPT code 9XX04 to be high, based on a search of 000 global day codes with between 45 and 75 minutes of intraservice time and between 109 and 149 minutes of total time in the RUC database. For CY 2027 we are proposing a work RVU of 8.05, based on the RUC survey 25th percentile, for CPT code 9XX04. We are proposing the RUC-recommended work RVU of 4.38 for CPT code 9XX07. The RUC did not recommend, and we are not proposing any direct PE inputs for these codes.

(38) Rotational Vestibular Assessment (CPT codes 92XX5 and 92XX6)

At the September 2025 CPT Editorial Panel Meeting, CPT code 92546 was deleted, and replaced with two new codes to report rotational vestibular assessment. The two new codes, CPT code 92XX5 (*Rotational vestibular assessment by sinusoidal harmonic acceleration (SHA) testing with calibrated, computer-controlled chair, with interpretation and report (do not report 92XX5 in conjunction with 92270)*) and 92XX6 (*Rotational vestibular assessment by sinusoidal harmonic acceleration (SHA) testing with calibrated, computer-controlled chair, with interpretation and report; with velocity step testing (VST) (List separately in addition to code for primary procedure)*) were surveyed for the September 2025 RUC meeting.

We are proposing the RUC-recommended work RVU of 0.92 for CPT code 92XX5.

We disagree with the RUC's recommended value of 0.48 for CPT code 92XX6 and we are instead proposing a work RVU of 0.35 which is the survey 25th percentile valuation. As valued by the RUC, the work RVU for add-on CPT code 92XX6 is half of the RUC's recommended work RVU of the base code (92XX5), despite the fact that CPT code 92XX6 has only 12 minutes of work time as compared with 45 minutes of work time for CPT code 92XX5. This leads to the intensity of CPT code 92XX6 being valued at double that of the base code,

which we do not believe would be typical given that the same SHA testing is taking place in both services. We disagree with the RUC that valuing the work RVU of the add-on CPT code 92XX6 at half the work of the base CPT code 92XX5 would be appropriate, as this does not account for the substantial preservice and postservice work time contained in CPT code 92XX5, which together account for 20 of the 45 total minutes. We agree with the RUC that the intensity of this code is higher than the base code, and our proposed work RVU of 0.35 assigns a higher intensity to CPT code 92XX6 than CPT code 92XX5, but we disagree that the intensity of the add-on service would be double that of the base code.

We are proposing the RUC recommended direct PE inputs for CPT codes 92XX5 and 92XX6 without refinement.

Additionally, in the CY 2023 PFS final rule (87 FR 69656 through 69663) we created an exception to the physician order requirement at 42 CFR 410.32(a)(4) to allow patients to directly access audiologists. We also delineated the vestibular function tests as those not applicable for use with the AB modifier (for direct access) – see Audiology Services on the PFS website at *https://www.cms.gov/medicare/payment/fee-schedules/physician/audiology-services*. Based on the foregoing, for the new Rotational Vestibular Assessment Codes, CPT codes 92XX5 and 92XX6 will be added to the audiology services code list but they will not be eligible to be billed with the AB modifier.

(39) Video Head Impulse - Vestibular Function (CPT codes 92X10 and 92X11)

At the September 2025 CPT Editorial Panel, the committee approved the addition of new CPT codes, 92X10 *(Video head impulse testing (vhit) with recording, interpretation and report of lateral semicircular canal function)* and 92X11 (*Video head impulse testing (vhit) with recording, interpretation and report of lateral and vertical semicircular canal function)* to report video head impulse testing (vHIT) and a corresponding parenthetical note. The RUC reviewed these services at the January 2026 meeting.

For CY 2027, we are proposing the RUC-recommended work RVUs of 0.53 for CPT code 92X10 and 0.84 for CPT code 92X11. We are proposing the RUC-recommended direct PE inputs for both CPT codes without refinement.

(40) Speech-Language Pathology Services (CPT codes 92X0X, 92X1X, 92X2X, 92X3X, 92X4X, 92X5X, 92X6X, 92X7X, 92X8X, 92X9X, and 92508)

At the September 2025 CPT Editorial Panel meeting, CPT code 92507 (*Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual*) was replaced with 10 new codes to report fluency disorder, speech sound production disorder, language comprehension and expression disorder, speech sound production disorder and language comprehension and expression disorder, and voice, upper airway dysfunction and/or resonance disorders. CPT codes 92X0X (*Treatment of fluency disorder (eg, stuttering and cluttering), direct (one-on-one) patient contact; initial 30 minutes*), 92X1X (*Treatment of fluency disorder (eg, stuttering and cluttering), direct (one-on-one) patient contact; each additional 15 minutes (list separately in addition to code for primary service)*), 92X2X (*Treatment of speech sound production disorder (eg, articulation, phonological process, apraxia, dysarthria), direct (one-on-one) patient contact; initial 30 minutes*), 92X3X (*Treatment of speech sound production disorder (eg, articulation, phonological process, apraxia, dysarthria), direct (one-on-one) patient contact; each additional 15 minutes (list separately in addition to code for primary service)*), 92X4X (*Treatment of language comprehension and expression disorder (eg, receptive and expressive language), direct (one-on-one) patient contact; initial 30 minutes*), 92X5X (*Treatment of language comprehension and expression disorder (eg, receptive and expressive language), direct (one-on-one) patient contact; each additional 15 minutes (list separately in addition to code for primary service)*), 92X6X (*Treatment of speech sound production disorder (eg, articulation, phonological process, apraxia, dysarthria) and language comprehension and expression disorder (eg, receptive and expressive language), direct (one-on-one) patient contact; initial 30 minutes*), 92X7X (*Treatment of speech sound production disorder (eg, articulation,*

phonological process, apraxia, dysarthria) and language comprehension and expression disorder (eg, receptive and expressive language), direct (one-on-one) patient contact; each additional 15 minutes (list separately in addition to code for primary service)), 92X8X (*Treatment of voice, upper airway dysfunction, and/or resonance disorders, direct (one-on-one) patient contact; initial 30 minutes*), 92X9X (*Treatment of voice, upper airway dysfunction, and/or resonance disorders, direct (one-on-one) patient contact; each additional 15 minutes (list separately in addition to code for primary service)*), and 92508 (*Treatment of speech, language, voice, communication, and/or auditory processing disorder, group, 2 or more individuals*) are new and/or revised codes for CY 2027. Additionally, the introductory guidelines were revised to clarify reporting of the services. The code family was surveyed for the January 2026 RUC HCPAC Review Board meeting.

For CY 2027, we are proposing the RUC-recommended work RVU for all 11 codes in the family. We are proposing the RUC-recommended work RVUs of 0.92 for CPT code 92X0X, 0.44 for CPT code 92X1X, 0.90 for CPT code 92X2X, 0.44 for CPT code 92X3X, 1.00 for CPT code 92X4X, 0.48 for CPT code 92X5X, 1.00 for CPT code 92X6X, 0.50 for CPT code 92X7X, 0.98 for CPT code 92X8X, 0.48 for CPT code 92X9X, and 0.28 for CPT code 92508).

We are proposing the RUC-recommended direct PE inputs for all the codes in the family without refinement.

We are proposing to designate these codes as always therapy services which means they must be furnished under a therapy plan of care regardless of who provides them and billed with a therapy modifier (this includes physicians and NPPs when they furnish the service or therapists furnish the services incident to the physician/NPP). We are also proposing to designate the new CPT codes that each represent the initial 30 minutes ─ 92X0X, 92X2X, 92X4X, 92X6X, and 92X8X ─ as subject to the multiple procedure payment reduction (MPPR) for therapy services. The new CPT codes that represent each additional 15 minutes ─ 92X1X, 92X3X, 92X5X, 92X7X and 92X9X ─ are not subject to the MPPR as they are all add-on codes which we

excluded in the CY 2011 PFS final rule along with contractor-priced and bundled codes (75 FR 73240) and noted in section 10.7 of chapter 5 of the Medicare Claims Processing Manual (MCPM).

(a) Pediatric G-code for Speech-Language Pathology Services

We have heard from interested parties the need to preserve CPT code 92507 (*Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual)* specifically related to the pediatric population. Interested parties stated that the 10 new CPT codes do not accurately capture the time and intensity of work as it relates to pediatric patients. In an effort to be responsive to interested parties, we are proposing to create and pay separately for a new HCPCS code, HCPCS code GSLPP, to accurately reflect the time and resources spent in providing these services to pediatric patients.

We propose the following code and descriptor for the proposed code: HCPCS code GSLPP (*Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual; for the pediatric population up to age 21*). We are proposing that HCPCS code GSLPP would be reported by a speech language pathologist performing these services specific to the pediatric population.

We are proposing that this code could be billed only once per patient per day. We are proposing to assign a XXX global period payment indicator for HCPCS code GSLPP. The XXX global period payment indicator would indicate that the global period does not apply to this service.

As previously discussed in this section, we are proposing to designate HCPCS code GSLPP as an always therapy service and add it to the list of codes that are subject to the MPPR for therapy services.

(b) Proposed Valuation for HCPCS code GSLPP

We note that the proposed valuation of HCPCS code GSLPP is meant to reflect the time and resource costs, for speech-language pathology services inherent to the pediatric population.

Therefore, we believe that CPT code 92507 serves as an appropriate reference for the purposes of valuing HCPCS code GSLPP. We believe there will be relatively the same work involved for HCPCS code GSLPP when compared to the work of CPT code 92507 as it relates to pediatric patients, considering the amount of time needed to furnish the elements discussed earlier in this section. Therefore, we are proposing a work RVU of 1.30, which represents the assigned work for 60 minutes of CPT code 92507. Additionally, we are proposing a work time of 60 minutes established for CPT code 92507, personally performed by the billing practitioner.

We are proposing the same direct PE inputs for HCPCS code GSLPP as CPT code 92507, as we believe that the relative resource costs for this service will remain the same. To help inform whether our proposed valuation reflects the typical service for the pediatric population, we are seeking comment on the typical time and intensity practitioners spend furnishing these services.

(41) Endoluminal Coronary Intravascular Ultrasound (IVUS) (CPT codes 92978 and 92979)

In April 2025, the RAW identified CPT code 92978 (*Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel (List separately in addition to code for primary procedure)*) as a code that has Medicare utilization of 10,000 or more that has increased by at least 100 percent from 2018 through 2023. CPT codes 92978 and 92979 (*Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; each additional vessel (List separately in addition to code for primary procedure)*) were surveyed for the January 2026 RUC meeting.

We disagree with the RUC-recommended work RVUs for these codes and instead we are proposing work RVUs of 1.40 for CPT code 92978 and 1.04 for CPT code 92979 to account for the significant decreases in physician intraservice time for both codes. The RUC's

recommendation to maintain current work RVUs for these codes does not appear to fully account for these intraservice time decreases. While we do not believe that the decrease in time as reflected in survey values should always equate to a one-to-one or linear decrease in newly valued work RVUs we do believe that, since the two components of work are time and intensity, absent an obvious or explicitly stated rationale for why the relative intensity of a given procedure has increased, significant decreases in time should be reflected in decreases to work RVUs although not necessarily in a linear manner, and we do not believe it is appropriate to decrease physician time while maintaining the current work RVUs.

We reviewed the RUC recommendations and found them to be high, relative to other codes with the same or similar work times. Based on a search of similarly timed codes in the RUC database, the RUC-recommended work RVU of 1.76 for CPT code 92978 is higher than 44 of 47 add-on codes with 15 minutes of physician intraservice time. Similarly, the RUC-recommended work RVU of 1.40 for CPT code 92979 would be the second highest work RVU for add-on codes with 12 to 14 minutes of physician intraservice time. Therefore, we disagree with the RUC recommended work RVU of 1.76 for CPT code 92978 and we are instead proposing a work RVU of 1.40 based on a crosswalk to CPT code 93572 (*Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress, when performed; each additional vessel (List separately in addition to code for primary procedure)*). This proposed work RVU is higher than the reverse building block work RVU of 1.06 and results in a higher intensity for the code than its current work RVU and physician time. The resulting increase in intensity more accurately accounts for the RUC's assertion that the intensity and complexity has increased with the evolution of these services because a higher proportion of the skin-to-skin time is now dedicated to more intense activities and interventions.

We also disagree with the RUC recommendation to maintain the current work RVU of 1.40 for CPT code 92979 and are proposing a work RVU of 1.04 based on the RUC-

recommended increment of 0.36 work RVUs between CPT codes 96978 and 96979. Similarly, this represents an increase in intensity compared to the code's current work RVU and work time to account for the increased intensity that has occurred with the evolution of these services.

The RUC did not recommend and we are not proposing any direct PE inputs for CPT codes 92978 and 92979.

(42) Autonomic Function Testing (CPT codes 95921, 95XX4, 95922, 95923, 95XX5, 95XX6, 95924, 95XX7, 95XX8, and 95XX9)

In February 2025, the CPT Editorial Panel created six new codes to report autonomic function testing with the use of a tilt table, sudomotor tests, and combined procedures to address an earlier RUC referral: CPT code 95XX4 (T*esting of autonomic nervous system function, with interpretation and report; use of tilt table*), CPT code 95XX5 (*Testing of autonomic nervous system function, with interpretation and report; sudomotor, thermoregulatory sweat test*), CPT code 95XX6 (*Testing of autonomic nervous system function, with interpretation and report; sudomotor, assessing the sympathetic skin response (SSR) potential*), CPT code 95XX7 (*Testing of autonomic nervous system function, with interpretation and report; combined parasympathetic and sudomotor testing, quantitative sudomotor axon reflex test (QSART) or silastic sweat imprint*), CPT code 95XX8 (*Testing of autonomic nervous system function, with interpretation and report; combined sympathetic adrenergic with at least 5 minutes of passive tilt (ie, tilt table) and sudomotor testing, quantitative sudomotor axon reflex test (QSART) or silastic sweat imprint*), and CPT code 95XX9 (*Testing of autonomic nervous system function, with interpretation and report; combined parasympathetic, sympathetic adrenergic function with at least 5 minutes of passive tilt (ie, tilt table), and sudomotor testing, quantitative sudomotor axon reflex test (QSART) or silastic sweat imprint*). The CPT Editorial Panel also revised four existing codes to include interpretation and report and clarification on tilt table use: CPT code 95921 (T*esting of autonomic nervous system function, with interpretation and report; cardiovagal innervation (parasympathetic function), including 2 or more of the following: heart*

rate response to deep breathing with recorded R-R interval, Valsalva ratio, and 30:15 ratio), CPT code 95922 (*Testing of autonomic nervous system function, with interpretation and report; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least 5 minutes of passive tilt (ie, tilt table)*), CPT code 95923 (*Testing of autonomic nervous system function, with interpretation and report; sudomotor, quantitative sudomotor axon reflex test (QSART) or silastic sweat imprint*), and CPT code 95924 (*Testing of autonomic nervous system function, with interpretation and report; combined parasympathetic and sympathetic adrenergic function testing with at least 5 minutes of passive tilt (ie, tilt table)*). This code family was surveyed for the April 2025 RUC meeting.

We are proposing the RUC-recommended work RVU for seven of the ten codes in this family. We are proposing a work RVU of 0.34 for CPT code 95XX4, a work RVU of 0.96 for CPT code 95922, a work RVU of 0.88 for CPT code 95923, a work RVU of 1.00 for CPT code 95XX5, a work RVU of 0.50 for CPT code 95XX6, a work RVU of 1.50 for CPT code 95924, and a work RVU of 1.17 for CPT code 95XX7. We note that several of these work RVUs were affected by the efficiency adjustment which was applied at the start of CY 2026, as the RUC recommendations were based on pre-adjustment work valuations.

We disagree with the RUC-recommended work RVU of 0.88 for CPT code 95921 and we are instead proposing a work RVU of 0.74 based on a crosswalk to CPT code 97813 (*Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient*). When reviewing this code family, we noticed that CPT code 95921 had one of the highest intensities in the family at the RUC-recommended work RVU of 0.88 despite having some of the shortest surveyed work times and describing one of the seemingly least intensive procedures. The revised code descriptor for CPT code 95921 describes a single test for cardiovagal innervation, and we do not agree that this service should be valued with a higher intensity than some of the other codes in this family that contain multiple kinds of

autonomic function testing. The RUC's recommended work RVU would also value CPT code 95921 at the same 0.88 as CPT code 95923 despite the latter code having significantly more total work time (32 minutes as compared to 25 minutes). We are aware that these codes share the same current work RVU, however the new surveyed work times indicate that CPT code 95921 typically takes less time to perform than CPT code 95923, and, since the two components of work are time and intensity, we believe that CPT code 95921 should be valued at a lower rate. Therefore we are proposing a work RVU of 0.74 based on a crosswalk to CPT code 97813, an acupuncture procedure with the identical intraservice and total work time as CPT code 95921. We also note that this valuation of CPT code 95921 maintains the current intensity of the procedure, as well as better maintaining relativity with the other codes in the family.

We disagree with the RUC-recommended work RVU of 1.75 for CPT code 95XX8 and we are instead proposing a work RVU of 1.56 based on a crosswalk to CPT code 77047 (*Magnetic resonance imaging, breast, without contrast material; bilateral*). We disagree with the RUC's recommended work RVU of 1.75, based on the survey median result, as it represents a significant increase in work valuation and intensity over the other codes in this family. For example, the RUC recommended a work RVU of 1.50 for CPT code 95924 in comparison to 1.75 for this code, despite CPT code 95XX8 having only 5 minutes of additional intraservice time and 3 minutes of additional total time (50 minutes as compared with 47 minutes). CPT code 95XX8 would require an anomalously high intensity relative to the rest of the family to justify the recommended work valuation of 1.75, which we do not agree would be warranted here given that this code is performing the same autonomic function tests that take place in CPT code 95922 and 95923. Therefore we are proposing a work RVU of 1.56 based on a crosswalk to CPT code 77047, a breast MRI procedure with the identical intraservice time and similar total work time as CPT code 95XX8. We believe that this valuation of CPT code 95XX8 better maintains relativity with the other codes in the family instead of requiring an anomalously high intensity as was the case at the RUC's recommended work RVU.

We disagree with the RUC-recommended work RVU of 1.91 for CPT code 95XX9 and we are instead proposing a work RVU of 1.77 based on a crosswalk to CPT code 78831 (*Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT), minimum 2 areas (eg, pelvis and knees, chest and abdomen) or separate acquisitions (eg, lung ventilation and perfusion), single day imaging, or single area or acquisition over 2 or more days*). As was the case with CPT code 95XX8, we believe that the RUC's recommended work RVU of 1.91 for CPT code 95XX9, based on the survey 25th percentile result, represents a significant increase in work valuation and intensity over the other codes in this family. While we do agree with the RUC that CPT code 95XX9 includes the most autonomic function tests and should have the highest intensity within the code family, we disagree that CPT code 95XX9 should be valued at a work RVU that results in an intensity approximately 50 percent higher than the rest of this family. To use the same example again, the RUC recommended a work RVU of 1.50 for CPT code 95924 in comparison to 1.91 for this code, despite CPT code 95XX9 having only 5 minutes of additional intraservice time and 7 minutes of additional total time (52 minutes as compared with 47 minutes). We believe that the work valuation and intensity are simply too high at the RUC's recommended work RVU of 1.91 as this does not maintain relativity with the other codes in this family, given that the same tests are being performed. Therefore, we are proposing a work RVU of 1.77 based on a crosswalk to CPT code 78831, a radiopharmaceutical procedure with the identical intraservice time and similar total work time as CPT code 95XX9. We note that this work valuation still assigns the highest intensity in the family to CPT code 95XX9, while bringing it more in accordance with its peer codes. We believe that this valuation of CPT code 95XX9 better maintains relativity with the other codes in the family instead of requiring an anomalously high intensity as was the case at the RUC's recommended work RVU.

We are proposing the RUC-recommended direct PE inputs for CPT codes 95921, 95XX4, 95922, 95923, 95XX5, 95XX6, 95924, 95XX7, 95XX8, and 95XX9 without refinement.

(43) Unattended Sleep Testing (CPT codes 95X18, 95X19, 95X20, 95X21, 95X22, and 95X23)

At the February 2025 CPT Editorial Panel meeting, CPT codes 95800 (*Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (eg, by airflow or peripheral arterial tone), and sleep time*), 95801 (*Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (eg, by airflow or peripheral arterial tone)*) and 95806 (*Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory airflow, and respiratory effort (eg, thoracoabdominal movement)*) were deleted. They were replaced with six new CPT codes: 95X18 (*Unattended sleep study, set-up, data acquisition and technical analysis; low complexity of 3-4 channels that generate at least 3-5 parameter categories*), 95X19 (*Unattended sleep study, set-up, data acquisition and technical analysis; moderate complexity of 5-10 channels that generate at least 6-8 parameter categories*), 95X20 (*Unattended sleep study, set-up, data acquisition and technical analysis; high complexity of 11 or more channels that generate at least 9 parameter categories*), 95X21 (*Unattended sleep study, interpretation and report by a physician or other qualified health care professional; low complexity of 3-4 channels that generate at least 3-5 parameter categories*), 95X22 (*Unattended sleep study, interpretation and report by a physician or other qualified health care professional; moderate complexity of 5-10 channels that generate at least 6-8 parameter categories*), and 95X23 (*Unattended sleep study, interpretation and report by a physician or other qualified health care professional; high complexity of 11 or more channels that generate at least 9 parameter categories*). This code family describes the reporting of unattended sleep studies with set-up, data acquisition, and technical analysis, and with interpretation and report by a physician or other qualified health care professional. These new codes were surveyed for the April 2025 RUC meeting.

For CY 2027, the RUC recommended a work RVU of 0.81 for CPT code 95X21, a work RVU of 1.05 for CPT code 95X22, and a work RVU of 1.60 for CPT code 95X23. These codes are professional component only services and have no direct PE inputs; we also note that the RUC recommendations for CPT codes 95X21 and 95X22 were affected by the efficiency adjustment which was applied at the start of CY 2026, as the RUC recommendations were based on pre-adjustment work valuations. For CPT code 95X21, we are proposing the RUC's recommended work RVU of 0.81 and for CPT code 95X22, we are proposing the RUC's recommended work RVU of 1.05.

However, we disagree with the RUC's recommended work RVU of 1.60 for CPT code 95X23 and we are instead proposing a work RVU of 1.42 based on a crosswalk to CPT code 92014 (*Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits*), which has 24 minutes of intraservice time and 37 minutes of total time. CPT code 95X23 is a similarly timed code with 20 minutes of intraservice time and 39 minutes of total time. We are aware that the RUC's recommended work RVU is lower than the survey 25th percentile work RVU and further understand that the increase in intensity from moderate complexity of 5 to 10 channels that generate at least 6 to 8 parameter categories to complexity of 11 or more channels that generate at least 9 parameter categories may not be linear. The additional parameters could be more complex, which could result in higher intensity and may not be fully captured in the previous two codes. We agree that the intensity for CPT code 95X23 should be higher; however, we do not believe that the intensity associated with the RUC recommended RVU of 1.60 is typical for this service since it would be nearly double the intensity of CPT codes 95X21 and 95X22. Therefore, we believe that CPT code 92014 is an appropriate crosswalk compared to the RUC's recommended crosswalk to CPT code 99203 (*Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision*

making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.). We believe that our proposed valuation of 1.42, based on the crosswalk from 92014, more accurately values CPT code 95X23 since it does not result in the sizable increase in intensity as recommended by the RUC. In addition, we have maintained relativity between the codes in this family with similarly timed codes.

For CPT codes 95X18, 95X19, and 95X20, which are Practice Expense (PE) only codes, we are proposing the RUC-recommended direct PE inputs. However, we note concerns regarding two direct PE inputs: CA021 (Perform procedure/service—NOT directly related to physician work time) and CA042 (Perform procedure/service in post-service period—NOT directly related to physician work time). For CPT codes 95X18 and 95X19, the RUC recommended 15 minutes for the CA021 activity, and 25 minutes for CPT code 95X20. The rationale for this increase from 15 minutes for CPT codes 95X18 and 95X19 to 25 minutes for CPT code 95X20 was not clearly stated in the PE Summary of Recommendations although this is an increase of 66.7 percent. Similarly, for the CA042 activity, the RUC recommended 40 minutes for CPT code 95X18, 50 minutes for CPT code 95X19, and 70 minutes for CPT code 95X20. We note that there is a 10-minute increase from CPT code 95X18 to CPT code 95X19, and a 20-minute increase from CPT code 95X19 to CPT code 95X20. The rationale for these 10-minute and 20-minute increases was also not clearly stated. We appreciate that explanations for the direct PE inputs were provided in the PE Summary of Recommendations, given that this is a non-standard clinical labor activity. However, as CPT code 95X18 describes a low-complexity study, CPT code 95X19 describes a moderate-complexity study, and CPT code 95X20 describes a high-complexity study, we welcome public comments providing additional information, particularly regarding the increases in time for these direct PE inputs across these three CPT codes.

Also, for CPT codes 95X18, 95X19, and 95X20, the RUC recommended use of the "other" formula for three new equipment items and based the time assumption of 960 minutes (that is, 16 hours). We are soliciting comments on whether it would be typical for the equipment

in question to be worn for the full 16 hours. According to the PE Summary of Recommendations, patients typically arrive later in the day (for example, around 4 p.m.) for an appointment to perform a test run with the equipment, then take the equipment home and return it the following morning (typically around 9 a.m.). Therefore, the RUC recommended a 16-hour period, representing two nights, as this duration currently exists in the RUC database and is generally consistent with clinical practice. However, we are seeking public comments on whether two nights of use are required and typical for home sleep testing, as the reported equipment time may represent the total period the patient has the device outside the office rather than the time it is actually in use.

Lastly, we received invoices for a new supply item and three new equipment items for CPT codes 95X18, 95X19, and 95X20. The new supply item is SA143 (Nox A1 Sensor Kit adult), and the new equipment items are EQ417 (Nox A1s System with SpO2, US), EQ418 (Apnea Link Air), and EQ419 (Apnea Trak Legacy). However, a single invoice for each supply or piece of equipment may not be reflective of typical costs, we encourage interested parties to submit invoices to improve the accuracy of pricing for these items in the direct PE database.

We are proposing the RUC-recommended direct PE inputs for CPT codes 95X18, 95X19, and 95X20 without refinement.

(44) Laser Treatment for Inflammatory Skin Diseases (CPT codes 96920, 96921, and 96922)

In May 2025, the CPT Editorial Panel revised three codes to reflect the intended use for inflammatory or auto-immune skin diseases (eg, psoriasis): CPT codes 96920 *(Laser treatment, 308-312 nanometer wavelengths, for inflammatory or auto-immune skin diseases (eg, psoriasis); total area less than 250 sq cm)*, 96921 *(Laser treatment, 308-312 nanometer wavelengths, for inflammatory or auto-immune skin diseases (eg, psoriasis); 250 sq cm to 500 sq cm)*, and 96922 *(Laser treatment, 308-312 nanometer wavelengths, for inflammatory or auto-immune skin diseases (eg, psoriasis); over 500 sq cm)*. These codes were last discussed in the CY 2025 PFS final rule (89 FR 97797 through 97801). These revisions were based on flaws in the prior

valuation process and a change in the patient population. The specialty society surveyed the code family for the September 2025 RUC meeting.

For CY 2027, we are proposing the RUC-recommended work RVUs of 1.00 for CPT code 96920, 1.24 for CPT code 96921, and 1.50 for CPT code 96922. We are proposing the RUC-recommended direct PE inputs for CPT codes 96920, 96921, and 96922 without refinement.

(45) Real-time Fluorescence Wound Imaging (CPT code 976XX)

In September 2025, the CPT Editorial Panel created a new code to report real-time florescence wound imaging, CPT code 976XX (*Real-time fluorescence wound imaging with clinical darkness to identify presence, location, load of bacteria and measure wound size, per day*). The specialty society did not conduct a survey for CPT code 976XX because they determined it would be unable to conduct a successful survey that met the RUC's minimum survey threshold, and therefore, the RUC recommended contractor pricing for CY 2027.

Due to persistent payment variability for the predecessor CPT codes 0598T and 0599T, and limited geographical uptake of the technology, the device manufacturer requested that CMS actively price CPT code 976XX and provided work RVU and direct PE input recommendations. After consideration of the manufacturer's recommendations, we are proposing a work RVU of 0.80 and physician pre-evaluation time of 6 minutes, intraservice time of 15 minutes, and immediate post service time of 5 minutes, totaling 26 minutes of physician time. For direct PE in the non-facility, we are proposing a direct crosswalk of clinical labor activities and time from CPT code 97610 (*Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day*), with the addition of 10 minutes for CA026 Clean surgical instrument package for CPT code 976XX, for a total of 42 minutes of clinical labor time. Additionally, we are proposing the following supply items and quantities in the non-facility for CPT code 976XX.

TABLE A-D4: PROPOSED SUPPLY ITEMS FOR CPT CODE 976XX

Supply Code	Supply Description	Supply Quantity in the Nonfacility
SA043	pack, cleaning, surgical instruments	1
SB007	drape, sterile barrier 16in x 29in	1
SB019	drape-towel, sterile 18in x 26in	1
SB022	gloves, non-sterile	2
SB028	gown, surgical, sterile	1
SB044	underpad 2ft x 3ft (Chux)	1
SC056	syringe 50-60ml	1
SF007	blade, surgical (Bard-Parker)	1
SG018	bandage, Kling, non-sterile 3in	1
SG035	dressing, 3in x 4in (Telfa, Release)	2
SG051	gauze, non-sterile 4in x 4in	8
SG052	gauze, self-adherent roll 0.5in to 2in (Fabco, Gauztex)	72
SG079	tape, surgical paper 1in (Micropore)	12
SH069	sodium chloride 0.9% irrigation (500-1000ml uou)	1
SJ046	silver nitrate applicator	2
SB061	MolecuLight DX Eco Dark Drapes	1

Additionally, we are proposing the following equipment items and equipment minutes in the non-facility to correspond with the 30 and 36 minutes of clinical labor time included in the default and instrument pack equipment formulas, respectively, for CPT code 976XX. The MolecuLight DX System (ER131) was added to the direct PE database for inclusion in CPT code 976XX assuming a 5-year useful life and purchase price of $21,500 based on the provided invoices. We are not proposing to include the MolecuLight carrying case in CPT code's 976XX's equipment costs as recommended by the device manufacturer. We have a longstanding policy that medical equipment must be at least $500 and all equipment inputs under $500 are considered indirect expense. We welcome public comment on the appropriateness of our proposed work RVU and the typicality of our proposed physician work times and direct PE inputs.

TABLE A-D5: PROPOSED EQUIPMENT ITEMS FOR CPT CODE 976XX

Equipment Code	Equipment Description	Equipment Minutes in the Nonfacility
EF015	mayo stand	30
EF031	table, power	30
EQ137	instrument pack, basic ($500-$1499)	36
EQ168	light, exam	30
ER131	MolecuLight DX System	30

We are seeking comment on whether this service will typically be billed alongside wound debridement codes (that is, greater than 50 percent of the time), and if so, which of the proposed direct PE inputs may be duplicative of those already included in the wound debridement codes,

such as CPT codes 11042 (*Debridement*, *subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less)* and 97597 (*Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 sq cm or less)*). We note that CPT code 976XX's predecessor codes, CPT codes 0598T and 0599T, were billed with wound debridement codes 35.1 percent and 46.6 percent of the time, respectively. However, we understand that such concurrent billing with wound debridement may become more common as adoption of this technology increases. For example, we are seeking comment on whether the following proposed supply items are duplicative of debridement codes if it is anticipated that these codes will be typically billed together: SB007, SB019, SB044, SC056, SF007, SF018, SG035, SG051, SG052, SG079, SH069 and SJ046. We are also seeking comment on whether these wound care supply items are typical for CPT code 976XX, given that the code descriptor specifies wound imaging but does not include any wound care elements. Finally, we note that the direct PE crosswalk code, CPT code 97610, is billed alone 64.4 percent of the time and with debridement CPT code 11042 only 4.3 percent of the time. Therefore, we are seeking comment on the appropriateness of this code as a direct PE crosswalk considering the different billing patterns of CPT code 97610 and 976XX based on its predecessor codes.

(46) Lactation Care Services (CPT Codes 978XX and 978X1)

At the May 2025 CPT Editorial Panel meeting, two new CPT codes were created for reporting lactation care directed by a physician or qualified health care professional (QHP): CPT codes 978XX (*Lactation care directed by a physician or other qualified health care professional, including history, assessment, training, and report; first 30 minutes*) and 978X1 (*Lactation care directed by a physician or other qualified health care professional, including history,*

assessment, training, and report; each additional 15 minutes). These new CPT codes were surveyed at the September 2025 AMA RUC Meeting.

For CY 2027, we are proposing the RUC-recommended work RVU of 0.18 for CPT code 978XX. The RUC did not recommend, and we are not proposing a work RVU for CPT code 978X1, which has been designed as a PE only service.

We are proposing the RUC-recommended direct PE inputs for CPT codes 978XX and 978X1, including the creation of a new clinical staff type for Lactation Consultant (L076A) and a new EF052 equipment item (scale, infant, digital, fine gradation). We are adopting CPT language and requirements for the Lactation Consultant: "The qualifications of the lactation consultant/counselor must be recognized by a physician society, nonphysician health care professional society/association, or other appropriate source." We are proposing to value this new clinical staff type at the same 0.76 rate per minute currently used by the RN (L051A) clinical staff type as recommended by the RUC; we are seeking comment regarding this new clinical staff type and whether there may be a more appropriate crosswalk than the RN clinical staff type. We are proposing the RUC-recommendation of the RN clinical staff type as a proxy for pricing purposes, but are seeking comment on whether Lactation Consultants are typically RNs with additional credentialing/certification to be qualified to serve as a lactation consultant.

(47) Adaptive Behavior Services (CPT Codes 97151, 97152, 97X1X, 97X2X, 97X3X, 97153, 97154, 97X4X, 97X5X, 97155, 97X6X, 97156, 97157, 97158)

At the September 2025 CPT Editorial Panel meeting, the CPT Editorial Panel deleted CPT codes 0362T (*Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior.*) and 0373T (*Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a*

patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior.), revised eight existing CPT codes: 97151 (*Behavior identification assessment, administered by a physician or other QHP, each 15 minutes of the physician's or other QHP's time face-to-face with patient and/or caregiver(s) administering assessments and discussing findings and recommendations, and non- face-to-face analyzing past data, scoring and/or interpreting the assessment, and preparing the report and/or treatment plan*), 97152 (*Behavior identification-supporting assessment, administered by technician, face-to-face with the patient, each 15 minutes*), 97153 (*Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient, each 15 minutes*), 97154 (*Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients, each 15 minutes*), 97155 (*Adaptive behavior direction of technician and analysis by physician or other QHP, face-to-face with a patient, each 15 minutes*), 97156 (*Family adaptive behavior treatment guidance with analysis, administered by physician or other QHP (with or without the patient present), including discussing protocols and treatment targets and/or training the caregiver(s) to implement assessment or treatment protocols with the patient, face-to-face with caregiver(s) for 1 patient, each 15 minutes*), 97157 (*Multiple-family group adaptive behavior treatment guidance with analysis, administered by physician or other QHP (without the patient present), face-to-face with multiple sets of caregivers for multiple patients, each 15 minutes*) and 97158 (*Group adaptive behavior treatment with analysis, administered by physician or other QHP, face-to-face with multiple patients, each 15 minutes*), and created six new CPT codes: 97X1X (*Behavior identification supporting assessment of harmful behavior, each 15 minutes of technician time face-to-face with a patient, requiring the following components: delivered by two technicians, for a patient who exhibits harmful behavior, conducted in an environment that is customized to the patient's behavior,*), 97X2X (*Behavior identification supporting assessment of harmful behavior,*

each 15 minutes of technician time face-to-face with a patient, requiring the following components: delivered by two technicians, for a patient who exhibits harmful behavior, conducted in an environment that is customized to the patient's behavior, additional technicians present, each 15 minutes (list separately in addition to code for primary procedure)), 97X3X (*Adaptive behavior non-face-to-face services, personally performed by a physician or other QHP, each 15 minutes, with any of the following elements, when performed: review and analysis of data and session notes on patient treatment targets, clinical decision making regarding the need to modify treatment targets, goals, or protocols and/or making those modifications, clinical decision making regarding the need for additional assessment and developing or modifying assessment protocols, developing discharge or transition plan, reviewing treatment targets and/or revised assessment or treatment protocols with technician(s).*), 97X4X (*Adaptive behavior treatment of harmful behavior, each 15 minutes of technician time with a patient, requiring the following components: delivered by two technicians, for a patient who exhibits harmful behavior, conducted in an environment that is customized to the patient's behavior.*), 97X5X (*Adaptive behavior treatment of harmful behavior, each 15 minutes of technician time with a patient, requiring the following components: delivered by two technicians, for a patient who exhibits harmful behavior, conducted in an environment that is customized to the patient's behavior, each additional technician present, each 15 minutes (List separately in addition to code for primary procedure)*), and 97X6X (*Adaptive behavior treatment with analysis, administered by physician or other qualified health care professional, face-to-face with 1 patient, each 15 minutes*), to better specify appropriate time, define terms, address reporting gaps, and clarify reporting for technician and physician/QHP face-to-face and non-face-to-face adaptive behavior services. The RUC HCPAC Review Board reviewed the 14 codes in the revised code family at the January 2026 RUC HCPAC.

The RUC is recommending contractor pricing for all twelve codes in the family. The existing CPT codes 97151 through 97158 are currently contractor priced. We propose to

contractor price the six new codes and make no change to the status indicator for the eight revised existing codes that are already contractor priced.

(48) Remote Monitoring (CPT Codes 98975, 98976, 98977, 98978, 98980, 98981, 98984, 98985, 98986, 98979, 99091, 99453, 99454, 99457, 99458, 99473, 99474, 99445, and 99470)

(a) Background and Overview

In recent years, we have established payment for two code families that describe certain remote monitoring services: remote physiologic monitoring (RPM) and remote therapy monitoring (RTM). In the CY 2018 PFS final rule, we summarized feedback from a comment solicitation aimed at informing new payment policies that would allow for separate payment for remote monitoring services (82 FR 53014). In the CY 2019 PFS final rule (83 FR 59574 through 59576), we established valuations and payment policy for the RPM code family. In the CY 2020 PFS final rule (84 FR 62697 through 62698), we explained that the RPM code family describes chronic care RPM services that involve the collection, analysis, and interpretation of digitally collected physiologic data, followed by the development of a treatment plan and the managing of a patient under the treatment plan (84 FR 62697). In the CY 2020 PFS final rule, we finalized that CPT codes 99457 and 99458 would be included as designated care management services, allowing RPM services to be furnished under the general supervision of the physician or other qualified health care professional (who is qualified by education, training, licensure/regulation and facility privileging) (84 FR 62698). In the CY 2023 PFS final rule, in response to comments, we clarified that RTM or RPM services could be billed concurrently with Chronic Care Management (CCM), Transitional Care Management (TCM), Principal Care Management (PCM), Chronic Pain Management (CPM), or Behavioral Health Integration (BHI) (86 FR 69528 through 69539).

In September 2024, the Current Procedural Terminology (CPT) Editorial Panel added one code and made code revisions to report RPM device supply for 2 to 15 days and 16 to 30 days within a 30-day period; created one new code and code revisions to report RPM treatment

management services for the first 10 minutes, first 20 minutes, and each additional 20 minutes thereafter; added three RTM device supply codes to report respiratory, musculoskeletal and cognitive behavioral therapy for 2 to 15 days and 16 to 30 days within a 30-day period; created one new code and made code revisions to report RTM treatment management services for the first 10 minutes, first 20 minutes, and each additional 20 minutes thereafter; and revised remote monitoring guidelines. We reviewed the RUC recommendations for these services in the CY 2026 PFS final rule (90 FR 49394 through 49404). In response to recent reports and recommendations from the Office of the Inspector General (Additional Oversight of Remote Patient Monitoring in Medicare Is Needed[2] and Billing for Remote Patient Monitoring in Medicare[3]), for CY 2027, we are proposing refinements to the policies surrounding remote physiologic and remote therapeutic monitoring, as detailed later in this section.

(b) Established Patient Requirements

In the CY 2021 PFS final rule (85 FR 84542 through 84546), we established that, when the PHE for COVID-19 ended, we again required that RPM services be furnished only to an established patient. Patients who received initial remote monitoring services during PHE were considered established patients for purposes of the new patient requirements that were effective after the last day of the PHE for COVID-19.

For CY 2027, we are proposing to require that RTM services also be furnished only to established patients. We are proposing this condition of payment because we believe that a practitioner with an established relationship with a patient would likely have had the opportunity to collect relevant patient history and conduct a physical exam, as appropriate. As a result, the practitioner would possess information needed to understand the current medical status and needs of the patient prior to ordering RTM services to collect and analyze the patient's data and

---

[2] *https://oig.hhs.gov/reports/all/2024/additional-oversight-of-remote-patient-monitoring-in-medicare-is-needed/.*
[3] *https://oig.hhs.gov/reports/all/2025/billing-for-remote-patient-monitoring/.*

use the results of remote therapeutic monitoring to manage the patient under a specific treatment plan or therapy plan of care.

This proposal would also assist in resolving OIG's findings that some practices did not have a prior relationship with patients for whom they billed remote monitoring services for (Billing for Remote Patient Monitoring in Medicare[4]). (c) Initiating Visit Requirements

For CY 2027, we are proposing that practitioners reporting RPM or RTM services must furnish a separately reportable initiating visit in association with the onset of RPM or RTM services, since these services require a level of care coordination that cannot be effective without appropriate evaluation of the patient's needs. The initiating visit would also ensure the billing practitioner assesses the beneficiary to determine clinical appropriateness of RPM or RTM and provide an opportunity to obtain the required beneficiary consent to receive RPM or RTM services. We are proposing that RPM or RTM services must be initiated by the billing practitioner during a face-to-face (in-person or telehealth) visit. CPT codes that do not involve a face-to-face visit by the billing practitioner or are not separately payable under Medicare cannot be used as the visit for RPM or RTM initiation. If RPM or RTM is not discussed with the patient at that visit, that visit cannot count as the initiating visit for RPM or RTM. The RPM or RTM initiating visit can be separately billed.

(d) Supervision Requirements

Currently, RPM or RTM services may be outsourced to third-party companies that provide services via telephone and online contact only, using staff who have little to no established relationship with the beneficiary or other members of the care team and have little to no interaction with the office staff and billing practitioner. After reviewing the findings discussed in recent OIG reports, such as companies "cold calling" beneficiaries to solicit them for remote monitoring services they may not need (Additional Oversight of Remote Patient Monitoring in

Medicare Is Needed[5]) and working to improve the transparency of "incident to" services, we believe outsourcing RPM/RTM services to a third party can fragment care, lead to insufficient involvement and oversight of the billing practitioner, or result in services that do not actually represent or facilitate all required aspects of RPM or RTM services. Provision of these services by entities having only a loose association with the treating practitioner can detract from longitudinal, patient-centered care. We do not believe that RPM or RTM services provided by clinical staff contracted by a third party can ensure the billing practitioner has adequate oversight, management, or collaboration to bill RPM or RTM services. If there is little oversight by the billing practitioner or a lack of clinical integration between a third-party providing RPM/RTM and the billing practitioner, we do not believe that the full scope of service elements required to bill these codes are being met.

We are proposing to only allow payment for RPM or RTM services when furnished by clinical staff employed by the practice. To count the time spent by clinical staff providing aspects of RPM or RTM services, the clinical staff must be a direct employee of the practitioner or the practitioner's practice. If finalized, this will mean that for the purposes of billing Medicare, beginning January 1, 2027, the RPM and RTM codes could not be billed in cases where the service is not performed by clinical staff of the billing practitioner and will not allow contracting out to third-party companies. This does not mean the clinical staff must necessarily always be physically located within the practice, nor does it require that the beneficiary be on-site for the provision of remote monitoring services. Under our proposed revised policy, the time spent by clinical staff providing RPM or RTM services can be counted, provided that the clinical staff are under the general supervision of the billing practitioner, all other requirements of the "incident to" regulations at § 410.26 are met, and the clinical staff is a direct employee of the practitioner or the practitioner's practice. We are seeking comment on this proposal, specifically on how

[5] *https://oig.hhs.gov/reports/all/2024/additional-oversight-of-remote-patient-monitoring-in-medicare-is-needed/*.

often third-party billing currently occurs and how this policy, if finalized, could impact access to remote monitoring services.

(e) Valuation

Remote physiologic monitoring (RPM) represents the remote monitoring of parameters such as weight, blood pressure, and pulse oximetry to monitor a patient's condition and inform their management. The remote physiologic monitoring code set currently includes CPT codes 99091, 99445, 99453, 99454, 99457, 99458, 99470, 99473, and 99474 (code descriptors in Table A-D6). Remote therapeutic monitoring (RTM) represents the monitoring of adherence to at-home therapeutic interventions. For RTM, there are distinct device supply codes for three types of therapeutic monitoring: respiratory system, cognitive behavioral therapy, and musculoskeletal system monitoring. The remote therapeutic monitoring code set currently includes CPT codes 98975, 98976, 98977, 98978, 98979, 98980, 98981, 98984, and 98985 (code descriptors in Table A-D6). There are three components of RPM and RTM services: education and setup, device supply, and treatment management.

TABLE A-D6: CY 2027 REMOTE MONITORING CODES

CPT Code	Long Descriptor
98975	Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); initial set-up and patient education on use of equipment
98976	Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of respiratory system, 16-30 days in a 30-day period
98977	Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of musculoskeletal system, 16-30 days in a 30-day period
98978	Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of cognitive behavioral therapy, 16-30 days in a 30-day period
98979	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least 1 real-time interactive communication with the patient or caregiver during the calendar month; first 10 minutes
98980	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes
98981	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; each additional 20 minutes (List separately in addition to code for primary procedure)
98984	Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of respiratory system, 2-15 days in a 30-day period
98985	Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of musculoskeletal system, 2-15 days in a 30-day period
98986	Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of cognitive behavioral therapy, 2-15 days in a 30-day period
99091	Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days
99445	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial: device(s) supply with daily recording(s) or programmed alert(s) transmission, 2-15 days in a 30-day period
99453	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment
99454	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, 16-30 days in a 30-day period
99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes
99458	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes (List separately in addition to code for primary procedure)
99470	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring 1 real-time interactive communication with the patient/caregiver during the calendar month; first 10 minutes
99473	Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration
99474	Self-measured blood pressure using a device validated for clinical accuracy; separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient

For CPT codes 99453 and 98975, which are PE-only codes describing RPM and RTM initial set-up and patient education on use of equipment, respectively, we are proposing to crosswalk the direct PE inputs from CPT code 99473 (*Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration*), as we believe the existing valuation of CPT codes 99453 and 98975 may not accurately reflect the resource costs involved in those services. Specifically, we are concerned that, due to lack of information regarding the typical device used to perform these procedures, these services are overvalued. We believe that the typical device used for these procedures in the physician office setting may not be accurately captured in the data previously used for valuation, as we have received very little invoice or pricing information from interested parties for the specific devices used in RTM and RPM services. We believe that a crosswalk to the direct PE inputs associated with CPT code 99473 may more accurately capture the resource costs associated with a typical device set-up and patient education on use of equipment. We are seeking comment on this proposal, specifically information regarding the typical clinical workflow for the initial set-up and patient education on use of equipment services used in furnishing RPM or RTM and their associated costs.

For CPT codes 99445 and 99454, which are PE-only codes describing RPM device(s) supply with daily recording(s) or programmed alert(s) transmission, we are proposing to crosswalk the direct PE inputs from CPT code 99474 (*Self-measured blood pressure using a device validated for clinical accuracy; separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient*). For CPT codes 98976, 98977, 98978, 98984, 98985, and 98986, which are PE-only codes describing RTM device(s) supply for data access or data transmissions, we are proposing to crosswalk the direct PE inputs from CPT code 93270 (*External patient and, when*

performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; recording (includes connection, recording, and disconnection)). We believe the existing valuation of CPT codes 99445, 99454, 98976, 98977, 98978, 98984, 98985, and 98986 may not accurately reflect the resource costs involved in these services, especially since we continue to lack data surrounding the typical RPM and RTM devices and the costs associated with them. Specifically, we are concerned that, due to lack of information regarding the typical device used to perform these procedures, these services are overvalued. We believe that the typical device used for these procedures in the physician office setting may not be accurately captured in the data previously used for valuation, as we have received very little invoice or pricing information from interested parties for the specific devices used in RTM and RPM services. We believe that the crosswalk to the direct PE inputs associated with the proposed codes discussed earlier may more accurately capture the resource costs associated with a typical device. We are soliciting comments on this proposal, specifically information regarding the typical devices used in furnishing RPM or RTM, not just their associated costs and invoices, but robust evidence detailing what providers are actually paying for these devices, including discounts or other typical pricing details. We are seeking other types of pricing data and information for RPM or RTM devices, including if the costs include software, hardware, or both, as well as more information about the typical devices.

For CPT codes 99470, 99457, 99458, 98979, 98980, and 98981, which describe the physician/QHP work associated with treatment management, we are proposing to eliminate PE inputs for these codes, as we believe resource costs for these services are accurately captured in the work RVUs, and we do not believe the typical clinical workflow for these services would involve clinical staff time. We are proposing that the current work RVUs and current work times for these codes be maintained. We welcome information regarding the typical clinical workflow for these services.

We are soliciting comments on these proposals, as well as requesting general feedback from the public that may be useful in further development of our payment policies for remote monitoring services that are currently separately payable under the PFS.

(f) Comment Solicitation

We have concerns about the administrative burden of the numerous remote monitoring codes and proliferation of this code family. We also continue to work to implement recommendations from the recent OIG reports that we are concerned cannot be fully resolved with the current coding structure of the remote monitoring code family, such as ensuring that beneficiaries receive all components of the remote monitoring service. For example, the OIG report found that, "About 43 percent of enrollees who received remote patient monitoring did not receive all 3 components of it, raising questions about whether the monitoring is being used as intended." (Additional Oversight of Remote Patient Monitoring in Medicare Is Needed[6]).

We are also considering, and are seeking comment on, bundling CPT codes 99453, 99445, 99454, 99091, 99470, 99457, 99458, 98975, 98984, 98976, 98985, 98977, 98986, 98978, 98979, 98980, and 98981 through the creation of new codes that describe initial set up and monthly monitoring/management for RPM and RTM, respectively. For payment for remote monitoring services under the PFS, we are also considering, and are seeking comment on, the creation of four new HCPCS G-Codes:

- GRPM1: RPM initial set-up and patient education.
- GRPM2: Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), per calendar month, including:

++ Device(s) supply with daily recording(s) or programmed alert(s) transmission.

++ 2 or more days of data transmission.

++ Treatment management services, requiring at least one real-time interactive communication with the patient/caregiver; time totaling at least 20 minutes.

---

[6] *https://oig.hhs.gov/reports/all/2024/additional-oversight-of-remote-patient-monitoring-in-medicare-is-needed/*.

- GRTM1: RTM initial set-up and patient education.
- GRTM2: Remote monitoring of therapeutic parameter(s) (eg, therapy adherence, therapy response, digital therapeutic intervention), per calendar month, including:

++ Device(s) supply for data access or data transmissions.

++ 2 or more days of data transmission.

++ Treatment management services, requiring at least one real-time interactive communication with the patient or caregiver; time totaling at least 20 minutes.

We are seeking comment on these HCPCS G-codes and are also seeking comment on any other revisions needed to the code descriptors to reflect the necessary service elements for this code family. These HCPCS G-codes would adopt all current conditions of payment for the remote therapeutic and remote physiologic codes finalized in prior rulemaking, as well as the proposed established patient, initiating visit, or supervision or both requirements outlined earlier in this section, if finalized. As drafted, all service elements outlined in the G-code descriptors would be required each calendar month. We are seeking public comment on these HCPCS G-codes and, after consideration of public comment, could finalize payment for these codes.

The creation of these G-codes could alleviate administrative burden, as this would reduce the number of remote monitoring codes from 17 to four. These HCPCS G-codes would also ensure that beneficiaries receive treatment management services when receiving remote monitoring services. According to the OIG Reports, billing for Remote Patient Monitoring in Medicare[7] and Additional Oversight of Remote Patient Monitoring in Medicare Is Needed[8], some beneficiaries do not regularly receive treatment management services. The OIG Report, Additional Oversight of Remote Patient Monitoring in Medicare Is Needed[9], also stated that forty-three percent of enrollees who received remote patient monitoring did not receive at least one of the three components (patient education and set-up, device supply, and treatment

---

[7] *https://oig.hhs.gov/reports/all/2025/billing-for-remote-patient-monitoring/*.
[8] *https://oig.hhs.gov/reports/all/2024/additional-oversight-of-remote-patient-monitoring-in-medicare-is-needed/*.
[9] *https://oig.hhs.gov/reports/all/2024/additional-oversight-of-remote-patient-monitoring-in-medicare-is-needed/*.

management). Although we have not required that providers bill for all three components, this data from the OIG Report raises questions about how these services are being used. By incorporating device supply, data transmission, and treatment management into one code, we could ensure that those service elements are always provided.

In the CY 2024 PFS final rule (88 FR 79071 through 79073), we finalized the policy to add the suite of services that comprise RPM and RTM services to the general care management code, G0511 beginning January 1, 2024 as the requirements for RPM and RTM services are similar to the non-face-to-face requirements for the general care management services furnished in RHCs and FQHCs. Beginning January 1, 2025, RHCs and FQHCs are required to bill the individual codes that make up the general care management HCPCS code, G0511 (89 FR 97998 through 98010). Accordingly, we are seeking comment on implementing these HCPCS G-codes in RHCs and FQHCs.

We are seeking comment on valuation for these HCPCS G-codes. For GRPM1 and GRTM1, which could be PE-only codes describing RPM and RTM initial set-up and patient education on use of equipment, respectively, we could crosswalk the direct PE inputs from CPT code 99473 (*Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration*). We are seeking comment on this valuation, specifically information regarding the typical clinical workflow for the initial set-up and patient education on the use of equipment services used in furnishing RPM or RTM and their associated costs.

For GRPM2, we could crosswalk the work RVU input of 0.61 RVUs from CPT code 99457 and the direct PE inputs from CPT code 99474 (*Self-measured blood pressure using a device validated for clinical accuracy; separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with*

report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient).

For GRTM2, we could crosswalk the work RVU input of 0.62 RVUs from CPT code 98980 and the direct PE inputs from CPT code 93270 (*External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; recording (includes connection, recording, and disconnection))*.

(49) National Payment for Non-Sheet Form Skin Substitutes

In the CY 2026 PFS final rule (90 FR 49500), we finalized contractor pricing for non-sheet form skin substitutes. We stated that these products have the potential to be payable as skin substitutes; but that the units, as expressed in a product's coding, are difficult to standardize for payment purposes. Therefore, we finalized that we would maintain the current coding mechanism for these products and would direct the Medicare Administrative Contractors (MACs) to determine appropriate payment, which is generally consistent with how these products are currently paid. We stated that we would continue to evaluate payments for these products to determine if an alternative payment methodology may be better suited to non-sheet products.

Based on ongoing analysis and feedback from internal and external interested parties, we have come to believe that, on the balance, the resource costs per cm^2 for non-sheet form skin substitutes is consistent with the resource costs associated with those associated with sheet form skin substitutes. For non-sheet skin substitute products, cm^2 reflects the wound surface area treated rather than the physical dimensions of the product. Therefore, for CY 2027, we are proposing to nationally price the non-sheet form skin substitutes consistent with the payment rates associated with the sheet form skin substitutes. For a list of the non-sheet form skin substitutes, please refer to the skin substitutes section located on the CMS website (*https://www.cms.gov/medicare/payment/fee-schedules/physician-fee-schedule/skin-substitutes*).

(50) Smoking and Tobacco Use Cessation (CPT codes 99406, 99407) and Screening, Brief Intervention, and Referral to Treatment (SBIRT) (HCPCS codes G2011, G0396, G0397)

The Trump Administration Executive Order, "Establishing the President's Make America Health Again Commission"[10] is a top priority for CMS, as such we continue to focus on the prevention and management of chronic disease. Chronic disease remains a significant public health concern, with three in four American adults having at least one chronic condition, and more than half having two or more chronic conditions. Many preventable chronic diseases are caused by a short list of risk behaviors, including smoking, poor nutrition, physical inactivity, and excessive alcohol use.[11] These patterns reinforce the need for accessible behavioral health services that can help individuals reduce these risk behaviors.

In the CY 2024 PFS final rule (88 FR 79006 through 79010), we finalized an increase in the valuation for timed behavioral health services under the PFS by applying an upward adjustment of 19.1 percent to the work RVUs for time-based psychotherapy codes payable under the PFS. This increase is being implemented over a 4-year transition period.

We believe similar adjustments are warranted for smoking and tobacco use cessation, CPT codes 99406 (*Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes*) and 99407 (*Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes*) and screening, brief intervention, and referral to treatment (SBIRT) services, HCPCS codes G2011 (*Alcohol and/or substance (other than tobacco) misuse structured assessment (eg, audit, dast), and brief intervention, 5-14 minutes*), G0396 (*Alcohol and/or substance (other than tobacco) misuse structured assessment (eg, audit, dast), and brief intervention 15 to 30 minutes*), and G0397(*Alcohol and/or substance (other than tobacco) misuse structured assessment (eg, audit, dast), and intervention, greater than 30 minutes*).

---

[10] *https://www.whitehouse.gov/presidential-actions/2025/02/establishing-the-presidents-make-america-healthy-again-commission/.*

[11] *https://www.cdc.gov/chronic-disease/about/index.html.*

Smoking and tobacco cessation and SBIRT services are evidence supported behavioral health interventions. Quitting smoking provides immediate health improvements including lowering the likelihood of developing lung cancer and other smoking-related cancers, and reduces the risks of coronary heart disease, stroke, and chronic obstructive pulmonary disease. Evidence based smoking and tobacco cessation treatments are effective, including the combination of behavioral counseling and medication therapy.[12] SBIRT effectively addresses substance use. In primary care and other clinical settings, SBIRT has been shown to help decrease unhealthy substance use and misuse.[13]

The smoking and tobacco cessation services (CPT codes 99406 and 99407) and SBIRT services HCPCS codes G0396 and G0397 were last valued in 2008, and the SBIRT service HCPCS code G2011 was created and last valued in 2019. Given the evidence supported role these services play in preventing and managing chronic disease and behavioral health conditions including alcohol and/or substance misuse, we believe that valuation should more accurately reflect the clinical intensity and work associated with these time-based services.

Therefore, we propose applying the same upward adjustment of 19.1 percent to the work RVUs for these time-based services aligning with the adjustments made to the time-based psychotherapy codes, in conjunction with the fourth and final year of the phase-in for time-based psychotherapy codes that we finalized in the CY 2024 PFS final rule (88 FR 79006 through 79010). Although the upward adjustment of 19.1 percent for the time-based psychotherapy codes has been implemented over a 4-year period, with CY 2027 being the fourth year, we are proposing to apply the full 19.1 percent to smoking and tobacco use cessation services and SBIRT services in this final year of the transition. This approach ensures that these services are brought into alignment with the psychotherapy codes at the completion of the 4-year phase-in timeline, rather than initiating a new multiyear phase-in period. We are proposing to refine the

---

[12] *https://progressreport.cancer.gov/prevention/tobacco/cessation-aids#jump-links-field-background.*
[13] *https://pmc.ncbi.nlm.nih.gov/articles/PMC5551279/.*

work RVU of smoking and tobacco use cessation services codes as follows: for CPT code 99406 by increasing the work RVU to 0.29 from the current 0.24, and CPT code 99407 by increasing the work RVU to 0.60 from the current 0.50; and for the SBIRT services codes, we are proposing to refine the work RVU as follows, for HCPCS code G2011 by increasing the work RVU to 0.39 from the current 0.33, for HCPCS code G0396 by increasing the work RVU to 0.77 from the current 0.65, and for HCPCS code G0397 by increasing the work RVU to 1.55 from the current 1.30.

(51) Psychiatric Collaborative Care Model (CoCM) (CPT codes 99492, 99493, 99494, G2214) and APCM BHI add-on codes (HCPCS Codes G0568, G0569)

Patients with chronic health conditions are "more likely to have related behavioral health concerns and find it easier to improve chronic conditions when these concerns are also addressed."[14] Integrating behavioral health with primary care has been shown to improve outcomes like reductions in depression severity and enhancing patient's experience of care.[15]

In the CY 2017 PFS final rule (81 FR 80230), we established separate payment for three services, HCPCS codes G0502 (*Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional; initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan; review by the psychiatric consultant with modifications of the plan if recommended; entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and*

---

[14] *https://integrationacademy.ahrq.gov/about/integrated-behavioral-health#:~:text=Integrated%20behavioral%20health%20offers%20many,these%20concerns%20are%20also%20addressed.*

[15] Balasubramanian, Bijal, Deborah Cohen, Katelyn Jetelina, Miriam Dickinson, Melinda Davis, Rose Gunn, Kris Gowen, Frank DeGruy 3rd, Benjamin Miller, Larry Green. "Outcomes of Integrated Behavioral Health with Primary Care." J Am Board Fam Med. 2017 Mar-Apr;30(2):130-139.doi: 10.3122/jabfm.2017.02.160234

participation in weekly caseload consultation with the psychiatric consultant; and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies), G0503 (*Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: tracking patient follow-up and progress using the registry, with appropriate documentation; participation in weekly caseload consultation with the psychiatric consultant; ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers; additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant; provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies; monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment*), and G0504 (*Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (list separately in addition to code for primary procedure); (use G0504 in conjunction with G0502, G0503*), used to bill for monthly services furnished using the psychiatric collaborative care model (CoCM), an evidence-based approach to behavioral health integration that enhances ‘‘usual’’ primary care by adding care management support and regular psychiatric inter-specialty consultation. The G-codes were valued to account for the work of the treating physician or other qualified health care professionals, based on a direct crosswalk to the work values for the complex Chronic Care Management (CCM) services,

CPT codes 99487 (*Complex chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; first 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.*) and 99489 (*Complex chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)*). The valuation also accounted for the work of the psychiatric consultant, based on an estimated 10 minutes of psychiatric consultant time per patient per month, such that the work RVU was based on a crosswalk to the work per minute of a level 3 established patient office visit. These G-codes were replaced by CPT codes 99492, 99493, and 99494, which we established for payment under the PFS in the CY 2018 PFS final rule (82 FR 53077 and 53078). In the CY 2021 PFS final rule (85 FR 84548 through 84574), we increased the work RVUs for certain CPT codes that rely upon or are analogous to office/outpatient evaluation and management (O/O) (E/M) visits, consistent with the increases in values finalized for O/O E/M visits for CY 2021, such that the CoCM services valuation were updated as follows: 99492 (work RVU increased from 1.70 to 1.88), 99493 (work RVU increased from 1.53 to 2.05) and 99494 (work RVU remained 0.82).

Interested parties have expressed concerns regarding the current valuation of CoCM and requested revaluation for these services. They stated that the current valuation undervalues the

medical decision-making performed by the billing practitioner and psychiatric consultant and undervalues the labor rates assigned to the CoCM service. The interested parties recommend valuing the work RVUs for the two physicians or other qualified health care professional based on a blended rate based on level 4 and 5 O/O E/M visits based on medical decision-making, CPT codes 99204 and 99205 (for new patients), and 99214 and 99215 (for established patients), to account for the medical decision-making required for the CoCM service. CPT code 99492 would be adjusted from a work RVU of 1.88 to 3.67, 99493 from a work RVU of 2.05 to 2.99, and 99494 from a work RVU of 0.82 to 1.50. The interested parties noted that their recommendation would result in a higher work RVU for the initial psychiatric collaborative care management service, CPT code 99492, compared to the subsequent psychiatric collaborative care management service, CPT code 99493, since the initial month generally involves a new patient requiring more medical decision making. The interested parties recommend valuing CPT code 99494 at 50 percent of CPT code 99493. In addition, the interested parties requested refinements to the direct PE inputs, specifically for the Behavioral Health Care Manager clinical labor type (L057B). They recommend increasing the clinical labor value for Behavioral Health Care Manager (L057B) from a per minute rate of $0.57 to $0.70 per minute by crosswalking the valuation to CORF social worker/psychologist (L045C), rather than to the genetic counselors (L057A) which was used when the original CoCM G-codes were established.

After reviewing the feedback from the interested parties, we reviewed the valuation of the CoCM codes and considered Medicare claims data for levels 3 through 5 O/O E/M services. The Medicare claims data shows that level 5 E/M visits (CPT codes 99205 and 99215), which represent the highest complexity of evaluation and management services, are billed substantially less frequently than level 3 E/M services (CPT codes 99203 and 99213) and level 4 E/M services (CPT codes 99204 and 99214). Based upon this billing pattern, we believe that a blended level 3 and 4 E/M rate would be more appropriate to value CoCM. Therefore, we propose to refine the work RVUs of CoCM as follows: CPT codes 99492 would be adjusted from a work RVU of 1.88

to 2.75, 99493 from a work RVU of 2.05 to 2.26, and 99494 from a work RVU of 0.82 to 1.13, which is 50 percent of 99493.

We also propose conforming changes to the valuation of HCPCS codes G2214, G0568, and G0569, which also describe psychiatric collaborative care services. For HCPCS code G2214 (*Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional),* we propose to refine the work RVU from 0.77 to 1.13, representing one half of the time described by the existing code that describes subsequent months of CoCM services (CPT code 99493), consistent with how the code was valued in the CY 2021 PFS final rule (85 FR 84547 through 84548). For HCPCS code G0568 (*Initial psychiatric collaborative care management, in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional, initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan, review by the psychiatric consultant with modifications of the plan if recommended, entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant, and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies (list separately in addition to the advanced primary care management code*)), we propose to refine the work RVU from 1.88 to 2.75, aligning with the direct crosswalk to the work RVU of CPT code 99492. For HCPCS code G0569 (*Subsequent psychiatric collaborative care management, in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other*

qualified health care professional, with the following required elements: tracking patient follow-up and progress using the registry, with appropriate documentation, participation in weekly caseload consultation with the psychiatric consultant, ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers, additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant, provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies, monitoring of patient outcomes using validated rating scales, and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment (list separately in addition to advanced primary care management code)), we propose to refine the work RVU from 2.05 to 2.26, as this code was valued based on a direct crosswalk to the work RVU of CPT code 99493.

Additionally, consistent with the changes proposed for CPT codes 99492-99494, we propose refinements to the direct PE inputs for HCPCS codes G2214, G0568, and G0569 by revaluing the rate of Behavioral Health Care Manager (L057B) with a per minute rate of $0.57 to $0.70. This proposed change is based on a crosswalk of valuing Behavioral Health Care Manager (L057B) to the clinical labor CORF social worker/psychologist (L045C), as opposed to basing the rates to genetic counselors as discussed in the CY 2017 final rule (81 FR 80350). We also note that HCPCS codes G2086 (*Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month*), G2087 (*Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month)*, and G2088 (*Office-based treatment for opioid use disorder, including care coordination, individual therapy and group*

therapy and counseling; each additional 30 minutes beyond the first 120 minutes (list separately in addition to code for primary procedure)) include clinical labor minutes for a Behavioral Health Care Manager (L057B), and therefore as part of this proposal, we are also proposing that that same increase in valuation for L057B from $0.57 to $0.70 would also apply to HCPCS codes G2086-G2088.

We welcome comments on these proposals.

(52) Tympanostomy (HCPCS code G0561)

In January 2026, the Practice Expense (PE) Subcommittee reviewed the following practice expense only add-on HCPCS code G0561 (*Tympanostomy with local or topical anesthesia and insertion of a ventilating tube when performed with tympanostomy tube delivery device, unilateral)* on the Medicare Physician Fee Schedule which is currently contractor priced.

The RUC recommended one direct PE input for a new supply item, an Automated PE tube delivery device (SD395), and submitted invoices to price the supply at $497.50. We are proposing the RUC-recommended direct PE input for HCPCS code G0561 without refinement.

The RUC did not recommend, and we are not proposing a work RVU for HCPCS code G0561, which has been designed as a PE only service.

(53) Evaluation and Management (E/M) Visit Complexity Add-On (HCPCS code G2211)

(a) Background

In the CY 2024 PFS final rule (88 FR 78970 through 78982), we finalized separate payment for the O/O E/M visit complexity add-on code, HCPCS code G2211 (*Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)*). This policy was originally proposed in CY 2019, as part of a proposed overhaul to the E/M code set (83 FR 59628) where we proposed two codes, one for primary care

and one for non-procedure specialty care. We learned that the CPT Editorial Panel and AMA RUC were planning to review and refine the O/O E/M code set, so we did not finalize this proposal or the other proposed changes to the E/M code set. The CPT Editorial Panel and AMA RUC reviewed and refined the O/O E/M code set, which were finalized by CMS in the CY 2021 PFS final rule (84 FR 62844 through 62856). We combined the two proposed complexity add-on codes into one, and we finalized separate coding and payment for HCPCS code add-on code GPC1X in the CY 2020 PFS final rule (84 FR 62854 through 62856). This became HCPCS code G2211 in the CY 2021 final rule (85 FR 84569). However, implementation of G2211 was delayed by Congress (section 113 of Division CC of the Consolidated Appropriations Act, 2021 (Pub. L. 116-260, December 27, 2020) (CAA, 2021)), and we began actively paying for HCPCS code G2211 in CY 2024.

In the CY 2026 PFS final rule (90 FR 49462 through 49464), we finalized our proposal to allow HCPCS code G2211 to be billed as an add-on code with the home or residence E/M visits code family (CPT codes 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350). We finalized refinements to the code descriptor of HCPCS code G2211 *(Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to home or residence or office/outpatient evaluation and management service, new or established)* to reflect this change.

This service is intended to recognize the longitudinal relationship between the patient and the practitioner, which differentiates the E/M visit from visits that are not longitudinal in nature. As discussed in section II.E. of this proposed rule, we are continuing to examine primary care in the PFS, and how we can appropriately recognize the resource costs of longitudinal and especially primary care, given the generality of E/M coding.

(b) Proposed Changes to the Billing Mechanism for Inherent Complexity

(i) Modifier MOD1

Since we began actively paying for HCPCS code G2211 in CY 2024, we have come to believe that the resource costs of furnishing longitudinal care for beneficiaries is not best characterized as a separate service requiring a separate code. Rather, we believe that since this work is an inherent part of the visit, it would be more accurately valued as a modifier to the base E/M code. We also believe that transitioning HCPCS code G2211 from an add-on code to a modifier will be more streamlined from an operational perspective. This should also reduce operational burden, as it will not require the submission of a separate claim line, because the modifier will be placed on the claim line for the associated E/M code. We are therefore proposing to replace HCPCS code G2211 with a modifier, which we will refer to in this proposed rule as MOD1, which is a placeholder that would be replaced with a two-digit HCPCS modifier, if finalized.

We are proposing that modifier MOD1 will be billed under the same circumstances that HCPCS code G2211 is billed now. We discussed in the CY 2024 final rule (88 FR 78973) that HCPCS code G2211 was intended to characterize the associated E/M code as a service with a practitioner who serves as the continuing focal point for all needed health care services, or with medical care that is part of ongoing care related to a patient's single, serious, or complex condition. HCPCS code G2211 was meant to describe the inherent complexity of these visits that would otherwise be unaccounted for. The application of the add-on code is not based on the characteristics of particular patients (even though the rationale for valuing the code is based on recognizing the typical complexity of patient needs), but rather the relationship between the patient and the practitioner.

We are proposing to match the code descriptor for HCPCS code G2211 to MOD1, with some technical changes. The new proposed modifier descriptor is: *Visit complexity inherent to new or established office/outpatient or home or residence evaluation and management service, associated with medical care services that serve as the continuing focal point for all needed*

health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition.

(ii) Modifier MOD1 Valuation

When HCPCS code G2211 was finalized in the CY 2020 PFS final rule (84 FR 82854 through 82855), we crosswalked it to 100 percent of the valuation of CPT code 90785 *(Interactive complexity (List separately in addition to the code for primary procedure))*, which was created to capture additional work that occurs with certain psychiatric and psychotherapy codes. We believed that this service was analogous to the additional work involved in maintaining a longitudinal relationship with patients as described by CPT code 90785. CPT code 90785 has a work RVU of 0.33 and a physician time of 11 minutes. In reexamining this policy after a few years of utilization, we have come to believe that a flat rate as described by G2211 does not reflect the variation in work of the various E/M visit levels.

TABLE A-D7: COMPARISON OF HCPCS CODE G2211 WITH BASE CODES

Base CPT code	Total NF RVU of HCPCS code G2211	Total NF RVF of Base CPT code	HCPCS code G2211 as percentage of base-code
99212	0.52	1.78	0.52/1.78: **29%**
99215	0.52	5.76	0.52/5.76: **9%**

Table A-D7 illustrates that the addition of HCPCS code G2211 as an add-on to the associated E/M visit represents a higher increase in total value for base codes with lower total non-facility RVUs than it does for more intense services. For example, HCPCS code G2211 has a total RVU of 0.52 in the non-facility (NF) setting. CPT code 99212 (*Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.*) has a total NF RVU of 1.78. So, when HCPCS code G2211 is appended to CPT code 99212, the overall value of the service is increased by 29 percent. However, when HCPCS code G2211 is appended to CPT code 99215 (*Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or*

examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.) with a NF total RVU of 5.76, it only represents a 9 percent increase in the total value of the service. We believe that HCPCS code G2211 should reflect an increase to the base code that is proportional across all types of E/M visits. Therefore, we are proposing a modifier to replace HCPCS code G2211 with the valuation of 16 percent of the base E/M code. We established this percentage using a weighted average of the percentage increase that G2211 comprised relative to the O/O E/M code, weighted by HCPCS code G2211 utilization and adjusted to achieve budget neutrality.

(c) G2211 in Medicare Accountable Care Organizations (ACOs)

(i) Background

The Medicare Shared Savings Program (Shared Savings Program) established under section 1899 of the Act, offers doctors, hospitals, and other health care providers an opportunity to create an Accountable Care Organization (ACO). Shared Savings Program ACOs are groups of doctors, hospitals, and other health care professionals that work together to give patients high-quality, coordinated service and health care, improve health outcomes, and manage costs.[16] In Original Medicare, physicians are reimbursed for reasonable and necessary services necessary for diagnosis or treatment of illness or injury. In an ACO, the doctor-patient relationship in Original Medicare is expanded such that the doctors, hospitals and other health care professionals are not just providing services under the reasonable and necessary standard, but there is additional work conducted to manage the beneficiaries' overall health, considering their personal health goals and values. This is how CMS defines an "accountable care relationship," and this relationship may lead patients to be less likely to get repeated medical tests or unnecessary services, since clinicians consider a patient's entire health history when developing a treatment plan, and the doctors and other health professionals communicate and collaborate to

[16] "Accountable Care and Accountable Care Organizations." *Centers for Medicare & Medicaid Services*, CMS Innovation Center, *https://www.cms.gov/priorities/innovation/key-concepts/accountable-care-accountable-care-organizations*. Accessed 16 June 2026.

improve the patient's long-term health.[17] CMS believes accountable care supports the professional ethos of health professionals to take responsibility for their patients in a way that beneficiaries expect. When these accountable care relationships succeed and the ACO succeeds in delivering high-quality care and reducing expenditures, the ACO may be eligible to share in the savings. For more information on the Shared Savings Program and policies directly relating to Shared Savings Program, see section III.G. of this proposed rule.

The CMS Innovation Center recently announced the Long-term Enhanced ACO Design (LEAD) Model which will launch on January 1, 2027. LEAD builds upon previous accountable care work and was designed to attract health care providers that have previously had limited participation in ACOs. It also aims to encourage health care providers to deliver preventive care, empower beneficiaries to be more actively involved in their care, and support health care providers who serve high needs and dually eligible beneficiaries to improve care and reduce costs.

(ii) Modifier MOD2

In the PFS, we have established a complexity add-code (HCPCS code G2211) that we are proposing to change to a modifier (MOD1) that supports care relationships which may approximate but are not accountable care. This modifier is meant to recognize the additional complexity of services associated with providing ongoing, longitudinal care to a beneficiary. We are proposing that the complexity of care established in that longitudinal relationship fundamentally differs in Original Medicare where physicians are providing all reasonable and necessary care for diagnosis and treatment of a clinical condition versus when they are in an accountable care relationship. As previously discussed, we are proposing applying the complexity add-on (we are proposing to change this to a modifier) to reflect the ongoing resource costs associated with being the focal point for all needed health care services performed

[17] "Accountable Care and Accountable Care Organizations." *Centers for Medicare & Medicaid Services*, *https://www.cms.gov/priorities/innovation/innovation-models/aco*. Accessed 16 June 2026.

under this reasonable and necessary standard.

We believe this standard is distinct from care provided in an ACO, where in addition to being responsible for all needed health care services that are part of ongoing care, clinicians are also responsible for managing the accountable care relationship, which involves managing a beneficiary's overall health, personal goals, values, and coordinating care with responsibility for both quality and cost. We consider the complexity associated with serving as the focal point of care for all necessary services within an accountable care relationship, responsibility for the entire patient, and responsibility for quality and cost of care, to be inherently more complex than serving in this role outside of an accountable care relationship. We are therefore proposing two levels for this modifier to reflect the additional resource costs associated with accountable care.

For example, the most common condition for which HCPCS code G2211 was billed in 2024 in Original Medicare was hypertension.[18] Outside of an accountable care relationship, the complexity add-on (proposing in this rule to change to a modifier) would be billed by clinicians for E/M visits managing a beneficiary's hypertension over time. The additional time and resource costs for serving as this focal point in care may address a patient's reservations about initiating pharmacologic treatment for hypertension (for example, perhaps the beneficiary wishes to trial complementary or alternative medicine approaches, so the clinician and patient engage in shared decision-making to understand the risks and benefits of this approach preceding pharmacologic intervention).[19] They may also discuss risk factor reduction (for example, smoking cessation) and lifestyle changes (for example, following the dietary approaches to stop hypertension or 'DASH' diet and meeting physical activity recommendations), or perhaps engage in motivational interviewing to facilitate behavior change. While the current HCPCS code G2211 is meant to take into account the additional time and resource intensity for these

---

[18] Ganguli I, Daley NE, Hicks AL, McWilliams JM, Rosenthal MB. Billing of Medicare's G2211 Longitudinal Care Code Among Traditional Medicare Beneficiaries. *JAMA.* 2026;335(11):1003–1006. doi:10.1001/jama.2026.0424.

[19] "Hypertension (High Blood Pressure)." *National Center for Complementary and Integrative Health*, U.S. Department of Health and Human Services, July 2018, *https://www.nccih.nih.gov/health/hypertension-high-blood-pressure*. Accessed 16 June 2026.

services, we expect even more from clinicians participating in an ACO.

For example, a beneficiary has general anxiety disorder and hypertension and monitors their blood pressure at home. They have an instance in which their blood pressure exceeds 140/90mmHg, and they also feel panic or a sense of impending doom or chest pain. They decide to go to the emergency room, but the slightly elevated blood pressure may or may not be the physiologic trigger of their symptoms. This patient may continue to seek care at the emergency room for similar episodes indefinitely unless their practitioner identifies this trend on their own and provides education to the patient on distinguishing the symptoms of anxiety from hypertension, and when it may be appropriate to go to the emergency room. If this same patient was in an ACO, that ACO might have already established admission discharge transfer (ADT) notifications which would alert the team (near-real time) for the admission. This would allow for earlier intervention to ensure that both the patient's anxiety and blood pressure were being managed in the correct setting, and that the patient had the best information to understand their intersecting conditions.

The additional time and resources associated with coordinating care for this complex patient considering both quality and cost are distinct. We are proposing differentiating the resource costs associated with HCPCS code G2211 outside of and within an accountable care environment to account for the additional resource costs associated with serving as the focal point of care for the entire beneficiary within an accountable care relationship. We are clarifying that we do not believe every encounter a patient has within an ACO qualifies as longitudinal. For example, if instead of presenting to the ED, the patient calls the clinic and is able to see another ACO participant, ACO professional, ACO provider/supplier (as each is defined at § 425.20, for the Shared Savings Program), or LEAD Participant Provider who is available the same day, this encounter would not necessarily meet the criteria of inherent complexity, if that practitioner is not supporting the beneficiary's longitudinal care, and if this visit is not more inherently complex. Simply providing an E/M visit while being part of an ACO does not necessarily meet

the threshold of inherent complexity.

We believe that MOD2 aligns with the goals of the Shared Savings Program and LEAD, which involve groups of health care providers working together to enhance beneficiary health through high quality, longitudinal primary and preventative care. One of the features of Shared Savings Program and LEAD ACOs is that beneficiaries benefit from ACO participants balancing goals of having total cost of care accountability and improving quality of care, while avoiding unnecessary services and medical errors. While the specifics vary between the Shared Savings Program and the LEAD model, in general, participating ACOs are required to report quality measures that align with these objectives, and they are measured against their past performance, and the performance of similar ACOs.[20]

While these measures span a broad area of topics, many measures are focused on longitudinal care and care coordination, such as chronic disease management, preventive care and screenings and reducing avoidable hospitalizations.[21] Current participation in the Shared Savings Program helps provide and future participation in LEAD will help provide a framework to allow health care providers to collaborate to give coordinated high-quality care, while also enabling investment to achieve those goals. For example, health care providers may join ACOs to help defray the costs of large capital investments such as electronic medical records.[22] Health care providers also cite help with care coordination and quality reporting as a reason to join, increasing their access to resources and expertise to help with these areas in their practice.[23] We also want to encourage health care providers to form and join ACOs to coordinate care for their beneficiaries. Similarly, ACO participants, ACO professionals, ACO providers/suppliers (as each is defined at § 425.20, for the Shared Savings Program), and LEAD Participant Providers

---

[20] *https://www.cms.gov/medicare/payment/fee-for-service-providers/shared-savings-program-ssp-acos/guidance-regulations#quality.*

[21] *https://www.cms.gov/priorities-innovation-key-concepts-accountable-care-accountable-care-organizations*

[22] *https://www.cbo.gov/publication/60213.*

[23] Berenson, R. A., Burton, R. A., & McGrath, M. (2016). Do accountable care organizations (ACOs) help or hinder primary care physicians' ability to deliver high-quality care? *Healthcare*, *4*(3), 155–159. *https://doi.org/10.1016/j.hjdsi.2016.02.011*.

often provide advanced primary care to beneficiaries regardless of whether a particular beneficiary is assigned, aligned, or attributed to their ACO. Advanced primary care is a patient-focused approach to care wherein health care providers take extra steps to actively manage a beneficiary's health care needs.[24] Further, additional beneficiaries to whom a health care provider provides care might be assigned to that ACO in the future, so encouraging similar care to be provided to all beneficiaries served by health care providers in ACOs would be in the interest of the ACO. This level of care coordination, which includes advanced primary care, is often inherent by virtue of participation in an ACO.[25]

We are proposing to match the descriptor of MOD2 to MOD1 and HCPCS G2211, with some small differences. The new proposed modifier descriptor is: *Visit complexity inherent to new or established office/outpatient or home or residence evaluation and management service, associated with medical care services furnished by a participant or practitioner participating in a Medicare accountable care organization. Services must serve as the continuing focal point for all needed health care services and/or be part of ongoing care related to a patient's single, serious condition or complex condition.*

(ii) Modifier valuation for Medicare ACO participants

With these goals in mind, we are proposing that, in place of reporting G2211, ACOs would have the option to report a modifier on a claim (referred to in this proposed rule as placeholder MOD2, which if finalized would be replaced with a two-digit HCPCS modifier), which will be valued at 32 percent of the associated E/M visit when performed by Shared Savings Program ACO participants, ACO professionals, and ACO providers/suppliers (as each is defined at § 425.20), as well as Participant Providers in the LEAD Model. We are proposing that MOD2 would pay twice the rate of MOD1 to better account for the inherent complexity of some

[24] *https://www.cms.gov/medicare/payment/fee-schedules/physician-fee-schedule/advanced-primary-care-management-services* and *https://www.medicare.gov/coverage/advanced-primary-care-management-services.*
[25] Centers for Medicare & Medicaid Services. Care Transformation Toolkit. CMS Innovation Center; 2021. Available at *https://www.mathematica.org/publications/care-transformation-toolkit*.

visits in the ACO context, specifically applying to Shared Savings Program and LEAD ACOs in situations that require increased time and intensity. This increased valuation is meant to reflect the cognitive work of providing longitudinal care, follow-up discussions through an assigned care coordinator with the beneficiary or other providers, and expanded access to educational resources, care options, and provider communication methods. The value-based care provided through a Shared Savings Program or LEAD ACO puts greater emphasis on integrated care, meaning health care providers work together to address a person's physical, mental, behavioral and social needs. In this way, providers treat an individual as a whole person, rather than focusing on a specific health issue or disease.[26, 27]

The differential payment we propose to provide to Shared Savings Program ACO participants, ACO professionals, and ACO providers/suppliers (as each is defined at § 425.20) and to LEAD Participant Providers would further support the CMS Innovation Center 2025 Strategy to Make America Healthy Again which focuses on empowering Americans to achieve their health goals and live healthier lives.[28] We recognize that not all E/M visits represent longitudinal care and so we would not expect MOD2 to be included on all claims for E/M visits, only visits that have an increased visit complexity that requires an increased valuation, as described in the examples provided earlier in this section.

(iii) Use of MOD2 modifier by ACOs

Modifier MOD2 would be exclusively available for ACO participants, ACO professionals, and ACO providers/suppliers (as each is defined at § 425.20, for the Shared Savings Program), as well as LEAD Participant Providers, when the visit complexity is met, provided the individual is a medical professional who can bill office and outpatient E/M visits or home visit services, regardless of specialty. Utilization and claims of either modifier will be included in ACOs' expenditure calculations for benchmarking and performance year

---

[26] *https://www.cms.gov/priorities/innovation/key-concepts/value-based-care.*
[27] *https://www.cms.gov/priorities/innovation/key-concepts/person-centered-care.*
[28] *https://www.cms.gov/priorities/innovation/about/strategic-direction.*

expenditures and used in the determination of total cost of care.

As described earlier in this section, we are proposing a differential payment for MOD2 that is meant to provide a meaningful increase in the way we pay for primary care provided by ACO participants, ACO professionals, and ACO providers/suppliers (as each is defined at § 425.20, for the Shared Savings Program), as well as LEAD Participant Providers who often provide additional care coordination to beneficiaries in their care as demonstrated by their participation in an ACO, as described in the examples provided earlier in this section. We are further proposing that the use of this modifier be voluntary; and ACO participants, ACO professionals, ACO providers/suppliers (as each is defined at § 425.20, for the Shared Savings Program), and LEAD Participant Providers would determine if this modifier is necessary based on visit complexity and would append MOD1, MOD2, or no modifier, as appropriate. Additionally, we are proposing that ACO participants, ACO professionals, and ACO provider/suppliers (as each is defined at § 425.20, for the Shared Savings Program), as well as LEAD Participant Providers may bill this modifier for all beneficiaries to whom they provide care, regardless of whether that beneficiary is assigned, aligned, or attributed to an ACO, to encourage similar care to be provided to all beneficiaries served by health care providers who participate in ACOs. Given that ACO Primary Care Flex (ACO PC Flex) Model participation is predicated on participation in the Shared Savings Program, we are proposing that ACO PC Flex Model ACOs may also utilize the MOD2 modifier. Finally, we are proposing that LEAD Participant Providers billing under a Participant TIN that is in a LEAD ACO may bill modifier MOD2. Refer to the discussion later in this section for additional information on the use of modifier MOD2 on alignment in the LEAD model.

(A) Impacts on assignment of beneficiaries to Shared Savings Program ACOs

HCPCS code G2211 is included in the definition of primary care services used for purposes of assignment under § 425.400(c). Although we are proposing that HCPCS code G2211 be deleted, under this proposal, it would remain in the regulations at § 425.400(c) to be included

for purposes of determining the population of OM beneficiaries for whose care the ACO is accountable under 42 CFR subpart F, and for determining whether an ACO has achieved savings under 42 CFR subpart G, and will continue to be used for assigning beneficiaries to an ACO in benchmark years during which HCPCS code G2211 was still an allowable service. If the proposal is finalized, the code will no longer be payable, and there will be no impact on future calculations of allowed charges used for purposes of assignment.

Modifier MOD2 can be appended to O/O or home or residence E/M services exclusively by ACO participants, ACO professionals, ACO providers/suppliers (as each is defined at § 425.20, for the Shared Savings Program), and LEAD Participant Providers who can bill O/O or home or residence E/M service, regardless of specialty. In performing claims-based assignment under the Shared Savings Program, CMS determines whether allowed charges for a beneficiary's primary care services (as identified for ACO professionals, including at Electing Teaching Amendment hospitals and Method II Critical Access Hospitals, and services furnished at an FQHC or RHC) in an ACO are greater than allowed charges for the beneficiary's primary care services in any other ACO, or other individual health care providers, or groups of health care providers identified by Medicare-enrolled billing TINs or CMS Certification Numbers that are not participating in the Shared Savings Program. In making this determination, we determine where the beneficiary received the plurality of his or her primary care services.

The allowed charges associated with O/O or home or residence E/M services billed with or without modifiers MOD1 or MOD2 will be used in determining beneficiary assignment. Since the CPT codes identified as O/O or home or residence E/M services are included in the definition of primary care services used for purposes of assignment as defined in 42 CFR 425.400(c), we do not believe that changes to the regulatory text are required. Certain operational changes will

need to be implemented which will be communicated via Change Request,[29] Medicare Learning Network (MLN) Matters® article,[30] or other sub-regulatory guidance.

(B) Impacts on assignment of beneficiaries to LEAD ACOs

In LEAD, if this proposal is finalized, we will handle the deletion of HCPCS code G2211 and the transition to the modifiers similarly to the Shared Savings Program. As indicated in Appendix C of the LEAD Request for Applications, the HCPCS code G2211 code is one of the Primary Care Qualified Evaluation and Management (PQEM) services that CMS uses to align beneficiaries to LEAD ACOs via claims-based alignment. We will continue to use HCPCS code G2211 allowable charges to conduct claims-based alignment in LEAD when HCPCS code G2211 was an allowable service in the requisite claims look back period. For example, when conducting initial claims-based alignment in Performance Year (PY) 2027, we will reference claims from October 1, 2025 to September 30, 2026. HCPCS code G2211 allowable charges will be included in the claims-based alignment run since it is an allowable service during this period.

When aligning beneficiaries to LEAD ACOs, CMS looks first for an existing primary care relationship within the claims lookback period. If 10 percent or more of a beneficiary's PQEM allowable charges (measured by dollar amount) were billed by physicians or non-physician health care providers with a primary-care specialty (family medicine, internal medicine, geriatrics, general practice, nurse practitioner, physician assistant, and clinical nurse specialist), alignment is based solely on these primary care providers. If less than 10 percent of a beneficiary's PQEM allowable charges were billed by primary-care specialties, alignment considers certain non-primary care providers that manage chronic or complex conditions (for example, cardiology, nephrology, endocrinology, psychiatry, etc.). The beneficiary is aligned to a LEAD ACO if the Participant TIN that furnished the largest share of allowable charges incurred for PQEM services during the lookback period is participating in a LEAD ACO.

---

[29] Available at *https://www.cms.gov/medicare/regulations-guidance/transmittals.*

[30] Available at *https://www.cms.gov/training-education/medicare-learning-networkr-mln/resources-training/mln-matters-articles.*

Once the claims-based alignment look back period rolls forward to include 2027 (and future years) the LEAD alignment methodology will include the allowed charges associated with modifier MOD1 and MOD2 when conducting claims-based alignment (the underlying O/O or home or residence E/M service that will be modified by MOD1 and MOD2 are already LEAD PQEM services). LEAD ACOs will be accountable for expenditures incurred by using either modifier MOD1 or MOD2. Expenditures associated with modifier MOD1 and MOD2 will be included in total Medicare Parts A and B expenditures when CMS conducts financial settlement for LEAD ACOs. More information on the impact to claims processing, capitated payments, and LEAD benchmarks will be shared with ACOs that were selected for participation in LEAD in PY 2027.

(iv) MOD1 and MOD2 Billed with Modifier -25

When we finalized the HCPCS code G2211 policy in the CY 2021 PFS final rule (85 FR 84572), we did not limit the use of HCPCS code G2211 with O/O E/M visits in which CPT Modifier -25 was appended. CPT Modifier -25 denotes a significant, separately identifiable O/O E/M visit by the same physician or other qualified health care professional on the same day as a procedure or other service. We finalized HCPCS code G2211 as payable in the CY 2024 PFS final rule (88 FR 78974), and in the CY 2025 PFS final rule (89 FR 97856 through 97858), we finalized that we would allow payment of HCPCS code G2211 with -Modifier 25 when the O/O E/M base code is reported by the same practitioner on the same day as an annual wellness visit (AWV), vaccine administration, or any Medicare Part B preventative service when furnished in the office or outpatient setting. For CY 2027, we are proposing to maintain the same limitations we established for HCPCS code G2211 in the CY 2025 PFS final rule (89 FR 97856 through 97858) for MOD1 and MOD2 when billed with Modifier -25.

Later in this section, we are making additional proposals related to changes for payment when modifier -25 is appended. Given these changes, we are seeking comment on whether we should consider changes to this policy, such as allowing MOD1 or MOD2 to be billed with

modifier -25 when an O/O E/M is performed on the same day as a 0-, 10-, or 90- day global procedure?

(54) Shared Medical Appointment (HCPCS code GSMAS)

In accordance with President Trump's Executive Order, "Establishing the President's Make America Healthy Again Commission,"[31] the Administration is directing agency focus towards understanding and drastically lowering chronic disease rates. As part of this commitment, we remain focused on the prevention and management of chronic disease, including through approaches that address underlying behavioral and lifestyle drivers of health.

In CY 2026, we solicited feedback on how CMS could further support the prevention and management of chronic diseases. In response to our request for information on chronic disease prevention and management, commenters indicated that many services that help prevent and manage chronic disease, such as lifestyle modification support, health education, and peer support, require time, coordination and multidisciplinary engagement that is not adequately supported under the current PFS. Additionally, many commenters indicated that social isolation and loneliness is a persistent barrier to effective care for Medicare beneficiaries. The commenters indicated that although health care providers are already implementing interventions to identify and address social isolation, these efforts are resource intensive and not adequately supported under the current PFS.

Based on this feedback, we recognize the importance of health care delivery approaches that enable multidisciplinary support, foster beneficiary engagement, and encourage sustainable lifestyle and behavioral changes. Shared medical appointments (SMAs) are one such approach to offer a group-based environment in which beneficiaries can receive clinical guidance while also engaging with peers facing similar health challenges. SMAs may also help address social isolation and loneliness for some beneficiaries.

---

[31] *https://www.whitehouse.gov/presidential-actions/2025/02/establishing-the-presidents-make-america-healthy-again-commission/.*

SMAs, also known as shared medical visits or group visits, are voluntary group-based sessions where multiple patients with a common chronic condition, such as type 2 diabetes mellitus, receive medical care together. In general, SMAs involve more than one healthcare provider, such as a person trained or skilled in delivering patient education or facilitating patient interaction and a prescribing practitioner to make and initiate a comprehensive care plan. SMAs generally last from 60 to 120 minutes and incorporate time for social integration, interactive education, and adjustments to the patient's care plan.[32] Compared with group education alone, SMAs allow patients to participate in clinical care activities that are tailored to the needs of both the group and the individual participants.[33] During the SMA session, a practitioner may meet with a patient individually in a private or semi-private manner or conduct the visit in a group setting where other patients are able to listen and, in some cases, contribute to the discussion.[34]

Reported advantages of shared medical appointments include providing patients more time with their health care provider, creating opportunities for patients to learn from and share self- management strategies with one another, improving access to care, incorporating nonpharmacologic treatment approaches, enhancing the overall quality of care, and helping reduce emergency department visits.[35]

Currently there is no CPT or HCPCS code specifically designated for SMAs. However, practitioners typically bill SMAs using existing Evaluation and Management (E/M) codes, CPT codes 99212-99215, based on medical decision-making criteria; and if another billable clinician such as a registered dietician assists with the SMA, the registered dietician may also bill for their portion of the SMA separately (for example, CPT code 97804 (*Medical nutrition therapy; group*

---

[32] *https://www.ncbi.nlm.nih.gov/books/NBK99776/#.*

[33] Kirsh, Susan R., Aron, David C., Johnson, Kimberly D., Santurri, Laura E., Stevenson, Lauren D., Jones, Katherine R., and Jagosh, Justin. "A realist review of shared medical appointments: How, for whom, and under what circumstances do they work?" Available from *https://pmc.ncbi.nlm.nih.gov/articles/PMC5291948/pdf/12913_2017_Article_2064.pdf.*

[34] Thompson-Lastad, Ariana. "Group Medical Visits as Participatory Care in Community Health Centers." Available from *https://pmc.ncbi.nlm.nih.gov/articles/PMC6500445/pdf/nihms-1015904.pdf.*

[35] Lacagnina, Salvatore, Tips, Jean, Pauly, Kaitlyn, Cara, Kelly, and Karlsen, Micaela. "Lifestyle Medicine Shared Medical Appointments." Available from *https://pmc.ncbi.nlm.nih.gov/articles/PMC7781059/.*

(2 or more individual(s)), each 30 minutes)). Therefore, we propose to create coding and valuation specifically for SMAs.

We propose that SMAs be limited to beneficiaries who have received a professional service from the billing physician or other qualified health professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice within the previous 12 months. We believe this requirement is necessary to ensure beneficiaries have an existing clinical relationship with the practitioner before the beneficiary is integrated into a group-based medical care setting.

We propose requiring beneficiaries to consent to SMA participation, since they may elect to receive individual medical appointments instead. Additionally, we propose that beneficiaries must consent to confidentiality terms because personal health information would be discussed in the group setting.

SMA sessions generally last 60 to 120 minutes and may include up to 25 patients, however SMAs most commonly consist of 6 to 10 patients.[36] We propose establishing SMAs as 60-minute sessions with a maximum of 10 beneficiaries per session.

The expansion of telehealth services has increased opportunities for SMAs to improve access for individuals in geographically remote areas, and those with transportation challenges. We propose that SMA sessions can be held either in-person or via telehealth, and we are proposing to add the SMA service to the Medicare Telehealth list accordingly.

We propose that each shared SMA session be documented in each participating beneficiary's medical record. Each beneficiary receives individualized clinical care, and the medical record must reflect the specific services that the individual beneficiary received during the SMA session. The need for individualized care may depend on the intervention and surrounding evidence. Therefore, if a beneficiary requires a level of individualized care that extends beyond what can appropriately be provided within the group-based session of a SMA,

---

[36] *https://www.hsrd.research.va.gov/publications/esp/shared-med-appt.pdf.*

that individualized care should be provided in a separate individual medical appointment. The services provided to the group as a whole at each session would also need to be captured in the medical record. We seek comments on additional guardrails to consider in preventing fraud, waste and abuse when billing SMAs, such as following an evidence-based protocol for delivery of the intervention, conducting fidelity checks to ensure it is being delivered as intended, identifying key outcomes and goals that are established in shared decision making, and ensuring that the interventionist is trained in the intervention as appropriate.

SMAs are an approach in managing chronic conditions, especially among motivated patients.[37] SMAs are an appropriate healthcare delivery approach for conditions that are modifiable with lifestyle change, including diabetes mellitus, obesity, hypertension, and hyperlipidemia, such that behavioral changes including diet, physical activity, and self-management- can influence health outcomes. Therefore, we propose to establish coding and payment for SMAs provided for medical conditions that are modifiable with lifestyle change. We seek comment on how to determine when SMAs would be appropriate, including identifying which medical conditions would be considered modifiable with lifestyle change, and suggest we would typically consider those conditions with medical guidelines that include lifestyle change as part of prevention and treatment of the condition in this category, such as evidence-based interventions that support lifestyle change.[38] For example, the 2026 Standards of Care in Diabetes published by the American Diabetic Association (ADA) include lifestyle changes including improving nutrient composition and reducing caloric intake, establishing physical activity regimens to support weight loss, and highlighting the role of Medical Nutrition Therapy (MNT) as part of nutrition education.[39] While the exact content the SMA and desired behavioral

---

[37] *https://pmc.ncbi.nlm.nih.gov/articles/PMC2464960/pdf/349.pdf.*

[38] Centers for Disease Control and Prevention. **"Evidence-Based Intervention Planning Guides."** *CDC: Cancer*, National Center for Chronic Disease Prevention and Health Promotion, 21 May 2024, https://www.cdc.gov/cancer/php/ebi-planning-guides/index.html. Accessed 7 July 2026

[39] American Diabetes Association Professional Practice Committee for Diabetes. "5. Facilitating Positive Health Behaviors and Well-Being to Improve Health Outcomes: Standards of Care in Diabetes—2026." *Diabetes Care*, vol. 49, suppl. 1, 2026, pp. S89–S131, *https://doi.org/10.2337/dc26-S005.*

change would vary (for example, improving diet and exercise as part of both prevention and management of Type 2 Diabetes) we would not consider medication adherence or titrating medications for Type 2 Diabetes to be appropriate for an SMA, but we would consider SMAs focused on improving nutrient composition to be an appropriate SMA activity, for example. CMS acknowledges the substantial changes in patients' lives associated with coping with chronic illness, the behavioral modifications inherent in managing serious and unexpected illnesses, however we would reserve SMA provision for just those conditions which may be treated or prevented with lifestyle changes.

SMAs typically involve multiple healthcare providers, usually two to four. The sessions are generally led by a physician, physician assistant (PA), or an advanced practice registered nurse (APRN), and may have ancillary staff help when the provider is meeting with patients individually.[40] We propose that a SMA session is billed and led by a physician or qualified nonphysician practitioner and may include other qualified healthcare professionals, clinical staff, or auxiliary personnel. We propose that HCPCS code GSMAS would be billed once per patient, per session and would accept any documentation to demonstrate the care was rendered so long as the physician or qualified nonphysician practitioner co-signature is included. In instances where another qualified healthcare professional, such as a registered dietitian, provides a service during the SMA session, such as CPT code 97804 (*Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes),* that service is considered part of the SMA and should not be billed separately, in addition to the physician or qualified nonphysician practitioner billing for the SMA.

We propose requiring each SMA session to include the following components:

- Evaluation and Management (E/M) elements, consistent with the complexity of the beneficiary's condition. Individualized clinical care with medical documentation in the medical

[40] *https://pmc.ncbi.nlm.nih.gov/articles/PMC7781059/pdf/10.1177_1559827620943819.pdf.*

record that reflects the specific services that the individual beneficiary received during the SMA session.

- Education, based upon evidence-based content, and discussions related to self-care, wellness, and disease management.
- Discussion of positive lifestyle changes, focusing on behavior modification. Medication management, as clinically appropriate and applicable.

In the event it is medically necessary for a beneficiary to receive an E/M visit on the same day as a SMA by the same physician or other qualified health professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, we propose that any time and effort cannot be counted more than once. We propose not to consider and treat this as two E/M same-day visits and seek public comment on this proposal. Additionally, we seek comments on what components must be required for each SMA session.

We propose the following descriptor for SMAs:

HCPCS code GSMAS: *Voluntary, group-based medical session involving multiple patients with common medical condition(s), receiving medical care in a group setting; billed and led by a physician or qualified nonphysician practitioner and may include services provided by other qualified healthcare professionals, clinical staff, or auxiliary personnel under the direction of the supervising physician or other practitioner. Session integrates group education, counseling, and peer support with individualized patient clinical assessment and care, 2-10 patients, billed once per patient, per session.*

Because SMA sessions would integrate group education, counseling, and peer support with individualized patient clinical assessment and care, in developing the valuation for the SMA HCPCS code, we propose to use a building block methodology that sums up the values associated with two reference codes. For the overall E/M elements of the SMA service, we are incorporating the work RVUs, work time and direct PE inputs associated with a level 3 O/O visit

for an established patient, CPT code 99213 (*Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.),* which has a work RVU of 1.30, and a total work time of 30 minutes, which is based on a pre-service evaluation time of 5 minutes, an intraservice time of 20 minutes, and a post service time of 5 minutes. E/M visit level selection does not need to be based on time; practitioners may select the visit level based on the level of medical decision making (MDM). Additionally, as we discussed earlier in this section, we propose that SMAs be limited to beneficiaries who have received a professional service from the billing physician or other qualified health professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice within the previous 12 months. Given this pre-existing clinical relationship and the anticipated clinical profile of beneficiaries that would participate in an SMA, we believe that the level 3 O/O visit for an established patient represents the most typical level of service for the individualized patient clinical assessment component of the SMA.

For the group education, counseling, and peer support elements of the SMA service, we are incorporating CPT code 96202 (*Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); initial 60 minutes*), which has a work RVU of 0.43 and a total work time of 15 minutes, which is based on a pre-service evaluation time of 2 minutes, an intraservice time of 10 minutes, and a post service time of 3 minutes.

While a SMA may include up to 10 beneficiaries in a 60-minute session, the individualized care for a participating beneficiary may vary, such that some beneficiaries may receive more or less individualized care than others; nonetheless, documentation in the medical

record must reflect the specific services that the individual beneficiary received during the SMA session. As we price services under the PFS based on a typical case, the proposed valuation for HCPCS code GSMAS reflects a typical SMA session and is not intended to represent the exact time distribution for every beneficiary in every SMA. We note that the total work time proposed is for the purposes of valuation and not meant as a requirement for billing. We believe this reflects a typical amount of time for both the individualized patient clinical assessment and the beneficiary's proportionate share of group education, counseling, and peer support that occurs concurrently across all participating beneficiaries during a SMA session.

Considering the aforementioned building block methodology for SMA valuation, we are proposing a work RVU of 1.73 and a total work time of 45 minutes, which is based on a pre-service evaluation time of 7 minutes, an intraservice time of 30 minutes, and a post service time of 8 minutes.

In addition to seeking comments on establishing the proposed HCPCS code GSMAS, we also seek comment on the proposed work RVUs, work times, and direct PE inputs.

(55) Vaccine adverse effects management (HCPCS Code GADV1)

Vaccines prevent serious illnesses and even death in persons who receive them and serve a public health benefit. Vaccines are intended to produce active immunity to specific antigens. An adverse reaction is an undesirable side effect that occurs after a vaccination. Vaccine adverse reactions are classified as (1) local; (2) systemic; or (3) allergic. Local reactions (for example, redness) are usually the least severe and most frequent. Systemic reactions (for example, fever) occur less frequently than local reactions, and severe allergic reactions (for example, anaphylaxis) are the least frequent reactions.[41] Modern vaccines are safe and effective; however, adverse events have been reported after administration of each type of available vaccine.[42] Vaccine providers should be familiar with identifying immediate-type allergic reactions,

---

[41] *https://www.cdc.gov/vaccines/hcp/imz-best-practices/preventing-managing-adverse-reactions.html#cdc_report_pub_study_section_3-preventing-adverse-reactions,* accessed 5/1/2026.

[42] Ibid.

including anaphylaxis, and be competent in treating these events at the time of vaccine administration. Providers, including practitioners, should also have a plan in place to contact emergency medical services immediately in the event of a severe acute vaccine reaction.[43]

Before a vaccine is licensed, the Food and Drug Administration (FDA) takes steps to make sure the vaccine is safe. FDA requires that a vaccine goes through extensive safety testing. Even though careful studies are done before a vaccine is licensed, rare adverse effects may not be found until a vaccine is given to millions of people with different backgrounds and medical histories.[44] According to clinical trial data, most vaccine-associated adverse events are mild; however, severe adverse reactions such as anaphylaxis, myocarditis, thrombotic events, and pneumonitis have been reported.[45] After a vaccine is licensed, the Vaccine Adverse Event Reporting System (VAERS) is one of the mechanisms used to monitor for any problems, or "adverse events," that happen after vaccination.[46]

We believe that the CPT evaluation and management code set may capture the work and clinical decision making involved in the evaluation and management of most vaccine adverse reactions. However, we believe that physician and nonphysician practitioners' work may not be accurately reflected under the CPT medical decision-making framework relating to the evaluation and management of rare and severe vaccine adverse reactions. E/M visits, like other services under the PFS, are valued based on an assumption of a typical case. We believe that these are additional resource costs that don't fit under a typical E/M. Therefore, we are proposing an add-on code and payment for diagnosis and management of a suspected vaccine adverse reaction for services going above and beyond those captured in an evaluation and management (E/M) visit. These services entail listening to patient concerns, answering questions, and building trust; selecting diagnosis strategies and conveying information in a manner specific to each

---

[43] Ibid.

[44] *https://vaers.hhs.gov/docs/VAERS_Brochure_for_Parents_and_Caregivers_EN_508_2026.pdf.*

[45] Suzuki T, Furuta H, Naganawa M, Hayashi K, Kiyotoshi H, Ohta C, Ninomiya S. COVID-19 Vaccine-Induced Severe Pneumonitis. Respirol Case Rep. 2025 Aug 21;13(8):e70274. doi: 10.1002/rcr2.70274. PMID: 40860748; PMCID: PMC12371123.

[46] Ibid.

patient's concerns, cultural and religious beliefs, and literacy level; providing patients with appropriate resources; and planning with patients the treatment of symptoms of vaccine adverse effects. We propose that this add-on code, HCPCS code GADV1 (*Office or other outpatient evaluation and management service(s) for the diagnosis and treatment of vaccine adverse effects, new or established patient; each 15 minutes personally performed by the physician or qualified healthcare professional (list separately in addition to CPT codes 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350)*), would be payable when a physician or nonphysician practitioner (NPP): (1) establishes and documents a temporal relationship to vaccination, and (2) performs a medically appropriate assessment to rule out alternative causes.

For the purposes of valuation, we are proposing a direct crosswalk for HCPCS code GADV1 to HCPCS code G2212 (*Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (List separately in addition to CPT codes 99205, 99215, 99483 for office or other outpatient evaluation and management services) (do not report G2212 on the same date of service as 99358, 99359, 99415, 99416) (do not report G2212 for any time unit less than 15 minutes)*) for 0.61 work RVUs and for direct PE inputs.

We welcome comments on whether a second HCPCS code for 15 minutes of physician or NPP work time should be finalized and structured as a stand-alone code to more accurately capture the work entailed in cases where a patient is being evaluated for only a vaccine related complaint, outside the context of an E/M visit being furnished for a separate complaint. We also welcome comments on whether in finalizing such a stand-alone HCPCS code we should crosswalk its work RVU and PE inputs to HCPCS code G2212.

Finally, we propose adding HCPCS code GADV1 to the Medicare Telehealth List.

(56) Health Coaching (CPT codes 0591T, 0592T, and 0593T)

Per the Trump Administration's Executive Order, "Establishing the President's Make America Healthy Again Commission,[47]" the Administration is directing agency focus towards understanding and drastically lowering chronic disease rates, through thinking on nutrition, physical activity, healthy lifestyles, over-reliance on medication and treatments, the effects of new technological habits, environmental impacts, and food and drug quality and safety. Furthermore, the Executive Order directs that agencies shall ensure the availability of expanded treatment options and the flexibility for health insurance coverage to provide benefits to support beneficial lifestyle changes and disease prevention.

As such, in the CY 2026 PFS proposed rule, we sought comment on a wide range of possible rulemaking topics to promote prevention and management of chronic disease, and in particular, asked more detailed questions surrounding health coaching and motivational interviewing. More specifically, we asked whether we should consider coding and payment for health coaching and motivational interviewing beyond the current contractor-priced CPT codes describing health coaching, as an incident-to service performed under general supervision of a billing practitioner, what an appropriate description would be, what types of clinical staff perform motivational interviewing, how long a session lasts, the overlap between motivational interviewing and health coaching, training requirements for motivational interviewing and health coaches, the types of clinical circumstances where motivational interviewing and health coaching are performed, relevance for audiovisual or audio-only telecommunication, the experience of payers and providers using the CPT Category III CPT codes, and relevance for Evidence-Based Programs that effectively manage or prevent chronic disease. Commenters responded, stating that health coaching could support CMS' goal of preventing or managing chronic disease. Many health coaches wrote about their personal experience working with patients with chronic

---

[47] *https://www.whitehouse.gov/presidential-actions/2025/02/establishing-the-presidents-make-america-healthy-again-commission/.*

diseases, assisting them in making behavioral and lifestyle changes to self-manage their conditions, and noted that health coaching is a low-cost and highly effective strategy that empowers patients to manage their health. Many commenters requested paying separately for health coaching via the creation of HCPCS G-codes or another payment mechanism that would allow providers to reliably schedule and bill for health coaching services. Commenters also emphasized the importance of requiring that these services be provided by health coaches with appropriate training and certification.

To ensure we adequately capture the time and resources for health coaching, we are proposing conditions of payment and valuation for 0591T (*Health and well-being coaching face-to-face; individual, initial assessment, 60-90 minutes*), 0592T (*Individual, follow-up session, at least 30 minutes)*, and 0593T (*Health and well-being coaching, group [2 or more individuals], at least 30 minutes*). CPT code 0593T would be billed once per beneficiary in the group.

We are also proposing to adopt the CPT prefatory language for 0591T, 0592T, and 0593T: "Health and well-being coaching is a patient-centered approach wherein patients determine their goals, use self-discovery or active learning processes together with content education to work toward their goals, and self-monitor behaviors to increase accountability, all within the context of an interpersonal relationship with a coach. The health and well-being coach is qualified to perform health and well-being coaching by education, training, national examination and, when applicable, licensure/regulation, and has completed a training program in health and well-being coaching whose content meets standards established by an applicable national credentialing organization. The training includes behavioral change theory, motivational strategies, communication techniques, health education and promotion theories, which are used to assist patients to develop intrinsic motivation and obtain skills to create sustainable change for improved health and well-being."

We are proposing that CPT codes 0591T, 0592T, and 0593T may be performed under direct supervision of the billing practitioner, as defined by § 410.26(a)(3). We also propose that

when the service is performed under direct supervision by auxiliary personnel, the auxiliary personnel must have received appropriate certification to perform the services, which includes, but is not limited to, fulfilling the National Board for Health and Wellness Coaching National Standards, the National Commission for Health Education Credentialing eligibility for Certified Health Education Specialists, or the American Holistic Nurses Credentialing national standards for Certified Nurse Coaches. In response to the Request for Information (RFI) in the CY 2026 PFS proposed rule (90 FR 49479 through 49480), we received comments from interested parties pointing us towards these standards. We also propose that appropriate certification for auxiliary personnel to perform the services can also be fulfilled by receiving training from the evidence-based health promotion and disease prevention programs funded under the Older Americans Act and overseen by the Administration for Community Living (ACL). These programs undergo review, meet significant evidence thresholds, and have training requirements built into the program requirements. We solicit comment on these certification standards for auxiliary personnel performing these services.

Furthermore, we understand that occasionally, community-based organizations (CBOs) are the entities that employ health coaches. As noted in the CY 2023 PFS final rule (87 FR 69790) and explained in the CY 2023 PFS proposed rule (87 FR 46102), when we refer to CBOs, we mean public or private not-for-profit entities that provide specific services to the community or targeted populations in the community to address the health needs of those populations. They may include community care hubs, community-action agencies, housing agencies, area agencies on aging, centers for independent living, aging and disability resource centers or other non-profits that apply for grants or contract with healthcare entities to perform social services. They may receive grants from other agencies in the U.S. Department of Health and Human Services, including Federal grants administered by the Administration for Children and Families (ACF), Administration for Community Living (ACL), the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), the

Substance Abuse and Mental Health Services Administration (SAMHSA), or State-funded grants to provide social services. Generally, we believe such organizations know the populations and communities they serve and may have the infrastructure or systems in place to assist practitioners to provide these services. We note that individuals employed by CBOs may operate under general supervision of the billing practitioner, as long as the training and certification guidelines outlined earlier in this section are met.

Finally, we are proposing national payment for CPT codes 0591T, 0592T, and 0593T. We are proposing to crosswalk work and direct PE inputs for 0591T and 0592T to CPT codes 99490 (Chronic care management) and 99439 (Chronic care management, each additional 20 minutes), respectively, since, like Chronic Care Management (CCM), these visit-based services are performed under general supervision. For 0593T, since it is a group visit billed in 30-minute increments, we are proposing to crosswalk the work and PE inputs to CPT code G0109 (Group diabetes self-management training). Therefore, we are proposing a work RVU of 1.00 for CPT code 0591T, 0.70 for CPT code 0592T, and 0.23 for CPT code 0593T. Since multiple sessions in the same calendar month may be needed, we are not proposing frequency limitations for these codes, as long as they are reasonable and necessary. We will monitor utilization and may re-evaluate these policies in future rulemaking. These services were added to the Medicare Telehealth Services List in the CY 2024 PFS Final Rule (88 FR 78859 through 78860).

We solicit comments on the valuation of these services and the conditions of payment. We are also soliciting comment on whether should consider creating HCPCS G-codes to describe these services for CY 2027, rather than actively pricing these Category III CPT codes that describe health coaching services, including what the potential benefits of G-codes would be compared to using the existing codes.

(57) Vascular Embolization or Occlusion Procedure with Use of a Pressure-Generating Catheter (HCPCS code G0577)

HCPCS code C9797 (*Vascular embolization or occlusion procedure with use of a pressure-generating catheter (eg, one-way valve, intermittently occluding), inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction*) was created for the April, 2025 Quarterly Release for the OPPS and Ambulatory Surgical System (ASC) to describe use of a pressure-generating catheter inclusive of imaging guidance for vascular embolization. Subsequently, we also created HCPCS code C8004 (*Simulation angiogram with use of a pressure-generating catheter (eg, one-way valve, intermittently occluding), inclusive of all radiological supervision and interpretation, intraprocedural road mapping, and imaging guidance necessary to complete the angiogram, for subsequent therapeutic radioembolization of tumors*) to describe the simulation angiogram associated with the use of the pressure-generating catheter described by HCPCS code C9797 for the April, 2025 OPPS Quarterly Release. For CY 2026, HCPCS code C9797 is assigned to APC 5194 with a payment rate of around $18,729 while HCPCS code C8004 is assigned to APC 5193 with a payment rate of around $11,874. Currently both HCPCS codes C9797 and C8004 are only payable in the OPPS and ASC settings, as there is currently no coding for the physician office setting describing use of this technology. Under the PFS, vascular embolization procedures are reported using CPT code 37243 (*Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction*) regardless of the technology used to perform the service.

Interested parties have indicated that use of this technology has expanded beyond the OPPS and ASC settings and into the physician office setting; however, the resource costs associated with CPT code 37243 do not accurately account for the use of innovative catheter technology. While this technology may not yet be typical and as such is appropriately absent from the valuation of CPT code 37342, we are concerned that the lack of appropriate coding and

payment for the use of innovative catheter technology may negatively impact access in the non-facility setting.

Beginning July 1, 2026, we began making separate payment for vascular embolization or occlusion procedure with the use of a pressure-generating catheter through the contractor priced HCPCS code G0577 (*Vascular embolization or occlusion procedure with use of a pressure-generating catheter (eg, one-way valve, intermittently occluding), inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction performed in the non-facility setting)* and are proposing to nationally price this service for CY 2027. We are seeking comment on whether there is a need for creation of a HCPCS G-code to mirror HCPCS code C8004 as currently there are no claims for this service in the HOPD setting.

In the CY 2026 PFS final rule, we finalized use of the relationship between the OPPS APC relative weights for APCs describing radiation treatment delivery services to inform the PE RVUs for those services under the PFS. We believe a similar policy is necessary here to establish the initial valuation for vascular embolization using a pressure generating catheter given the lack of pricing information in the non-facility setting. Therefore we are proposing to use the relative relationship between the approximate APC payment amounts between CPT code 37243 and HCPCS code C9797 to value the PE portion of HCPCS code G0577 and a direct crosswalk to the work and MP RVUs associated with CPT code 37243 as well as the physician time. We are seeking comments on these values. We would also note that this valuation is preliminary and we will consider updates for future rulemaking if use of this technology becomes more widespread in the non-facility setting.

(58) Accounting for E/M Resource Overlap Between Stand-Alone Visits and Global Periods

(a) Background

Surgical procedures with a global surgery period include all the necessary services normally provided by the practitioner before, during, and after a procedure. The global surgery

payment includes things like pre-operative visits, typical intra-operative services for that procedure, post-operative follow-up visits, supplies, and other services such as dressing changes, and removal of items used during or after surgery like sutures, staples, splints, or casts.[48] The payment and coding structure of global surgery periods includes the same foundational pieces as other codes in the PFS: work RVUs, practice expense RVUs, and malpractice RVUs. The work RVUs include time crosswalked from E/M codes to reflect the valuation of things such as pre-operative and post-operative visits. Given that global surgical packages already account for the resource costs associated with visits, standalone E/M codes are not billable on the same day as a procedure code unless they are significant and separately identifiable from the procedure. These visits are identified through appending of modifier –25 to the claim. This proposal is meant to address the likely overlap and duplication of payment between the E/M services already paid for during the global surgical package, and any additional E/M services billed for through the use of modifier –25 as significant and separately identifiable.

The PFS has other existing policies where we reduce payments if multiple procedures are furnished on the same day for the same patient, the multiple procedure payment reduction (MPPR) policies. MPPR is a longstanding Medicare policy to reduce payment by 50 percent for the second and subsequent surgical procedures furnished on the same day to the same patient, largely based on the efficiencies in PE and pre- and post-surgical physician work. Since the implementation of the PFS, MPPR policies were also established on nuclear medicine diagnostic procedures, the professional and technical component of diagnostic imaging, the technical component of diagnostic cardiovascular and ophthalmology procedures, and always-therapy services. In the 2019 PFS proposed rule (83 FR 35840 through 35841), as part of a suite of proposals designed to modify the payment structure of E/M visits, we proposed to reduce payment by 50 percent for the least expensive 0-day global procedure or visit that the same

[48] *https://www.cms.gov/files/document/mln907166-global-surgery-booklet.pdf.*

physician (or a physician in the same group practice) furnishes on the same day as a separately identifiable E/M visit, currently identified on the claim by an appended modifier -25.

In the 2019 PFS final rule (83 FR 59638 through 59640), many commenters opposed this proposal, stating that current billing rules allow these services to be billed only when modifier -25 is used, which makes it clear that the visits are significant and separately identifiable. Other commenters described that the RUC review process includes adjustments to account for any costs that the RUC considers duplicative, which means that CMS is making an unnecessary second adjustment. Commenters also stated that CMS provided insufficient rationale for a 50 percent payment reduction instead of other potential adjustments. Some physician organizations and patient advocacy groups also stated concerns that physicians might respond to financial incentives to bring patients back for necessary visits on a different day to avoid triggering the payment reduction. MedPAC, among others, were supportive of the proposal, stating that when a standalone E/M visit occurs on the same day as a procedure, there are efficiencies such as pre-service and post-service clinician work and practice expense, that are not currently accounted for in the system. Other commenters suggested alternative reductions, such as a 5 percent or 25 percent reduction.

In our response to commenters in the CY 2019 final rule (83 FR 59638 through 59640), we stated that we continued to have concerns about 0- and 10-day global periods on the same day as E/M visits. We appreciated the efforts of the RUC to address overlaps when they recognize that a code is often reported with a same day E/M visit, but we also noted that the RUC tends to recommend only minor adjustments to physician time and direct PE inputs to account for overlap. We also discussed that there are several thousand codes with global periods, and while we routinely prioritize review of high-volume services, we believe code-level reviews are not a practical solution to ensuring the accuracy of accounting for these types of efficiencies. We also stated that if practitioners begin deliberately scheduling visits on separate days to avoid

the payment adjustment, this could create undue burden and create potential medical risk for beneficiaries.

We did not finalize this proposal in CY 2019 for a few reasons. First, we had concerns related to balancing the appropriate valuation of these codes with potential disruption to patient care. We reiterated that we find the possible practice of scheduling medical services to maximize payment highly problematic, and we invited interested party feedback regarding how to address these challenges. Second, we did not finalize any of the suite of proposals related to the valuation of the E/M code set in CY 2019, as the AMA and the CPT Editorial Panel stated plans to revisit coding for O/O E/M, and we delayed further action to allow that process to play out (83 FR 59638).

(b) Proposed Changes to Payments Using Modifier -25

As we stated in the CY 2019 final rule (83 FR 59638 through 59640), we continue to believe that there are efficiencies when the same physician (or a physician in the same group practice) provides an E/M service for the same patient in conjunction with a procedure with a global period, and that we are likely duplicating payment under the current payment methodology. We are proposing to reduce payment, as described later in this section, when a separately identifiable O/O E/M visit is furnished by the same physician (or a physician in the same group practice) on the same day as a 0-, 10-, and 90-day global procedure. Under this proposal, the most expensive service (either surgical or E/M visit) would be paid at 100 percent, and all other surgical procedure(s) or E/M visit(s) would be paid at 50 percent. For example, a patient receives an O/O E/M visit using CPT code 99212 (*Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code section, 10 minutes must be met or exceeded.*) at a dermatologist's office, and then has two skin lesions removed, one using CPT code 11300 (*Shaving of epidermal or dermal lesion, single lesion, trunk, arms, or legs; lesion diameter*

0.5cm or less) and one using CPT code 11301 (*Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm)*. Using 2026 RVU values, the total non-facility (NF) RVU of CPT code 99212 is 1.78, the total NF RVU of CPT code 11300 is 2.89, and the total NF RVU of CPT code 11301 is 3.48. Since CPT code 11301 is the highest paid service, CPT code 11301 will be paid at 100 percent (total RVU of 3.48), and CPT code 11300 and the payment for CPT code 99212 will both be reduced by 50 percent, CPT code 11300 down to 1.445 RVUs and CPT code 99212 down to 0.89 RVUs.

The 50 percent value aligns with our previous proposal from CY 2019 PFS proposed rule (83 FR 35840 through 35841) and matches the longstanding surgical MPPR discussed previously in this section. We welcome comments on the value of this adjustment, including whether it would be more appropriate to match a different MPPR value, such as 25 percent.

While we are proposing to apply this policy only to O/O E/M visits, we are seeking comments on whether it should also apply to other E/M visits, such as inpatient E/M visits.

We reiterate that we do not find it appropriate to schedule medical services for patients to maximize payment, which would create undue burden and potential medical risk for beneficiaries. We have a number of data analysis tools to monitor for potentially problematic utilization patterns which may be useful in future, if necessary, for monitoring for this practice, including distinct claims editing to identify problematic utilization patterns, comparative billing reports to identify to providers their outlier status, and medical review capabilities to determine if the patterns are problematic and indicative of waste or abuse. We are also seeking comment on whether or not it is necessary to revise the conditions of payment to mitigate such payment abuses.

(c) Intravitreal Eye Injections

We are also seeking comment on how this policy might apply to an E/M visit reported on the same day as intravitreal eye injection, such as CPT code 67028, a high volume 000-day global code. In recent years, since new injected medications were developed to treat retinal

diseases, there has been new focus from auditors (such as the OIG), MACs, professional eye associations and the AMA, to better understand the standard of care for patients receiving these treatments, in terms of when same-day eye examinations are clinically indicated and separately identifiable from the injection procedure, for the injected eye or the fellow eye. We have heard that patients with retinal diseases require examination every one to three months based on their treatment response, and importantly, both eyes are examined at each visit because of the high incidence of bilateral (though often asynchronous) involvement. The associations have written to CMS outside of the rulemaking process, indicating that around 50 percent of the time, a separately reported E/M visit on the same day to examine the eye(s) may be prompted or required by the symptom or condition for which the injection is being provided. The fellow eye could require examination if the patient reports symptoms in that eye when they present for an injection, and same-day exams determine if the type of medication is appropriate and the length of time between injections can be extended. To help us ensure accurate payment, we are seeking to better understand the clinical circumstances involved, and any overlap with resources already accounted for in valuation of the global procedure, such as for (1) established patients without symptoms in the fellow eye; (2) established patients with symptoms in the fellow eye, whether prior or newly reported upon presenting for their injection; (3) new patients; (4) does it vary according to diagnosis and exam findings; (5) are injections in the fellow eye always deferred to another day; and (6) how CMS might be able to confirm or ensure that the visit being reported is significant and separately identifiable absent medical record review, for example, should we expect to see a new or different diagnosis code on the claim.

We are also seeking to better understand whether the E/M work associated with new patients is typically included in valuation of the minor procedures, or whether there is extra work for new patients that is significant and separately identifiable enough to always warrant separate payment.

(59) Revisions to Teaching Physician Policy Related to the Primary Care Exception

(a) Background

As a general matter, E/M visit codes under the PFS can only be reported when the care is personally provided by a qualified practitioner. Currently, under the primary care exception described at § 415.174, in the case of certain visit codes of lower and mid-level complexity, Medicare contractors may be able to make PFS payment for a service provided by a resident without the presence of a teaching physician, but in specific outpatient primary care centers and when certain conditions must be met. For example, the teaching physician must direct the care from such proximity as to constitute immediate availability (that is, to effectively provide direct supervision).

During the Public Health Emergency (PHE) for the 2019 Novel Coronavirus (COVID–19) pandemic, CMS allowed through an interim final rule (85 FR 19230 through 19292) that all levels of an O/O E/M service provided in specified primary care centers may be provided under supervision of the teaching physician by interactive telecommunications technology (85 FR 19259). At the conclusion of the PHE this flexibility expired, such that only lower and mid-level complexity visits (as specified by CMS in program instructions) could be provided without the presence of a teaching physician under the terms specified in § 415.174.

Additionally, in the CY 2020 PFS final rule (84 FR 62851 through 62854), E/M visits were revised to allow visits to be based on time and medical decision making. According to our claims data, we note that the most commonly billed O/O E/M visit level is now a moderate level visit (level 4), whereas in the past, a mid-level (level 3) visit was most common.

(b) Revisions to current policy

We have received multiple requests from interested parties requesting us to allow residents to perform moderate and high (level 4 and 5) E/M visits under the supervision of the teaching physician and to defer to the clinical judgment of that graduate medical education (GME) program as to whether or not these high level visits may be performed without the presence of the teaching physician.

After consideration and evaluation of interested parties' requests, we are proposing that all levels of an O/O E/M service provided in primary care centers, and meeting the requirements in § 415.174, may be provided under direct supervision of the teaching physician in such cases where the teaching physician believes such care is clinically appropriate and without the presence of a teaching physician. Specifically, we are proposing modifications to the requirements at § 415.174 Exception: Evaluation and management services furnished in certain centers, to expand coverage of services for teaching physicians as part of a graduate medical education (GME) program. We are proposing to modify the requirements for certain E/M codes to allow physician fee schedule payment for a service furnished by a resident provided under direct supervision. We are proposing to modify paragraph (a) to state that certain evaluation and management codes (as specified by CMS in program instructions), may be paid by the physician fee schedule and are thus proposing to remove the language "of lower and mid-level complexity" to potentially allow for certain moderate and higher-level evaluation and management codes to be billed if the visit meets all the criteria in § 415.174. We are proposing § 415.174 (a) to read as follows: "In the case of certain evaluation and management codes (as specified by CMS in program instructions), Medicare Administrative Contractors (MACs) may make physician fee schedule payment for a service furnished by a resident without the presence of a teaching physician. For the exception to apply, all of the following conditions must be met."

We believe this proposal would provide some autonomy to residents as well as the teaching physician if the specific GME program would support it. We considered that some visits may take more time in the beginning since residents are still learning and we will continue to monitor the visit levels over time. We welcome comments on this proposal.

(60) Bundled Payments Under the PFS for Substance Use Disorders (HCPCS Codes G2086, G2087, and G2088)

In the CY 2020 PFS final rule (84 FR 62673), we finalized the creation of new coding and payment describing a bundled episode of care for the treatment of Opioid Use Disorder

(OUD). Then, in the CY 2021 PFS final rule, we finalized a revision to the code descriptors for HCPCS codes G2086, G2087, and G2088 by replacing ''opioid use disorder'' with ''a substance use disorder'' in response to requests to expand these bundled payments to be inclusive of other substance use disorders (SUDs), not just OUD, stating we agreed that doing so could expand access to needed care.

The codes are:

- HCPCS code G2086: *Office-based treatment for a substance use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month.*
- HCPCS code G2087: *Office-based treatment for a substance use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month.*
- HCPCS code G2088: *Office-based treatment for a substance use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes (List separately in addition to code for primary procedure).*

Interested parties have pointed out disparities in payment for HCPCS codes G2086 through G2088 compared to payment for similar services under the Medicare Opioid Treatment Program (OTP) benefit. They state that both OTPs and non-OTP outpatient addiction treatment settings can provide American Society of Addiction Medicine ASAM Level 1.7's suite of services that include medically managed outpatient treatment services, including evaluation and management of intoxication, withdrawal, biomedical concerns, and common low complexity psychiatric concerns. They state that the only clinical difference between these places of service at ASAM Level 1.7 is that OTPs can provide methadone for the treatment of OUD, and the other cannot due to Federal regulations. OTPs are also governed by extensive Federal and State regulations, unlike office-based practices which are not federally regulated settings but may be subject to extensive State regulations. They note that since the time these codes were created,

there is now a new Level 1.0 that describes remission monitoring services or services to patients in stable remission, similar to services described by outpatient E/M codes. The new Level 1.5 provides outpatient counseling and psychotherapeutic services, appropriate for patients with mild SUDs and those in early remission, and a new Level 1.7 that describes medically-managed outpatient treatment, including withdrawal management. They state that the services described by HCPCS codes G2086-G2088 align with Level 1.5, but that there is no existing coding under the PFS to describe level 1.7.

We welcome additional information on this topic, including whether we should consider updates to the rates for HCPCS codes G2086 through G2088, and/or whether additional coding is needed to describe the ASAM 1.7 level of care.

(61) Software as a Medical Service (SaMS) Laboratory Analyses

In recent years, there have been rapid developments in the use of software-based technologies with novel functionalities, including artificial intelligence, to support clinical decision-making in the outpatient and physician office settings. New clinical software, which includes clinical decision support software, clinical risk modeling, and computer aided detection (CAD), is becoming increasingly available to practitioners. These technologies often perform data analysis of diagnostic images from patients, relying on complex algorithms or statistical predictive modeling to aid in the diagnosis or treatment planning of a patient's condition. In previous rulemaking, we have referred to these algorithm-driven services that assist practitioners in making clinical assessments or diagnoses as Software as a Service (SaaS). Some of the software functions that are used in these services are FDA-regulated medical devices. Unlike prescription digital therapeutics (PDTs), for example PDTs that provide cognitive behavioral therapy to treat substance disorders or chronic insomnia, SaaS technologies do not currently treat illnesses or patient injuries. SaaS is also separate from remote patient monitoring (RPM) and remote therapeutic monitoring (RTM), which are digital healthcare tools for tracking patient data outside traditional office settings (90 FR 49394). For CY 2027, we propose a change in

terminology. We now understand that in other industries, the existing SaaS terminology is used for general cloud-based computing service models outside of a health care context, which may cause confusion as we are using it to describe specific services that provide a medical function for purposes of PFS Medicare payment policy. To dispel any ambiguity and clarify that distinction, we propose to change our terminology from SaaS to Software as a Medical Service (SaMS) to refer to software-based technologies that support clinical decision making through algorithmic analysis, including those that provide clinical or diagnostic functionality. We welcome public comments on the proposed change in terminology. For further discussion of this terminology and other OPPS SaMS proposals, please see the CY 2027 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Proposed Rule (91 FR 41918).

In recent years, we have seen an increase in laboratory tests that combine laboratory analyses, such as genomic sequencing or immunoassays, with computer algorithms to produce a clinical test result. The AMA CPT Editorial Panel created a category called Multi-Analyte Assays with Algorithmic Analysis, to categorize test codes that combined laboratory analyses with computer algorithms to generate clinical information. More recently, however, we are seeing the development of distinct algorithmic analyses alone.

For example, when the genomic sequencing of an individual is performed, this sequencing will likely only need to be performed once. However, once the genomic sequence has been generated, the subsequent algorithmic analyses of that sequence data can be performed an infinite number of times to produce a wide range of results and/or diagnostic or risk-related information. These secondary analyses of original genomic sequences can be proprietary and unique to a single laboratory but could also be conducted at a range of settings. For purposes of this proposal, we are referring to subsequent stand-alone algorithmic analyses that are separate from a CLIA certified laboratory's examination of human material, as defined by 42 CFR 493.2, as "SaMS laboratory analyses performed on laboratory tests".

Currently, certain SaMS analyses performed on laboratory tests are treated as clinical diagnostic laboratory tests (CDLTs) and paid under the Clinical Laboratory Fee Schedule (CLFS). Section 1861(s) of the Act specifies items and services included as "medical and other health services" under Part B, including diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests as described in section 1861(s)(3) of the Act. Section 1861(s)(17) of the Act states that no diagnostic tests performed in any laboratory shall be included within paragraph (3) unless such laboratory meets CLIA certification requirements under section 353 of the Public Health Service Act, among other requirements. Sections 1833(h) and 1834A of the Act and the implementing regulations at 42 CFR part 414, subpart G, set forth the CLFS ratesetting methodologies for CDLTs. We do not believe it is appropriate to consider these secondary algorithmic analyses to be CDLTs or establish CLFS payment rates for these analyses because these secondary algorithmic analyses do not require laboratory services or entities, regulated by CLIA, to perform them. Referring to the example above, while an individual's genomic sequence must be performed by a CLIA certified laboratory entity to allow for Medicare payment under the CLFS, the subsequent algorithmic analyses of the sequence data as part of the SaMS analyses performed on laboratory tests can be performed by any non-regulated entity with the computer software needed to perform the analyses.

Our position is that the secondary analyses are "other diagnostic tests" under section 1861(s)(3) of the Act as opposed to "diagnostic laboratory tests." As noted previously, Medicare will not pay for CDLTs on the CLFS unless they are furnished by laboratories that meet applicable CLIA certification requirements.

Tests that examine materials derived from the human body are assigned to and paid under the CLFS only when furnished by such certified laboratories, in accordance with 42 CFR 410.32(d). Because SaMS analyses performed on laboratory tests are downstream evaluations of the data generated by a prior laboratory test, an entity that performs only algorithmic analyses of previously sequenced data may not qualify as a CLFS laboratory under 42 CFR 493.2 or require

CLIA certification. We believe SaMS that evaluate data generated by a prior laboratory test should not be treated as CDLTs for Medicare payment purposes.

We are also concerned that paying for these analyses based on existing CLFS payment methodologies may create significant vulnerabilities for the Medicare program, due to the lack of data transparency and CDLTs not being subject to beneficiary cost-sharing or budget neutrality. Section 414.508 outlines the ratesetting methodologies CMS uses to set payment rates for new tests on the CLFS. Under § 414.508(b), CMS determines the payment amount based on either crosswalking or gapfilling methodologies until applicable information is available to establish a payment amount under the methodology described in § 414.507(b). Crosswalking is used if it is determined that a new CDLT is comparable to an existing test, multiple existing test codes, or a portion of an existing test code. Gapfilling is used when no comparable existing CDLT is available. Public consultation for payment for new clinical diagnostic laboratory tests is required in determining payment amounts, receiving public comments and recommendations (and data on which the recommendations are based) as well as recommendations from the Advisory Panel on CDLTs per 42 CFR 414.506.

A significant challenge to the ratesetting process for CMS is the lack of transparent data received from laboratories outlining resource costs of a test, particularly for the algorithmic portions of tests that are combined with other analytes. In the past, laboratories have explained to CMS that the algorithmic components of laboratory tests are highly proprietary and details cannot be shared. Thus, we have worked with the limited information available on the details of methods or resources for the algorithmic portions of tests or analyses and has thus far relied on the other laboratory methods provided in the CPT descriptor (i.e., NGS sequencing, RT-PCR, or DNA methylation analysis). As we have gathered more information on SaMS analyses performed on laboratory tests, we now believe that since these analyses are entirely computer-based, comparison based on laboratory methodologies is not appropriate. Additionally, in contrast to the PFS, the CLFS generally does not include beneficiary cost-sharing or budget

neutrality adjustments, which limits transparency regarding pricing and creates challenges for ensuring appropriate valuation of these services.

Finally, CMS has an interest in ensuring that services that are fundamentally similar are paid for and treated in the same way, regardless of the setting of care in which the service is furnished. Since SaMS analyses performed on laboratory tests do not require performance by a CLIA-certified laboratory and perform algorithmic analyses on previously generated data, we believe SaMS analyses performed on laboratory tests are substantively similar to other SaMS technologies that are currently paid under the PFS. Accordingly, we believe that whether the SaMS performs algorithmic analyses of an imaging test (*e.g.* CT scan) or whether it performs an algorithmic analysis on data generated from a laboratory test, all algorithmic analyses should be treated consistently with other comparable SaMS analyses and belong within the broader proposed framework for SaMS. We believe that this approach for SaMS technologies would promote stability and predictability in payment for similar services.

Therefore, for CY 2027, we are proposing to contractor price ten HCPCS codes describing various SaMS analysis performed on laboratory tests under the PFS. Table A-D8 shows the list of currently payable SaMS analysis performed on laboratory tests under the CLFS that we are proposing to contractor price under the PFS. These ten HCPCS codes were identified by the CPT descriptor for the code. If there were no laboratory methods included in the code descriptor, and only a computer analysis was described, we identified the code as a SaMS analysis performed on laboratory tests. We refer to the 2027 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Proposed Rule (91 FR 41918) for discussion of payment for these services under the OPPS, where we are proposing to assign the same SaMS analysis performed on laboratory tests to new technology APCs.

We would appreciate public comment on any other SaMS analysis performed on laboratory tests that should be removed from the CLFS and contractor priced under the PFS. We are seeking comment more broadly on other approaches to payment for these services, including,

but not limited to, a direct crosswalk to the proposed OPPS new technology APC dollar amounts for all proposed analyses, a subset of these analyses, or specific analyses as opposed to contractor pricing.

In addition, for CY 2027 and subsequent years, we propose to assign any new codes that describe SaMS analysis performed on laboratory testto contractor pricing for payment under the PFS. We request public comment on these proposals, including the list of ten HCPCS codes that we identified as SaMS analysis performed on laboratory tests, as well as any additional HCPCS codes that we should designate as SaMS analysis performed on laboratory tests and pay under the PFS rather than as CDLTS paid on the CLFS. We may finalize a policy that includes such payment for additional HCPCS codes in the PFS final rule based on public comment.

TABLE A-D8 : PROPOSED SAMS ANALYSES PERFORMED ON LABORATORY TESTS FOR CY 2027

HCPCS Code	Long Descriptor
0510U	Oncology (pancreatic cancer), augmentative algorithmic analysis of 16 genes from previously sequenced rna whole transcriptome data, reported as probability of predicted molecular subtype
0511U	Oncology (solid tumor), tumor cell culture in 3d microenvironment, 36 or more drug panel, reported as tumor-response prediction for each drug
0512U	Oncology (prostate), augmentative algorithmic analysis of digitized whole-slide imaging of histologic features for microsatellite instability (msi) status, formalin-fixed paraffin embedded (ffpe) tissue, reported as increased or decreased probability of msi-high (msi-h)
0513U	Oncology (prostate), augmentative algorithmic analysis of digitized whole-slide imaging of histologic features for microsatellite instability (msi) and homologous recombination deficiency (hrd) status, formalin fixed paraffin-embedded (ffpe) tissue, reported as increased or decreased probability of each biomarker
0208U	Oncology (medullary thyroid carcinoma), mrna, gene expression analysis of 108 genes, utilizing fine needle aspirate, algorithm reported as positive or negative for medullary thyroid carcinoma
0414U	Oncology (lung), augmentative algorithmic analysis of digitized whole slide imaging for 8 genes (alk, braf, egfr, erbb2, met, ntrk1-3, ret, ros1), and kras g12c and pd-l1, if performed, formalin-fixed paraffin-embedded (ffpe) tissue, reported as positive or negative for each biomarker
0418U	Oncology (breast), augmentative algorithmic analysis of digitized whole slide imaging of 8 histologic and immunohistochemical features, reported as a recurrence score
0220U	Oncology (breast cancer), image analysis with artificial intelligence assessment of 12 histologic and immunohistochemical features, reported as a recurrence score
0376U	Oncology (prostate cancer), image analysis of at least 128 histologic features and clinical factors, prognostic algorithm determining the risk of distant metastases, and prostate cancer-specific mortality, includes predictive algorithm to androgen deprivation-therapy response, if appropriate
81416	Exome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis, each comparator exome (eg, parents, siblings) (list separately in addition to code for primary procedure)

(62) Caregiver Training Services (CTS)

In the CY 2025 PFS final rule (89 FR 97817 through 97821), we finalized new G-codes and payment for direct care CTS: HCPCS codes G0541 *(Caregiver training in direct care*

strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; initial 30 minutes), G0542 *(Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; each additional 15 minutes (list separately in addition to code for primary service) (use g0542 in conjunction with g0541))*, and G0543 *(Group caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face with multiple sets of caregivers)*.

We are seeking comment on whether the resource costs associated with these services are best reflected through this existing coding or whether these resources costs are reflected in the valuation of other codes paid under the PFS, such as E/M visits.

(63) Comment Solicitation on Payment for Physician-Patient Clinical Trial Discussions

Despite the U.S. investing over $50 billion annually in biomedical research, fewer than 7 percent of adult cancer patients enroll in clinical trials.[49] A central and modifiable reason is that physicians rarely initiate conversations about clinical trials with their patients. For example, national survey data show that 70 percent of oncologists discuss trials with less than a quarter of their patients[50], yet more than 50 percent of eligible patients enroll when actively offered a clinical trial.[51]

---

[49] Unger JM, Shulman LN, Facktor MA, Helson H, Fleury ME. National estimates of the participation of patients with cancer in clinical research studies based on commission on cancer accreditation data. J Clin Oncol. 2024;42:2139-2148.

[50] Lee SJC, Murphy CC, Gerber DE, et al. Reimbursement matters: overcoming barriers to clinical trial accrual. Med Care. 2021;59(5):461–466. PMC8026490.

[51] Unger JM, Vaidya R, Hershman DL, Minasian LM, Fleury ME. Systematic review and meta-analysis of the magnitude of structural, clinical, and physician and patient barriers to cancer clinical trial participation. J Natl Cancer Inst. 2019;111(3):245–255.

Time and administrative burden are documented as the top barrier to conversations between physician and patients about participation in clinical trials in virtually every survey.[52] The current valuation of existing visit codes does not account for the additional time and resource costs associated with the structured physician counseling regarding clinical trial eligibility, options, risks and benefits associated with counseling a beneficiary on whether to enroll in a clinical trial.

We are therefore seeking comment on whether we should effectuate payment for these resource costs through the creation of a HCPCS G-code describing a minimum of 20 minutes of physician or other QHP time spent on clinical trial counseling. We are seeking comment on accurate valuation for this service, including inputs for work and practice expense, and whether the service should be available as a Medicare telehealth service. Interested parties suggested a work RVU value between 1.00 and 1.50 RVUs would accurately account for the physician work associated with this service. We are also seeking comment on what documentation requirements we might consider for such a service, such as the trial(s) discussed and the patient's decision.

[52] Kumar A, Bhatt DL, Fonarow GC, et al. Barriers for cancer clinical trial enrollment: a qualitative study of the perspectives of healthcare providers. Contemp Clin Trials Commun. 2022;28:100939. PMC9189774.

TABLE A-D9: CY 2027 WORK RVUs FOR NEW, REVISED, AND POTENTIALLY MISVALUED CODES

HCPCS	Descriptor	Current work RVU	RUC work RVU	CMS work RVU	CMS time refinement
0591T	Health and well-being coaching face-to-face; individual, initial assessment	C	C	1.00	Yes
0592T	Health and well-being coaching face-to-face; individual, follow-up session, at least 30 minutes	C	C	0.70	Yes
0593T	Health and well-being coaching face-to-face; group (2 or more individuals), at least 30 minutes	C	C	0.23	Yes
10005	Fine needle aspiration biopsy, including ultrasound guidance; first lesion	1.42	1.35	1.35	No
10006	Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion	0.98	1.00	1.00	No
15X19	Skin cell suspension autograft (SCSA), trunk, arms, and/or legs; first 100 sq cm or less, or 1% of body area of infants and children	NEW	10.97	10.97	No
15X20	Skin cell suspension autograft (SCSA), trunk, arms, and/or legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof	NEW	0.59	0.59	No
15X21	Skin cell suspension autograft (SCSA), face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children	NEW	11.28	11.28	No
15X22	Skin cell suspension autograft (SCSA), face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof	NEW	0.98	0.98	No
20985	Computer-assisted surgical navigational procedure for musculoskeletal procedures	2.44	2.44	2.44	No
209X1	Placement of localization marker(s) (eg, fiducial marker[s]), intraosseous, percutaneous, including imaging guidance, when performed; first target site	NEW	3.00	3.00	No
209X2	Placement of localization marker(s) (eg, fiducial marker[s]), intraosseous, percutaneous, including imaging guidance, when performed; each additional target site	NEW	1.76	1.76	No
209XX	Ablation therapy for reduction or eradication of bone tumor, including adjacent soft tissue when involved by tumor extension, cryoablation, open	NEW	2.70	2.70	No
22210	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; cervical	24.75	24.75	23.12	No
22212	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; thoracic	20.47	23.20	21.72	No
22214	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar	20.49	21.72	19.53	No
22216	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; each additional vertebral segment	5.88	3.00	3.00	No
23470	Arthroplasty, glenohumeral joint; hemiarthroplasty	17.44	15.60	13.81	No
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))	21.58	19.35	17.49	No
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft	19.11	16.70	15.37	No
27278	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive, including imaging guidance, unilateral; placement of intra-articular structural bone graft, metal and/or synthetic device(s) without cortical piercing, including use of osteopromotive material and/or obtaining bone graft, when performed	7.66	7.66	7.66	No
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive, including imaging guidance, unilateral; placement of transarticular and/or intra-articular device(s) that engage bone with intrinsic fixation (eg, screw[s], flange[s], blade[s]) piercing the lateral cortex of the sacrum and the medial cortex of the ilium (with or without piercing the lateral cortex of the ilium), including use of osteopromotive material and/or obtaining bone graft, when performed	11.83	11.00	11.00	No
27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)	19.11	16.70	15.94	No
27X05	Implantation of medial knee extra-articular shock absorber, including fluoroscopic guidance	NEW	13.16	13.16	No
27XX8	Acellular scaffold(s) (eg, aragonite) implant(s), for osteochondral lesion(s), knee, open	NEW	9.53	9.53	No
33340	Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation	9.99	9.99	9.00	No
33X01	Insertion of permanent cardiac contractility modulation (CCM) system, including fluoroscopic guidance and programming of sensing and therapeutic parameters, with evaluation when performed; pulse generator and transvenous electrodes	NEW	8.83	8.83	No
33X02	Insertion of permanent cardiac contractility modulation (CCM) system, including fluoroscopic guidance and programming of sensing and therapeutic parameters, with evaluation when performed; pulse generator only	NEW	5.66	5.66	No
33X03	Insertion of permanent cardiac contractility modulation (CCM) system, including fluoroscopic guidance and programming of sensing and therapeutic parameters, with evaluation when performed; transvenous electrode, single	NEW	6.00	6.00	No
33X04	Insertion of permanent cardiac contractility modulation (CCM) system, including fluoroscopic guidance and programming of sensing and therapeutic parameters, with evaluation when performed; transvenous electrode, dual	NEW	6.23	6.23	No
33X05	Removal of permanent cardiac contractility modulation (CCM) system; pulse generator and transvenous electrodes	NEW	9.90	9.90	No

HCPCS	Descriptor	Current work RVU	RUC work RVU	CMS work RVU	CMS time refinement
33X06	Removal of permanent cardiac contractility modulation (CCM) system; pulse generator only	NEW	4.79	4.79	No
33X07	Removal of permanent cardiac contractility modulation (CCM) system; transvenous electrode, single	NEW	7.30	7.30	No
33X08	Removal of permanent cardiac contractility modulation (CCM) system; transvenous electrode, dual	NEW	8.39	8.39	No
33X09	Removal and replacement of permanent cardiac contractility modulation (CCM) system, pulse generator only	NEW	6.00	6.00	No
33X10	Repositioning of previously implanted cardiac contractility modulation (CCM) transvenous electrode(s), including fluoroscopic guidance and programming of sensing and therapeutic parameters	NEW	5.00	5.00	No
33X11	Relocation or revision of skin pocket for implanted cardiac contractility modulation (CCM) pulse generator	NEW	5.12	5.12	No
33X12	Insertion of left heart ventricular assist device (VAD), including radiological supervision and interpretation, open; aorta exposure with creation of conduit by transthoracic (eg, median sternotomy, thoracotomy) incision	NEW	17.52	17.52	No
33X13	Removal of left heart ventricular assist device (VAD) with resection and stapling of graft conduit and skin closure (eg, infraclavicular, supraclavicular)	NEW	6.58	6.58	No
33X15	Insertion of left heart ventricular assist device (VAD), including radiological supervision and interpretation, open; axillary, subclavian, or innominate artery exposure with creation of conduit by infraclavicular or supraclavicular incision, unilateral	NEW	13.65	13.65	No
33X50	Transcatheter tricuspid valve replacement (TTVR) with prosthetic valve, percutaneous approach, including right heart catheterization, temporary pacemaker insertion, and selective right ventricular or right atrial angiography, when performed	NEW	24.38	17.52	Yes
33X51	Transcatheter tricuspid valve edge-to-edge repair (T-TEER), percutaneous approach; initial clip	NEW	23.92	17.06	Yes
33X52	Transcatheter tricuspid valve edge-to-edge repair (T-TEER), percutaneous approach; each additional clip during same session	NEW	8.00	6.34	No
36465	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein)	2.29	2.29	2.29	No
36466	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg	2.93	2.93	2.62	No
36470	Injection of sclerosant; single incompetent vein (other than telangiectasia)	0.73	0.73	0.73	No
36471	Injection of sclerosant; multiple incompetent veins (other than telangiectasia), same leg	1.46	1.18	1.18	No
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated	3.41	3.41	3.41	No
36474	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites	1.71	1.71	1.71	No
38X03	Microvascular anastomosis between a single vein opening and any number of lymphatic vessels, per limb; initial anastomosis	NEW	16.00	14.00	No
38X04	Microvascular anastomosis between a single vein opening and any number of lymphatic vessels, per limb; each additional anastomosis	NEW	6.00	6.00	No
39540	Repair, diaphragmatic hernia (other than neonatal), via laparotomy; traumatic, acute	14.21	24.00	24.00	No
39541	Repair, diaphragmatic hernia (other than neonatal), via laparotomy; traumatic, chronic	15.36	26.00	26.00	No
39545	Plication of diaphragm for eventration or paralysis, via thoracotomy	14.30	18.45	18.45	No
395X2	Thoracoscopy, surgical, with plication of diaphragm for eventration or paralysis	NEW	20.00	20.00	No
39X11	Thoracoscopy, surgical, with repair of diaphragmatic hernia (other than neonatal); traumatic, chronic	NEW	25.44	25.44	No
39X12	Thoracoscopy, surgical, with repair of diaphragmatic hernia (other than neonatal); nontraumatic (ie, Bochdalek, Morgagni)	NEW	25.94	25.94	No
39X13	Implantation of mesh or other prosthesis with open, laparoscopic, or thoracoscopic diaphragmatic hernia repair	NEW	3.00	3.00	No
39XX1	Division of median arcuate ligament and release of celiac trunk, with ganglionectomy, when performed	NEW	26.41	26.41	No
39XX2	Laparoscopy, surgical, with division of median arcuate ligament and release of celiac trunk, with ganglionectomy, when performed	NEW	25.94	25.94	No
39XX3	Repair, diaphragmatic hernia (other than neonatal), via laparotomy; nontraumatic (ie, Bochdalek, Morgagni)	NEW	25.75	25.75	No
39XX4	Repair, diaphragmatic hernia (other than neonatal), via thoracotomy; traumatic, chronic	NEW	26.41	26.41	No
39XX5	Repair, diaphragmatic hernia (other than neonatal), via thoracotomy; nontraumatic (ie, Bochdalek, Morgagni)	NEW	25.94	25.94	No
39XX7	Laparoscopy, surgical, with repair of diaphragmatic hernia (other than neonatal); traumatic, acute	NEW	22.04	22.04	No
39XX8	Laparoscopy, surgical, with repair of diaphragmatic hernia (other than neonatal); traumatic, chronic	NEW	26.60	26.60	No
39XX9	Laparoscopy, surgical, with repair of diaphragmatic hernia (other than neonatal); nontraumatic (ie, Bochdalek, Morgagni)	NEW	27.00	27.00	No
42808	Excision or destruction of lesion of pharynx, without magnification, any method	2.29	2.29	2.29	No
42XX1	Transoral removal of oropharyngeal and/or pharyngeal neoplasm under magnification (eg, microscope or telescope), includes robotic assistance, when performed; tongue base	NEW	20.00	20.00	No
42XX2	Transoral removal of oropharyngeal and/or pharyngeal neoplasm under magnification (eg, microscope or telescope), includes robotic assistance, when performed; lateral pharyngeal wall, including tonsil	NEW	20.05	20.05	No
44XX1	Duodenoduodenostomy or duodenojejunostomy for congenital duodenal obstruction	NEW	50.00	50.00	No

HCPCS	Descriptor	Current work RVU	RUC work RVU	CMS work RVU	CMS time refinement
44XX2	Laparoscopy, surgical; duodenoduodenostomy or duodenojejunostomy for congenital duodenal obstruction	NEW	52.60	52.60	No
48XXX	Ablation, irreversible electroporation of tumor(s) of the pancreas, open, including imaging guidance	NEW	25.19	25.19	No
4XX01	Endoscopic submucosal dissection (ESD) of upper gastrointestinal tract, including mucosal closure, when performed	NEW	15.00	15.00	No
4XX02	Endoscopic submucosal dissection (ESD) of lower gastrointestinal tract, including mucosal closure, when performed	NEW	16.38	16.38	No
51715	Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck	3.64	-	3.64	No
55705	Biopsy, prostate, any approach, nonimaging-guided	1.88	1.88	1.88	No
55707	Biopsy, prostate, transrectal, including imaging guidance, regional	2.63	2.63	2.63	No
55708	Biopsy, prostate, transrectal, including imaging guidance, regional and fusion-targeted lesion(s)	3.39	3.39	3.39	No
55709	Biopsy, prostate, transperineal, including imaging guidance, regional	3.23	3.23	3.23	No
55710	Biopsy, prostate, transperineal, including imaging guidance, regional and fusion-targeted lesion(s)	3.81	3.81	3.81	No
55711	Biopsy, prostate, transrectal or transperineal, including imaging guidance, fusion-targeted lesion(s) without regional; first targeted lesion	2.61	2.37	2.37	No
55714	Biopsy, prostate, including imaging guidance, in-bore CT- or MRI-guided; first targeted lesion	3.62	3.62	3.62	No
55715	Biopsy, prostate, including imaging guidance, in-bore CT- or MRI-guided; each additional targeted lesion	1.05	1.80	1.80	No
59030	Fetal scalp blood sampling	1.94	0.90	0.90	No
59051	Fetal monitoring during labor by consulting physician (ie, non-attending physician) or other qualified health care professional, with interpretation and report	0.72	0.93	0.93	No
59160	Curettage, postpartum	2.69	2.93	2.93	No
59300	Repair of first or second-degree episiotomy or laceration, by other than attending physician or other qualified health care professional performing vaginal delivery care (separate procedure)	2.35	1.76	1.76	No
59320	Cerclage of cervix, during pregnancy; vaginal	2.42	3.02	3.02	No
59325	Cerclage of cervix, during pregnancy; abdominal	3.96	6.34	6.34	No
59412	External cephalic version	1.71	2.63	2.63	No
59414	Delivery of placenta only (separate procedure)	1.61	1.61	1.61	No
59871	Removal of cerclage suture under anesthesia (other than local)	2.08	2.15	2.15	No
59X10	Uterine tamponade (eg, balloon, catheter, vacuum, packing material)	NEW	2.15	2.15	No
59X11	Repair of episiotomy or laceration; third-degree laceration	NEW	2.47	2.47	No
59X12	Repair of episiotomy or laceration; fourth-degree laceration	NEW	4.14	4.14	No
59XX1	Initial day labor management; straightforward, per day	NEW	3.50	4.03	No
59XX2	Initial day labor management; complex, per day	NEW	4.50	5.18	No
59XX3	Subsequent day labor management; straightforward, per day	NEW	3.00	3.45	No
59XX4	Subsequent day labor management; complex, per day	NEW	4.20	4.83	No
59XX5	Vaginal delivery, with or without episiotomy;	NEW	8.00	9.20	No
59XX6	Vaginal delivery, with or without episiotomy; after previous cesarean delivery	NEW	9.00	10.35	No
59XX7	Cesarean delivery; primary	NEW	12.00	13.80	No
59XX8	Cesarean delivery; repeat	NEW	14.66	16.86	No
59XX9	Subtotal or total hysterectomy after cesarean delivery	NEW	15.56	15.56	No
5XX14	Biopsy, prostate, transrectal or transperineal, including imaging guidance, fusion-targeted lesion(s) without regional; each additional targeted lesion (List separately in addition to code for primary procedure)	NEW	0.80	0.68	No
61781	Stereotactic computer-assisted (navigational) procedure; cranial, intradural	3.66	3.66	3.66	No
61782	Stereotactic computer-assisted (navigational) procedure; cranial, extradural	3.10	2.06	2.06	No
61783	Stereotactic computer-assisted (navigational) procedure; spinal	3.66	3.66	3.66	No
62287	Decompression, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle-based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar	9.03	7.06	6.23	No
63045	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; cervical	17.50	17.25	17.25	No
63046	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; thoracic	16.82	16.71	16.71	No
63047	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar	14.99	14.99	14.99	No
63048	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional vertebral segment, cervical, thoracic, or	3.38	3.38	3.38	No

HCPCS	Descriptor	Current work RVU	RUC work RVU	CMS work RVU	CMS time refinement
	lumbar				
64400	Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular)	0.73	0.73	0.73	No
64405	Injection(s), anesthetic agent(s) and/or steroid; greater occipital nerve	0.92	0.84	0.84	No
70544	Magnetic resonance angiography, head, including image postprocessing; without contrast material(s)	1.17	1.17	1.17	No
70545	Magnetic resonance angiography, head, including image postprocessing; with contrast material(s)	1.17	1.17	1.17	No
70546	Magnetic resonance angiography, head, including image postprocessing; without contrast material(s), followed by contrast material(s) and further sequences	1.44	1.44	1.44	No
70547	Magnetic resonance angiography, neck, including image postprocessing; without contrast material(s)	1.17	1.17	1.17	No
70548	Magnetic resonance angiography, neck, including image postprocessing; with contrast material(s)	1.46	1.46	1.46	No
70549	Magnetic resonance angiography, neck, including image postprocessing; without contrast material(s), followed by contrast material(s) and further sequences	1.76	1.76	1.76	No
70XX4	Magnetic resonance angiography, head and neck, including image postprocessing; without contrast material(s)	NEW	1.77	1.77	No
70XX5	Magnetic resonance angiography, head and neck, including image postprocessing; with contrast material(s)	NEW	2.10	2.10	No
70XX6	Magnetic resonance angiography, head and neck, without contrast material(s) in 1 or both body regions, followed by contrast material(s) and further sequences in 1 or both body regions, including image postprocessing	NEW	2.23	2.23	No
73200	Computed tomography, upper extremity; without contrast material	0.98	1.00	1.00	No
73201	Computed tomography, upper extremity; with contrast material(s)	1.13	1.16	1.16	No
73202	Computed tomography, upper extremity; without contrast material, followed by contrast material(s) and further sections	1.19	1.24	1.24	No
77402	Radiation treatment delivery; Level 1 (eg, single-electron field, multiple-electron fields, or 2D photons), including imaging guidance, when performed	0.00	-	0.00	No
77407	Radiation treatment delivery; Level 2, single-isocenter (eg, 3D or IMRT), photons, including imaging guidance, when performed	0.00	-	0.00	No
77412	Radiation treatment delivery; Level 3, multiple isocenters with photon therapy (eg, 2D, 3D, or IMRT) or a single-isocenter photon therapy (eg, 3D or IMRT) with active motion management, or total skin electrons, or mixed-electron/photon field(s), including imaging guidance, when performed	0.00	-	0.00	No
77520	Proton treatment delivery; simple, without compensation	C	-	0.00	No
77522	Proton treatment delivery; simple, with compensation	C	-	0.00	No
77523	Proton treatment delivery; intermediate	C	-	0.00	No
77525	Proton treatment delivery; complex	C	-	0.00	No
90832	Psychotherapy, 30 minutes with patient	1.94	-	2.02	No
90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service	1.71	-	1.79	No
90834	Psychotherapy, 45 minutes with patient	2.56	-	2.67	No
90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service	2.17	-	2.26	No
90837	Psychotherapy, 60 minutes with patient	3.78	-	3.94	No
90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service	2.86	-	2.98	No
90839	Psychotherapy for crisis; first 60 minutes	3.58	-	3.73	No
90840	Psychotherapy for crisis; each additional 30 minutes	1.71	-	1.79	No
90845	Psychoanalysis	2.40	-	2.50	No
90846	Family psychotherapy (without the patient present), 50 minutes	2.74	-	2.86	No
90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	2.86	-	2.98	No
90849	Multiple-family group psychotherapy	0.67	-	0.70	No
90853	Group psychotherapy (other than of a multiple-family group)	0.67	-	0.70	No
90901	Biofeedback training by any modality (eg, EMG, EEG, ECG); initial 15 minutes of direct patient contact by physician or other qualified health care professional	0.41	0.61	0.61	No
90912	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; initial 15 minutes of one-on-one physician or other qualified health care professional contact with the patient	0.90	0.90	0.90	No
90913	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; each additional 15 minutes of one-on-one physician or other qualified health care professional contact with the patient	0.50	0.50	0.50	No
90X03	Biofeedback training by any modality (eg, EMG, EEG, ECG); each additional 15 minutes of direct patient contact by physician or other qualified health care professional	NEW	0.48	0.48	No
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder, group, 2 or more individuals	0.33	0.28	0.28	No
92978	Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel	1.76	1.76	1.40	No

HCPCS	Descriptor	Current work RVU	RUC work RVU	CMS work RVU	CMS time refinement
92979	Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; each additional vessel	1.40	1.40	1.04	No
92X0X	Treatment of fluency disorder (eg, stuttering and cluttering), direct (one-on-one) patient contact; initial 30 minutes	NEW	0.92	0.92	No
92X10	Video head impulse testing (vHIT), with recording, interpretation, and report; of lateral semicircular canal function	NEW	0.53	0.53	No
92X11	Video head impulse testing (vHIT), with recording, interpretation, and report; of lateral and vertical semicircular canal function	NEW	0.84	0.84	No
92X1X	Treatment of fluency disorder (eg, stuttering and cluttering), direct (one-on-one) patient contact; each additional 15 minutes	NEW	0.44	0.44	No
92X2X	Treatment of speech sound production disorder (eg, articulation, phonological process, apraxia, dysarthria), direct (one-on-one) patient contact; initial 30 minutes	NEW	0.90	0.90	No
92X3X	Treatment of speech sound production disorder (eg, articulation, phonological process, apraxia, dysarthria), direct (one-on-one) patient contact; each additional 15 minutes	NEW	0.44	0.44	No
92X4X	Treatment of language comprehension and expression disorder (eg, receptive and expressive language), direct (one-on-one) patient contact; initial 30 minutes	NEW	1.00	1.00	No
92X5X	Treatment of language comprehension and expression disorder (eg, receptive and expressive language), direct (one-on-one) patient contact; each additional 15 minutes	NEW	0.48	0.48	No
92X6X	Treatment of speech sound production disorder (eg, articulation, phonological process, apraxia, dysarthria) and language comprehension and expression disorder (eg, receptive and expressive language), direct (one-on-one) patient contact; initial 30 minutes	NEW	1.00	1.00	No
92X7X	Treatment of speech sound production disorder (eg, articulation, phonological process, apraxia, dysarthria) and language comprehension and expression disorder (eg, receptive and expressive language), direct (one-on-one) patient contact; each additional 15 minutes	NEW	0.50	0.50	No
92X8X	Treatment of voice, upper airway dysfunction, and/or resonance disorders, direct (one-on-one) patient contact; initial 30 minutes	NEW	0.98	0.98	No
92X9X	Treatment of voice, upper airway dysfunction, and/or resonance disorders, direct (one-on-one) patient contact; each additional 15 minutes	NEW	0.48	0.48	No
92XX5	Rotational vestibular assessment by sinusoidal harmonic acceleration (SHA) testing with calibrated, computer-controlled chair, with interpretation and report;	NEW	0.92	0.92	No
92XX6	Rotational vestibular assessment by sinusoidal harmonic acceleration (SHA) testing with calibrated, computer-controlled chair, with interpretation and report; with velocity step testing (VST)	NEW	0.48	0.35	No
93X01	Programming of the cardiac contractility modulation (CCM) system (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, including review and report by a physician or other qualified health care professional	NEW	0.90	0.90	No
93X02	Interrogation device evaluation (in person) with analysis, review, and report by a physician or other qualified healthcare professional, including connection, recording, and disconnection, per patient encounter, implantable cardiac contractility modulation (CCM) system	NEW	0.80	0.80	No
93X03	Interrogation device evaluation (remote), up to 90 days, cardiac contractility modulation (CCM) system, with interim analysis, review, and report(s) by a physician or other qualified health care professional	NEW	0.59	0.59	No
93X04	Interrogation device evaluation (remote), up to 90 days, cardiac contractility modulation (CCM) system, remote data acquisition(s), receipt of transmissions, technician review, technical support, and distribution of results	NEW	0.00	0.00	No
95921	Testing of autonomic nervous system function, with interpretation and report; cardiovagal innervation (parasympathetic function), including 2 or more of the following: heart rate response to deep breathing with recorded R-R interval, Valsalva ratio, and 30:15 ratio	0.88	0.88	0.74	No
95922	Testing of autonomic nervous system function, with interpretation and report; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least 5 minutes of passive tilt (ie, tilt table)	0.96	0.96	0.96	No
95923	Testing of autonomic nervous system function, with interpretation and report; sudomotor, quantitative sudomotor axon reflex test (QSART) or silastic sweat imprint	0.88	0.88	0.88	No
95924	Testing of autonomic nervous system function, with interpretation and report; combined parasympathetic and sympathetic adrenergic function testing with at least 5 minutes of passive tilt (ie, tilt table)	1.73	1.50	1.50	No
95X18	Unattended sleep study, set-up, data acquisition and technical analysis; low complexity of 3-4 channels that generate at least 3-5 parameter categories	NEW	0.00	0.00	No
95X19	Unattended sleep study, set-up, data acquisition and technical analysis; moderate complexity of 5-10 channels that generate at least 6-8 parameter categories	NEW	0.00	0.00	No
95X20	Unattended sleep study, set-up, data acquisition and technical analysis; high complexity of 11 or more channels that generate at least	NEW	0.00	0.00	No

HCPCS	Descriptor	Current work RVU	RUC work RVU	CMS work RVU	CMS time refinement
	9 parameter categories				
95X21	Unattended sleep study, interpretation and report by a physician or other qualified health care professional; low complexity of 3-4 channels that generate at least 3-5 parameter categories	NEW	0.81	0.81	No
95X22	Unattended sleep study, interpretation and report by a physician or other qualified health care professional; moderate complexity of 5-10 channels that generate at least 6-8 parameter categories	NEW	1.05	1.05	No
95X23	Unattended sleep study, interpretation and report by a physician or other qualified health care professional; high complexity of 11 or more channels that generate at least 9 parameter categories	NEW	1.60	1.42	No
95XX4	Testing of autonomic nervous system function, with interpretation and report; use of tilt table	NEW	0.34	0.34	No
95XX5	Testing of autonomic nervous system function, with interpretation and report; sudomotor, thermoregulatory sweat test	NEW	1.00	1.00	No
95XX6	Testing of autonomic nervous system function, with interpretation and report; sudomotor, assessing the sympathetic skin response (SSR) potential	NEW	0.50	0.50	No
95XX7	Testing of autonomic nervous system function, with interpretation and report; combined parasympathetic and sudomotor testing, quantitative sudomotor axon reflex test (QSART) or silastic sweat imprint	NEW	1.17	1.17	No
95XX8	Testing of autonomic nervous system function, with interpretation and report; combined sympathetic adrenergic with at least 5 minutes of passive tilt (ie, tilt table) and sudomotor testing, quantitative sudomotor axon reflex test (QSART) or silastic sweat imprint	NEW	1.75	1.56	No
95XX9	Testing of autonomic nervous system function, with interpretation and report; combined parasympathetic, sympathetic adrenergic function with at least 5 minutes of passive tilt (ie, tilt table), and sudomotor testing, quantitative sudomotor axon reflex test (QSART) or silastic sweat imprint	NEW	1.91	1.77	No
96156	Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)	2.40	-	2.50	No
96158	Health behavior intervention, individual, face-to-face; initial 30 minutes	1.66	-	1.73	No
96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes	0.57	-	0.60	No
96164	Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes	0.24	-	0.25	No
96165	Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes	0.11	-	0.12	No
96167	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes	1.77	-	1.85	No
96168	Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes	0.63	-	0.66	No
96920	Laser treatment, 308-312 nanometer wavelengths, for inflammatory or autoimmune skin diseases (eg, psoriasis); total area less than 250 sq cm	0.81	1.00	1.00	No
96921	Laser treatment, 308-312 nanometer wavelengths, for inflammatory or autoimmune skin diseases (eg, psoriasis); 250 sq cm to 500 sq cm	0.88	1.24	1.24	No
96922	Laser treatment, 308-312 nanometer wavelengths, for inflammatory or autoimmune skin diseases (eg, psoriasis); over 500 sq cm	1.12	1.50	1.50	No
97151	Behavior identification assessment, administered by a physician or other qualified health care professional (QHP), each 15 minutes of the physician's or other QHP's time face-to-face with patient and/or caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring and/or interpreting the assessment, and preparing the report and/or treatment plan	C	C	C	No
97152	Behavior identification–supporting assessment, administered by technician, face-to-face with the patient, each 15 minutes	C	C	C	No
97153	Adaptive behavior treatment by protocol, administered by technician, face-to-face with 1 patient, each 15 minutes	C	C	C	No
97154	Group adaptive behavior treatment by protocol, administered by technician, face-to-face with 2 or more patients, each 15 minutes	C	C	C	No
97155	Adaptive behavior direction of technician and analysis by physician or other qualified health care professional, face-to-face with a patient, each 15 minutes	C	C	C	No
97156	Family adaptive behavior treatment guidance with analysis, administered by physician or other qualified health care professional (with or without the patient present), including discussing protocols and treatment targets and/or training the caregiver(s) to implement assessment or treatment protocols with the patient, face-to-face with caregiver(s) for 1 patient, each 15 minutes	C	C	C	No
97157	Multiple-family group adaptive behavior treatment guidance with analysis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of caregivers for multiple patients, each 15 minutes	C	C	C	No
97158	Group adaptive behavior treatment with analysis, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes	C	C	C	No
97610	Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day	0.39	-	0.39	No
976XX	Real-time fluorescence wound imaging with clinical darkness to identify presence, location, load of bacteria, and measure wound size, per day	NEW	C	0.80	Yes
978X1	Lactation care directed by a physician or other qualified health care professional, including history, assessment, training, and report;	NEW	0.00	0.00	No

HCPCS	Descriptor	Current work RVU	RUC work RVU	CMS work RVU	CMS time refinement
	each additional 15 minutes				
978XX	Lactation care directed by a physician or other qualified health care professional, including history, assessment, training, and report; first 30 minutes	NEW	0.18	0.18	No
97X1X	Behavior identification–supporting assessment of harmful behavior; each 15 minutes of technician time face-to-face with a patient, requiring the following components: ● delivered by 2 technicians, ● for a patient who exhibits harmful behavior, ● conducted in an environment that is customized to the patient's behavior.	NEW	C	C	No
97X2X	Behavior identification–supporting assessment of harmful behavior; additional technicians present, each 15 minutes	NEW	C	C	No
97X3X	Adaptive behavior non-face-to-face services, personally performed by a physician or other qualified health care professional, each 15 minutes, with any of the following elements, when performed: ● review and analysis of data and session notes on patient treatment targets, ● clinical decision-making regarding the need to modify treatment targets, goals, or protocols and/or making those modifications, ● clinical decision-making regarding the need for additional assessment and developing or modifying assessment protocols, ● developing discharge or transition plan, ● training on or reviewing treatment targets and/or revised assessment or treatment protocols with technician(s).	NEW	C	C	No
97X4X	Adaptive behavior treatment of harmful behavior; each 15 minutes of technician time with a patient, requiring the following components: ● delivered by 2 technicians, ● for a patient who exhibits harmful behavior, ● conducted in an environment that is customized to the patient's behavior.	NEW	C	C	No
97X5X	Adaptive behavior treatment of harmful behavior; each additional technician present, each 15 minutes	NEW	C	C	No
97X6X	Adaptive behavior treatment with analysis, administered by physician or other qualified health care professional, face-to-face with 1 patient, each 15 minutes	NEW	C	C	No
98975	Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); initial set-up and patient education on use of equipment	0.00	0.00	0.00	No
98976	Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of respiratory system, 16-30 days in a 30-day period	0.00	0.00	0.00	No
98977	Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of musculoskeletal system, 16-30 days in a 30-day period	0.00	0.00	0.00	No
98978	Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of cognitive behavioral therapy, 16-30 days in a 30-day period	C	C	0.00	No
98979	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least 1 real-time interactive communication with the patient or caregiver during the calendar month; first 10 minutes	0.31	0.31	0.31	No
98980	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least 1 real-time interactive communication with the patient or caregiver during the calendar month; first 20 minutes	0.62	0.62	0.62	No
98981	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least 1 real-time interactive communication with the patient or caregiver during the calendar month; each additional 20 minutes	0.61	0.61	0.61	No
98984	Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of respiratory system, 2-15 days in a 30-day period	0.00	0.00	0.00	No
98985	Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of musculoskeletal system, 2-15 days in a 30-day period	0.00	0.00	0.00	No
98986	Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of cognitive behavioral therapy, 2-15 days in a 30-day period	C	C	0.00	No
99091	Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days	1.10	1.10	1.10	No
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes	0.24	-	0.29	No
99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	0.50	-	0.60	No
99445	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate); device(s) supply with daily recording(s) or programmed alert(s) transmission, 2-15 days in a 30-day period	0.00	0.00	0.00	No

HCPCS	Descriptor	Current work RVU	RUC work RVU	CMS work RVU	CMS time refinement
99453	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate); initial set-up and patient education on use of equipment	0.00	0.00	0.00	No
99454	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate); device(s) supply with daily recording(s) or programmed alert(s) transmission, 16-30 days in a 30-day period	0.00	0.00	0.00	No
99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring 1 real-time interactive communication with the patient/caregiver during the calendar month; first 20 minutes	0.61	0.61	0.61	No
99458	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring 1 real-time interactive communication with the patient/caregiver during the calendar month; each additional 20 minutes	0.61	0.61	0.61	No
99470	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring 1 real-time interactive communication with the patient/caregiver during the calendar month; first 10 minutes	0.31	0.31	0.31	No
99473	Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration	0.00	0.00	0.00	No
99474	Self-measured blood pressure using a device validated for clinical accuracy; separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient	0.18	0.18	0.18	No
99492	Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional, initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan, review by the psychiatric consultant with modifications of the plan if recommended, entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant, and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.	1.88	1.88	2.75	No
99493	Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: tracking patient follow-up and progress using the registry, with appropriate documentation, participation in weekly caseload consultation with the psychiatric consultant, ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers, additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant, provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies, monitoring of patient outcomes using validated rating scales, and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.	2.05	2.05	2.26	No
99494	Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional	0.82	0.82	1.13	No
9XX04	Percutaneous transcatheter therapeutic drug-delivery by intracoronary drug-delivery balloon (eg, drug-coated, drug-eluting), including mechanical dilation by nondrug-delivery balloon angioplasty, single major coronary artery and/or its branch(es)	NEW	10.00	8.05	No
9XX07	Percutaneous transcatheter therapeutic drug-delivery by intracoronary drug-delivery balloon (eg, drug-coated, drug-eluting), single major artery and/or its branches	NEW	4.38	4.38	No
G0396	Alcohol and/or substance (other than tobacco) misuse structured assessment (eg, audit, dast), and brief intervention 15 to 30 minutes	0.65	-	0.77	No
G0397	Alcohol and/or substance (other than tobacco) misuse structured assessment (eg, audit, dast), and intervention, greater than 30 minutes	1.30	-	1.55	No
G0561	Tympanostomy with local or topical anesthesia and insertion of a ventilating tube when performed with tympanostomy tube delivery device, unilateral	C	0.00	0.00	No

HCPCS	Descriptor	Current work RVU	RUC work RVU	CMS work RVU	CMS time refinement
G0568	Initial psychiatric collaborative care management, in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional, initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan, review by the psychiatric consultant with modifications of the plan if recommended, entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant, and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies	1.88	1.88	2.75	No
G0569	Subsequent psychiatric collaborative care management, in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: tracking patient follow-up and progress using the registry, with appropriate documentation, participation in weekly caseload consultation with the psychiatric consultant, ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers, additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant, provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies, monitoring of patient outcomes using validated rating scales, and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment	2.05	2.05	2.26	No
G2011	Alcohol and/or substance (other than tobacco) misuse structured assessment (eg, audit, dast), and brief intervention, 5-14 minutes	0.33	-	0.39	No
G2214	Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional	0.77	0.77	1.13	No
GACP1	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), first 20 minutes of clinical staff time with the patient, family member(s), directed by a treating physician or other treating qualified health care professional	NEW	-	1.00	No
GACP2	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), each additional 20 minutes with the patient, family member(s), directed by a treating physician or other treating qualified health care professional)	NEW	-	0.70	No
GADV1	Office or other outpatient evaluation and management service(s) for the diagnosis and treatment of vaccine adverse effects, new or established patient; each 15 minutes personally performed by the physician or qualified healthcare professional	NEW	-	0.61	No
GSLPP	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual; for the pediatric population up to age 18 or 21	NEW	-	1.30	No
GSMAS	Voluntary, group-based medical session involving multiple patients with common medical condition(s), receiving medical care in a group setting; billed and led by a physician or qualified nonphysician practitioner and may include services provided by other qualified healthcare professionals, clinical staff, or auxiliary personnel under the direction of the supervising physician or other practitioner. Session integrates group education, counseling, and peer support with individualized patient clinical assessment and care, 2-10 patients, billed once per patient, per session.	NEW	-	1.73	No
G0577	Vascular embolization or occlusion procedure with use of a pressure-generating catheter (eg, one-way valve, intermittently occluding), inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction performed in the non-facility setting	NEW	-	11.45	No

TABLE A-D10: CY 2026 DIRECT PE REFINEMENTS

HCPCS code	HCPCS code description	Input Code	Input code description	NF/F	Labor activity (where applicable)	RUC recommendation or current value (min or qty)	CMS refinement (min or qty)	Comment	Direct costs change in Dollars
10005	Fna bx w/us gdn 1st les	EQ250	ultrasound unit, portable	NF		37	0	G1: See preamble text	-5.97

HCPCS code	HCPCS code description	Input Code	Input code description	NF/F	Labor activity (where applicable)	RUC recommendation or current value (min or qty)	CMS refinement (min or qty)	Comment	Direct costs change in Dollars
10005	Fna bx w/us gdn 1st les	ER130	Fine Needle Aspiration portable ultrasound	NF		0	37	G1: See preamble text	11.74
10006	Fna bx w/us gdn ea addl	EQ250	ultrasound unit, portable	NF		17	0	G1: See preamble text	-2.74
10006	Fna bx w/us gdn ea addl	ER130	Fine Needle Aspiration portable ultrasound	NF		0	17	G1: See preamble text	5.39
976XX	R-t fluor wound imaging pr d	EF015	mayo stand	NF		0	30	G1: See preamble text	0.03
976XX	R-t fluor wound imaging pr d	EF031	table, power	NF		0	30	G1: See preamble text	0.47
976XX	R-t fluor wound imaging pr d	EQ137	instrument pack, basic ($500-$1499)	NF		0	36	G1: See preamble text	0.08
976XX	R-t fluor wound imaging pr d	EQ168	light, exam	NF		0	30	G1: See preamble text	0.10
976XX	R-t fluor wound imaging pr d	ER131	MolecuLight DX System	NF		0	30	G1: See preamble text	2.56
976XX	R-t fluor wound imaging pr d	L037D	RN/LPN/MTA	NF	Greet patient, provide gowning, ensure appropriate medical records are available	0	3	G1: See preamble text	1.62
976XX	R-t fluor wound imaging pr d	L037D	RN/LPN/MTA	NF	Obtain vital signs	0	3	G1: See preamble text	1.62
976XX	R-t fluor wound imaging pr d	L037D	RN/LPN/MTA	NF	Provide education/obtain consent	0	1	G1: See preamble text	0.54
976XX	R-t fluor wound imaging pr d	L037D	RN/LPN/MTA	NF	Prepare room, equipment and supplies	0	2	G1: See preamble text	1.08
976XX	R-t fluor wound imaging pr d	L037D	RN/LPN/MTA	NF	Prepare, set-up and start IV, initial positioning and monitoring of patient	0	2	G1: See preamble text	1.08
976XX	R-t fluor wound imaging pr d	L037D	RN/LPN/MTA	NF	Assist physician or other qualified healthcare professional---directly related to physician work time (100% of physician intra-service time)	0	15	G1: See preamble text	8.10
976XX	R-t fluor wound imaging pr d	L037D	RN/LPN/MTA	NF	Clean room/equipment by clinical staff	0	3	G1: See preamble text	1.62
976XX	R-t fluor wound imaging pr d	L037D	RN/LPN/MTA	NF	Clean surgical instrument package	0	10	G1: See preamble text	5.40
976XX	R-t fluor wound imaging pr d	L037D	RN/LPN/MTA	NF	Check dressings, catheters, wounds	0	1	G1: See preamble text	0.54

HCPCS code	HCPCS code description	Input Code	Input code description	NF/F	Labor activity (where applicable)	RUC recommendation or current value (min or qty)	CMS refinement (min or qty)	Comment	Direct costs change in Dollars
976XX	R-t fluor wound imaging pr d	L037D	RN/LPN/MTA	NF	Review home care instructions, coordinate visits/prescriptions	0	2	G1: See preamble text	1.08
976XX	R-t fluor wound imaging pr d	SA043	pack, cleaning, surgical instruments	NF		0	1	G1: See preamble text	11.09
976XX	R-t fluor wound imaging pr d	SB007	drape, sterile barrier 16in x 29in	NF		0	1	G1: See preamble text	0.51
976XX	R-t fluor wound imaging pr d	SB019	drape-towel, sterile 18in x 26in	NF		0	1	G1: See preamble text	0.47
976XX	R-t fluor wound imaging pr d	SB022	gloves, non-sterile	NF		0	2	G1: See preamble text	0.60
976XX	R-t fluor wound imaging pr d	SB028	gown, surgical, sterile	NF		0	1	G1: See preamble text	5.13
976XX	R-t fluor wound imaging pr d	SB044	underpad 2ft x 3ft (Chux)	NF		0	1	G1: See preamble text	0.32
976XX	R-t fluor wound imaging pr d	SB061	MolecuLight DX Eco Dark Drape	NF		0	1	G1: See preamble text	6.25
976XX	R-t fluor wound imaging pr d	SC056	syringe 50-60ml	NF		0	1	G1: See preamble text	1.13
976XX	R-t fluor wound imaging pr d	SF007	blade, surgical (Bard-Parker)	NF		0	1	G1: See preamble text	0.68
976XX	R-t fluor wound imaging pr d	SG018	bandage, Kling, non-sterile 3in	NF		0	1	G1: See preamble text	0.34
976XX	R-t fluor wound imaging pr d	SG035	dressing, 3in x 4in (Telfa, Release)	NF		0	2	G1: See preamble text	0.10
976XX	R-t fluor wound imaging pr d	SG051	gauze, non-sterile 4in x 4in	NF		0	8	G1: See preamble text	0.24
976XX	R-t fluor wound imaging pr d	SG052	gauze, self-adherent roll 0.5in to 2in (Fabco, Gauztex)	NF		0	72	G1: See preamble text	5.76
976XX	R-t fluor wound imaging pr d	SG079	tape, surgical paper 1in (Micropore)	NF		0	12	G1: See preamble text	0.12
976XX	R-t fluor wound imaging pr d	SH069	sodium chloride 0.9% irrigation (500-1000ml uou)	NF		0	1	G1: See preamble text	3.34
976XX	R-t fluor wound imaging pr d	SJ046	silver nitrate applicator	NF		0	2	G1: See preamble text	0.38

TABLE A-D11: CY 2026 NEW INVOICES FOR DIRECT PE INPUTS

CPT/HCPCS codes	Item Name	CMS code	Average price	No. of Invoices	NF Allowed Services
10005, 10006	Fine Needle Aspiration portable ultrasound	ER130	83750	1	66,742
27279	Dorsal SI joint articular fixation device	SD390	14,451.00	1	41
51715	urethral bulking agent	SD396	1175	18	1,926
61782	Single Use Instrumentation Wire	SD391	48.40	1	3,565
61782	Patient Tracker	SD392	130.00	2	3,565
61782	Adhesive Pad	SD393	9.50	1	3,565
61782	Cube 4D Navigation system (monitor, 2 mounts, cart, pointer)	ER129	93,850.00	1	3,565
90901	disposable paper shorts	SB060	0.82	1	51,307
92X10, 92X11	Face cushion	SD394	1.475	1	2,349
92X10, 92X11	Monocular Video Frenzel base unit with vestibular software	EQ420	3424.5	1	2,349
92X10, 92X11	Lateral VHIT module	EQ421	7589.7	1	2,349
92X11	Larp/Ralp module	EQ422	6138.9	1	1,565
92XX5, 92XX6	VNG Open Chair System	EF051	113,900.00	1	36,179
95921, 95922, 95924, 95XX7, 95XX8, 95XX9	Filtered Mouthpiece	SD387	1.72	1	152,213
95923, 95XX7, 95XX8, 95XX9	Gel Trode 2x2 Return Electrode	SD388	4.95	1	88,241
95923, 95XX7, 95XX8, 95XX9	Meridian Electrode w/Expanding Foam	SD389	13.25	1	88,241
95X18	Apnea Link Air	EQ418	1,500.00	1	58,431
95X19	Apnea Trak Legacy	EQ419	5,623.00	1	222,669
95X20	Nox A1 Sensor Kit adult	SA143	22.46	1	6,192
95X20	Nox A1s System with SpO2, US	EQ417	14,000.00	1	6,192
976XX	MolecuLight DX Eco Dark Drape	SB061	6.25	1	175,391
976XX	MolecuLight DX System	ER131	21500	1	175,391
978XX, 978X1	scale, infant, digital, fine gradation	EF052	1,409.31	5	-
G0561	Automated PE tube delivery device	SD395	497.5	2	3

TABLE A-D12: CY 2026 INVOICES RECEIVED FOR EXISTING DIRECT PE INPUTS

CPT/HCPCS codes	Item Name	CMS code	Current price	Updated price	Percent change	Number of invoices	Estimated non-facility allowed services for HCPCS codes using this item
27278	Dorsal SI Joint Arthrodesis Implant	SD356	$11,500.00	$12,500.00	9%	1	512
36465, 36466	Varithena admin pack	SA125	$40.00	$55.00	38%	1	119,660
36465, 36466	Varithena (foam)	SD324	$3,195.00	$3,495.00	9%	1	119,660
36516	liposorber system	EQ174	$7,800.00	$56,000.00	618%	1	535
88364, 88365, 88367, 88368, 88369, 88373	Universal Detection Kit	SA117	$6.05	$6.38	5%	1	66,767
93241, 93243, 93245, 93247	extended external ECG patch, medical magnetic tape recorder	SD339	$315.00	$365.00	16%	31	675,748
97113	aquatic therapy pool	EQ050	$36,000.00	$192,171.88	434%	3	1,562,410
97610	kit, low frequency ultrasound wound therapy (MIST)	SA119	$320.18	$100.00	-69%	1	179,021
99151, 99152, G0500	pack, moderate sedation	SA044	$19.20	$15.69	-18%	1	158,962
G2082	Esketamine (56 mg vial)	SH109	$834.20	$895.10	7%	1	4,386
G2083	Esketamine (84 mg vial)	SH110	$1,251.31	$1,324.66	6%	1	32,576
111 codes	pack, basic injection	SA041	$12.73	$15.00	18%	-	-
306 codes	pack, cleaning and disinfecting, endoscope	SA042	$25.3600	$28.3250	12%	-	-
4568 codes	pack, minimum multi-specialty visit	SA048	$4.01	$2.99	-25%	-	-
168 codes	pack, ophthalmology visit (no dilation)	SA050	$2.263	$1.807	-20%	-	-
239 codes	pack, pelvic exam	SA051	$14.38	$8.59	-40%	-	-
1079 codes	pack, post-op incision care (staple)	SA052	$6.50	$8.20	26%	-	-
469 codes	pack, post-op incision care (suture & staple)	SA053	$7.49	$9.52	27%	-	-
1708 codes	pack, post-op incision care (suture)	SA054	$6.53	$8.43	29%	-	-
12 codes	pack, post-op incision care, craniotomy	SA055	$10.93	$14.55	33%	-	-
24 codes	pack, post-op incision care, neurosurgical	SA056	$9.48	$12.77	35%	-	-
38 codes	pack, urology cystoscopy visit	SA058	$75.67	$56.65	-25%	-	-
120 codes	pack, drapes, ortho, large	SA080	$33.33	$29.35	-12%	-	-
145 codes	pack, ophthalmology visit (w-dilation)	SA082	$3.12	$2.73	-13%	-	-
119 codes	pack, protective, ortho, large	SA083	$12.16	$13.45	11%	-	-
27 codes	pack, protective, ortho, small	SA084	$6.71	$7.43	11%	-	-
100 codes	guidewire, hydrophilic	SD089	$27.42	$34.29	25%	-	-

TABLE A-D13: CY 2026 NO PE REFINEMENTS

HCPCS	Description
15X19	Scsa t/a/l 1st 100 sq cm/<
15X20	Scsa t/a/l ea addl 100 sq cm
15X21	Scsa f-dgt 1st 100 sq cm/<
15X22	Scsa f-dgt ea addl 100 sq cm
20985	Cptr-asst navig px muscsk px
209X1	Plmt loclzj mrk ntross prq 1
209X2	Plmt loclz mrk ntross prq ea
209XX	Abltj ther rdctj/erad b1 tum
22210	Incis 1 vertebral seg cerv
22212	Incis 1 vertebral seg thorac
22214	Incis 1 vertebral seg lumbar
22216	Incis addl spine segment
23470	Reconstruct shoulder joint

HCPCS	Description
23472	Reconstruct shoulder joint
27130	Total hip arthroplasty
27278	Arthrd si jt i-artic b1 grf
27279	Arthrd si jt tartclr&/iartic
27447	Total knee arthroplasty
27X05	Impl med kne xartic shck abs
27XX8	Aclr scaf impl ostchndrl les
33340	Perq clsr tcat l atr apndge
33X01	Ins perm ccm pg&trnsvn eltrd
33X02	Ins perm ccm pulse gen only
33X03	Ins perm ccm trnsvns eltrd 1
33X04	Ins perm ccm trnsvn eltrd dl
33X05	Rmv perm ccm pg&trnsvn eltrd
33X06	Rmv perm ccm pulse gen only
33X07	Rmv perm ccm trnsvns eltrd 1
33X08	Rmv perm ccm trnsvn eltrd dl
33X09	Rmvl&rplcmt perm ccm pg only
33X10	Repos prv ccm transvns eltrd
33X11	Rlc/rev skn pckt impl ccm pg
33X12	Insj l heart vad aorta expos
33X13	Rmvl l hrt vad rescj&staplg
33X15	Insj l hrt vad ax subcl/inom
33X50	Ttvr w/prosth valve perq
33X51	T-teer perq initial clip
33X52	T-teer perq each addl clip
36465	Njx noncmpnd sclrsnt 1 vein
36466	Njx noncmpnd sclrsnt mlt vn
36470	Njx sclrsnt 1 incmptnt vein
36471	Njx sclrsnt mlt incmptnt vn
36473	Endovenous mchnchem 1st vein
36474	Endovenous mchnchem add-on
38X03	Mvasc anast 1vn&lymph vsl 1
38X04	Mvasc anast 1vn&lymph vsl ea
39540	Rpr diphrg hrna lapt tr aqt
39541	Rpr diphrg hrna lapt tr chrn
39545	Plctj diaphragm evntrn/palys
395X2	Thrsc plctj dphrm evnt/palys
39X11	Thrsc diphrg hrna traum chr
39X12	Thrsc rpr diphrg hrna ntraum
39X13	Impl mesh diphrg hrna rpr
39XX1	Div med arc lig&rls cel trnk
39XX2	Laps surg div median arc lig
39XX3	Rpr diphrg hrna lapt ntraumt
39XX4	Rpr diphrg hrna thrc tr chrn
39XX5	Rpr diphrg hrna thrcm ntraum
39XX7	Lap rpr dphrg hrna traum aqt
39XX8	Lap rpr dphrg hrna traum chr
39XX9	Laps rpr dphrg hrna nontraum
42808	Exc/dstr les pharynx wo magn
42XX1	Trnsorl rmvl neo tongue base
42XX2	Trnsorl rmv neo lat phrn wal
44XX1	Dd/dj cgen duol obstrcj
44XX2	Laps surg dd/dj cgen duo obs
48XXX	Abltj ire tum pancreas open

HCPCS	Description
4XX01	Esd upper gi tract
4XX02	Esd lower gi tract
55705	Bx prst8 any approach nonimg
55707	Bx prst8 trct regional
55708	Bx prst8 trct reg&fus trgt
55709	Bx prst8 tprnl regional
55710	Bx prst8 tprnl reg&fus trgt
55711	Bx prst8 trct/tprn fus trgt1
55714	Bx prst8 in-bore ct/mri 1
55715	Bx prst8 in-bore ct/mr ea
59030	Fetal scalp blood sampling
59051	Fetal mntr drg labor w/i&r
59160	D & c after delivery
59300	Rpr 1st/2nd episiotomy/lac
59320	Revision of cervix
59325	Revision of cervix
59412	External cephalic version
59414	Delivery of placenta only
59871	Remove cerclage suture
59X10	Uterine tamponade
59X11	Rpr episio/lac 3rd degree
59X12	Rpr episio/lac 4th degree
59XX1	Initial day labor mgmt sf
59XX2	Initial day labor mgmt cplx
59XX3	Sbsq day labor mgmt sf
59XX4	Sbsq day labor mgmt complex
59XX5	Vag dlvr w/w/o episiotomy
59XX6	Vag dlvr after prev cesarean
59XX7	Cesarean delivery primary
59XX8	Cesarean delivery repeat
59XX9	Stot/tot hyst after cesarean
5XX14	Bx prst8 trc/tprn fus trg ea
61781	Scan proc cranial intra
61782	Scan proc cranial extra
61783	Scan proc spinal
62287	Dcmprn pq nuc pul 1/mlt lmbr
63045	Lam facetec & foramot crv
63046	Lam facetec & foramot thrc
63047	Lam facetec & foramot lumbar
63048	Lam facetec &foramot ea addl
64400	Njx aa&/strd trigeminal nrv
64405	Njx aa&/strd gr ocpl nrv
70544	Mra head w/post-pxessing c-
70545	Mra head w/post-pxessing c+
70546	Mra head w/pst-pxessg c-/c+
70547	Mra neck w/post-pxessing c-
70548	Mra neck w/post-pxessing c+
70549	Mra neck w/pst-pxessg c-/c+
70XX4	Mra h&n w/pst-pxessg c-
70XX5	Mra h&n w/pst-pxessg c+
70XX6	Mra h&n w/pst-pxessg c-/c+
73200	Ct upper extremity w/o dye
73201	Ct upper extremity w/dye
73202	Ct uppr extremity w/o&w/dye

HCPCS	Description
90901	Biofeedback train any 1st 15
90912	Bfb training 1st 15 min
90913	Bfb training ea addl 15 min
90X03	Biofeedback train any ea add
92508	Tx sp lang voice comm group
92X0X	Tx fluency do 1st 30 min
92X10	Vhit lat smcrclr canal funcj
92X11	Vhit lat&ver smcrcl cnl func
92X1X	Tx fluency do ea addl 15 min
92X2X	Tx sp sound production do 1
92X3X	Tx sp sound production do ea
92X4X	Tx lang cmpre&xprsn do 1st
92X5X	Tx lang cmpre&xprsn do ea
92X6X	Tx sp sound&lang cmpre do 1
92X7X	Tx sp sound&lang cmpre do ea
92X8X	Tx voic uairw dysf&/res do 1
92X9X	Tx voic uairw dys&/res do ea
92XX5	Rotl vstblr assmt sha tstg
92XX6	Rotl vstblr assmt sha w/vst
93X01	Prgrmg ccm sys phys/qhp ip
93X02	Interrog ccm sys phys/qhp ip
93X03	Interog ccm sys phys/qhp rem
93X04	Interrog ccm sys tech remote
95921	Tst ans cardiovagal innervaj
95922	Tst ans vsmtr adrnrgc inrvaj
95923	Tst ans sudomotor qsart
95924	Tst ans parasymp&symp w/tilt
95X18	Unatn slp std setup lo 3-4ch
95X19	Unatn slp st setup mod5-10ch
95X20	Unatn slp std setup hi 11+ch
95X21	Unatn slp std i&r low 3-4 ch
95X22	Unatn slp std i&r mod 5-10ch
95X23	Unatn slp std i&r hi 11+ch
95XX4	Tst ans use of tilt table
95XX5	Tst ans sudomotor thermoreg
95XX6	Tst ans sudomotor ssr pot
95XX7	Tst ans parasymp&sdmtr qsart
95XX8	Tst ans symp adrngc w/tilt
95XX9	Tst ans parasymp symp adrngc
96920	Lsr tx inflam/ai skn<250sqcm
96921	Lsr tx inflam/ai 250-500sqcm
96922	Lsr tx inflam/ai skn>500sqcm
978X1	Lactation care ea add 15 min
978XX	Lactation care 1st 30 min
9XX04	Prq tcat ther rx ntrac balo1
9XX07	Prq tcat ther rx dlvr balo 1
G0561	Temp tube delivery, unil

4. Potentially Misvalued Services Under the PFS

a. Background

Section 1848(c)(2)(B) of the Act directs the Secretary to conduct a periodic review, not less often than every 5 years, of the relative value units (RVUs) established under the PFS. Section 1848(c)(2)(K) of the Act requires the Secretary to periodically identify potentially misvalued services using certain criteria and to review and make appropriate adjustments to the relative values for those services. Section 1848(c)(2)(L) of the Act also requires the Secretary to develop a process to validate the RVUs of certain potentially misvalued codes (PMVC) under the PFS, using the same criteria used to identify PMVC, and to make appropriate adjustments.

As outlined in section II.D. of the proposed rule, under Valuation of Specific Codes, each year we develop appropriate adjustments to the RVUs taking into account recommendations provided by the American Medical Association (AMA)/Specialty Society Relative Value Scale (RVS) Update Committee (referred to as the RUC), MedPAC, and other interested parties. For many years, the RUC has provided us with recommendations on the appropriate relative values for new, revised, and potentially misvalued PFS services. We review these recommendations on a code-by-code basis and consider these recommendations in conjunction with analyses of other data, such as claims data, to inform the decision-making process as authorized by statute. We may also consider analyses of work time, work RVUs, or direct practice expense (PE) inputs using other data sources, such as the Veterans Health Administration (VHA), National Surgical Quality Improvement Program (NSQIP), the Society for Thoracic Surgeons (STS), and the Merit-based Incentive Payment System (MIPS) data. In addition to considering the most recent available data, we assessed the results of physician surveys and specialty recommendations submitted to us by the RUC for our review. We also consider information provided by other interested parties such as from the general medical-related community and the public. We conduct a review to assess the appropriate RVUs in the context of contemporary medical practice. We note that section 1848(c)(2)(A)(ii) of the Act authorizes the use of

extrapolation and other techniques to determine the RVUs for physicians' services for which specific data are not available and requires us to take into account the results of consultations with organizations representing physicians who provide the services. In accordance with section 1848(c) of the Act, we determine and make appropriate adjustments to the RVUs.

In its March 2006 Report to the Congress (*https://www.medpac.gov/document/report-to-the-congress-2006-medicare-payment-policy/),* MedPAC discussed the importance of appropriately valuing physicians' services, stating that misvalued services can distort the market for physicians' services, as well as for other health care services that physicians order, such as hospital services. In that same report, MedPAC postulated that physicians' services under the PFS can become misvalued over time. MedPAC stated, "When a new service is added to the physician fee schedule, it may be assigned a relatively high value because of the time, technical skill, and psychological stress that are often required to furnish that service. Over time, the work required for certain services would be expected to decline as physicians become more familiar with the service and more efficient in furnishing it." We believe services can also become overvalued when PE costs decline. This can happen when the costs of equipment and supplies fall, or when equipment is used more frequently than is estimated in the PE methodology, reducing its cost per use. Likewise, services can become undervalued when physician work increases, or PE costs rise.

As MedPAC noted in its March 2009 Report to Congress *(https://www.medpac.gov/docs/default-source/reports/march-2009-report-to-congress-medicare-payment-policy.pdf*), in the intervening years since MedPAC made the initial recommendations, CMS and the RUC have taken several steps to improve the review process. Also, section 1848(c)(2)(K)(ii) of the Act augments our efforts by directing the Secretary to specifically examine, as determined appropriate, potentially misvalued services in the following categories:

- Codes that have experienced the fastest growth.
- Codes that have experienced substantial changes in PE.

- Codes that describe new technologies or services within an appropriate time-period (such as 3 years) after the relative values are initially established for such codes.
- Codes which are multiple codes that are frequently billed in conjunction with furnishing a single service.
- Codes with low relative values, particularly those that are often billed multiple times for a single treatment.
- Codes that have not been subject to review since implementation of the fee schedule.
- Codes that account for the majority of spending under the PFS.
- Codes for services that have experienced a substantial change in the hospital length of stay or procedure time.
- Codes for which there may be a change in the typical site of service since the code was last valued.
- Codes for which there is a significant difference in payment for the same service between different sites of service.
- Codes for which there may be anomalies in relative values within a family of codes.
- Codes for services where there may be efficiencies when a service is furnished at the same time as other services.
- Codes with high intraservice work per unit of time.
- Codes with high PE RVUs.
- Codes with high--cost supplies.
- Codes as determined appropriate by the Secretary.

Section 1848(c)(2)(K)(iii) of the Act also specifies that the Secretary may use existing processes to receive recommendations on the review and appropriate adjustment of potentially misvalued services. In addition, the Secretary may conduct surveys, other data collection activities, studies, or other analyses, as the Secretary determines to be appropriate, to facilitate the review and appropriate adjustment of potentially misvalued services. This section

also authorizes the use of analytic contractors to identify and analyze potentially misvalued codes, conduct surveys or collect data, and make recommendations on the review and appropriate adjustment of potentially misvalued services. Additionally, this section provides that the Secretary may coordinate the review and adjustment of any RVU with the periodic review described in section 1848(c)(2)(B) of the Act. Section 1848(c)(2)(K)(iii)(V) of the Act specifies that the Secretary may make appropriate coding revisions (including using current processes for consideration of coding changes), which may involve consolidating individual services into bundled codes for payment under the PFS.

b. CY 2027 Identification and Review of Potentially Misvalued Services

In the CY 2012 PFS final rule with comment period (76 FR 73058 through 73059), we finalized a process for the public to nominate PMVC. In the CY 2015 PFS final rule with comment period (79 FR 67606 through 67608), we modified this process whereby the public and interested parties may nominate PMVC for review by submitting the code with supporting documentation by February 10th of each year. Supporting documentation for codes nominated for the annual review of PMVC may include the following:

- Documentation in peer reviewed medical literature or other reliable data that demonstrate changes in physician work due to one or more of the following: technique, knowledge and technology, patient population, site-of-service, length of hospital stay and work time.
- An anomalous relationship between the code being proposed for review and other codes.
- Evidence that technology has changed physician work.
- Analysis of other data on time and effort measures, such as operating room logs or national and other representative databases.

- Evidence that incorrect assumptions were made in the previous valuation of the service, such as a misleading vignette, survey, or flawed crosswalk assumptions in a previous evaluation.

- Prices for certain high-cost supplies or other direct PE inputs that are used to determine PE RVUs are inaccurate and do not reflect current information.

- Analyses of work time, work RVU, or direct PE inputs using other data sources (for example, VA, NSQIP, the STS National Database, and the MIPS data).

- National surveys of work time and intensity from professional and management societies and organizations, such as hospital associations.

We evaluate the supporting documentation submitted with the nominated codes and assess whether the nominated codes appear to be PMVC appropriate for review under the annual process. In the following year's PFS proposed rule, we publish the list of nominated codes and indicate for each nominated code whether we agree with its inclusion as a PMVC. The public has the opportunity to comment on these and all other proposed PMVC. In each year's final rule, we finalize our list of PMVC.

In each proposed rule, we seek nominations from the public and from interested parties of codes that they believe we should consider as potentially misvalued. We receive public nominations for PMVC by February 10th and we display these nominations on our public website (*https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices*), where we include the submitter's name, their associated organization and the submitted studies for full transparency. We sometimes receive submissions for specific PE-related inputs for codes, and discuss these PE-related submissions, as necessary under the Determination of PE RVUs section of the rule. We summarize later in this section this year's submissions under the PMVC initiative. For CY 2027, we received 15 requests concerning various codes as PMVC.

The nominations are as follows:

(1) Nasal sinus irrigation (CPT codes 31000 and 31002)

We received a request from one nominator to review nasal sinus irrigation codes, CPT 31000 *(Lavage by cannulation; maxillary sinus (antrum puncture or natural ostium))*, and CPT 31002 *(Lavage by cannulation; sphenoid sinus)*, as potentially misvalued. We reviewed this code family for the CY 2026 PFS final rule and our extensive discussion and rationale for finalizing the current values can be found at 90 FR 49310 through 49311.

We appreciate the information we received from the nominator. However, we note the information was the same as last year's submission. Additionally, the aforementioned CY 2026 PFS final rule specifically mentions for nasal sinus irrigation that interested parties were encouraged to submit relevant documentation, such as invoices or other evidence that demonstrates the typical resource costs for providing these services (90 FR 49311). However, we did not receive any invoices from the nominator.

In consideration of the information provided in this potentially misvalued nomination request as well as our previous valuation review and decision stated in the CY 2026 PFS final rule, we are seeking comments on the typicality and usage of the nasal sinus irrigation codes, CPT codes 31000 and 31002.

(2) Urethral bulking material (CPT code 51715)

We received a request from a nominator to review CPT code 51715 *(Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck)* as potentially misvalued. The nominator stated that CPT code 51715 currently does not include a supply for the implant material necessary to properly perform CPT code 51715 in the office setting, which is a clinically desired place of service for this treatment. The nominator requested that CMS create a supply code for a urethral bulking agent sold in 2 mL vials, with a non-facility quantity of 1 priced at an average of $1,175 and incorporate this new supply into CPT code 51715 to appropriately value the service in the non-facility setting.

We appreciate the nominator submitting invoices regarding the pricing of this urethral bulking agent. Given the information provided by the nominator as well as factoring in the

amount of time that has passed since CPT code 51715 was last formally reviewed in the 1990s, we are proposing to create a new supply code (SD396) for this urethral bulking agent. The SD396 supply is based on a 2 mL vial which we are proposing to price at the requested $1,175 based on an average of the submitted invoices. We are proposing to add 1 quantity of this supply to CPT code 51715 in the non-facility setting to reflect current clinical practice. Given the cost of this supply and the length of time since last review, we are also seeking comment on whether CPT code 51715 should be referred to the RUC for review.

(3) Complex cystometrogram (CPT codes 51728 and 51729)

We received a request from a nominator to review CPT code 51728 *(Complex cystometrogram (ie, calibrated electronic equipment); with voiding pressure studies (ie, bladder voiding pressure), any technique)* and CPT code 51729 (*Complex cystometrogram (ie, calibrated electronic equipment); with voiding pressure studies (ie, bladder voiding pressure) and urethral pressure profile studies (ie, urethral closure pressure profile), any technique)*. The nominator submitted invoices to request a pricing increase in the supply codes SD017 (catheter balloon), SD027 (catheter pressure), and SD131 (tubing pressure) for CPT codes 51728 and 51729. The invoices submitted from the requestor are dated from January 2025 to October 2025 and the nominator specifically is requesting an increase in the price of the SD017 supply from $35.89 to $74.00, an increase in the price of the SD027 supply from $19.35 to $86.80, and an increase in the price of the SD131 supply from $2.90 to $25.48.

We appreciate the information submitted from the nominator and note we previously reviewed these supply codes in the CY 2026 PFS final rule and stated, “Given the differences between the names of the items in question, and the significant increases in requested pricing, we proposed not to update the pricing of these three supplies as we cannot verify that the invoices refer to the same supply items.” (90 FR 49279) Taking into consideration the invoice for the SD017 supply listed a ‘‘Abdominal Sensor Catheter’’, the invoice for the SD027 supply listed a ‘‘Single Sensor Catheter’’, and the invoice for the SD131 supply listed a ‘‘Tubing, Pump,

Infusion Line'' our rationale that we cannot verify the names of items in question remains the same. Therefore, based on a lack of additional information submitted to explain the differences in names of the supply codes in question, we are not proposing to update the pricing of these three supplies as we are still unable to verify that these invoices refer to the same supply items.

(4) Carpal tunnel release procedure (CPT code 64728)

We received a request from one nominator to review CPT code 64728 *(Decompression; median nerve at the carpal tunnel, percutaneous, with intracarpal tunnel balloon dilation, including ultrasound guidance)* as potentially misvalued. The nominator stated that this code is misvalued due to the following reasons: 1) the anomalous relationship between the valuation for CPT code 64728 and other CPT codes for carpal tunnel release procedures; 2) Incorrect assumptions were made based on the previous valuation of the service, including a misleading survey and flawed crosswalk assumptions; and 3) Analysis of work relative value units (RVUs) from reliable data sources support increased valuation. The nominator requested an increase in work RVUs to appropriately reflect the intensive work associated with this procedure.

This code family was reviewed in the CY 2026 PFS final rule and our extensive discussion for finalizing a work RVU of 2.70 can be found in 90 FR 49374 through 49376. We previously addressed the concerns of the nominator in this preamble and we have received no new data for CY 2027 which would support a higher valuation for CPT code 64728. Based on the lack of new information submitted for CY 2027, we do not believe this code to be potentially misvalued. We are seeking comment on this issue, including the submission of new information to support the request.

(5) Electronic analysis of implanted neurostimulator pulse generator/transmitter (CPT codes 95970, 95976, 95977)

We received a request from one nominator to review CPT codes 95970 (*Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose*

lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/ transmitter, without programming), 95976 (*Electronic analysis of implanted neurostimulator pulse generator/ transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional*), and 95977 (*Electronic analysis of implanted neurostimulator pulse generator/ transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional*).

The nominator stated they believe this code family is potentially misvalued due to differing valuations relative to the recently reviewed CPT codes 93150 (*Therapy activation of implanted phrenic nerve stimulator system, including all interrogation and programming*), 93151 (*Interrogation and programming (minimum one parameter) of implanted phrenic nerve stimulator system*), and 93153 (*Interrogation without programming of implanted phrenic nerve stimulator system*), despite being clinical similar services. The nominator also believed there were discrepancies in equipment used to perform each procedure as opposed to what is included in the current valuation due to inaccurate assumptions about what clinical specialties most commonly furnish these procedures. To support their requests, the nominator shared 2024 utilization data showing an increase in certain clinical specialties furnishing these services. We

appreciate the additional information and are seeking comment on the appropriate valuation of this code family as well as any additional information on the typical specialty and resource costs associated with furnishing these procedures.

(6) Scalp cooling (CPT code 97007, 97008, 97009)

We received a request from one nominator to review the mechanical scalp cooling family of services described by CPT codes 97007 *(mechanical Scalp cooling, including individual cap supply with head measurement, fitting, and patient education)*, 97008 *(mechanical scalp cooling; including hair preparation, individual cap placement, therapy initiation, and pre-cooling period)*, and 97009 *(mechanical scalp cooling; each 30 minutes)*, as potentially misvalued. We reviewed this code family for the CY 2026 PFS final rule and our extensive discussion and rationale for finalizing the current values can be found at 90 FR 49405 through 49406.

The nominator stated that they believe this code family may be potentially misvalued based on newly available empirical evidence (a Time and Motion Study) that demonstrates incorrect assumptions were made during our prior valuation decision for the CY 2026 PFS final rule. They reference in their nomination that the August 2024 Time and Motion Study demonstrated that the clinical staff and PE inputs required to furnish this service are materially greater than those reflected in the current valuation and were not made available to CMS prior to our valuation review and decision for CY 2026. Specifically, the nominator recommended an increase in PE clinical staff time to 103 minutes for CPT code 97007, 52 minutes for 97008, and 23 minutes for 97009.

We appreciate the information we received from the nominator. However, we disagree with their assertion that CMS did not have the results of the August 2024 Time and Motion Study when making our valuation decision for CY 2026. The aforementioned CY 2026 PFS final rule discussion outlines the information considered for the valuation decision and specifically mentions the August 2024 Time and Motion Study results as well as the public comments received for the CY 2026 PFS proposed rule, which reflect the requested increase in PE clinical

staff time. We assure the nominators and readers of this discussion that all the information provided in this potentially misvalued nomination request was considered when making our previous valuation review and decision for CY 2026. Accordingly, we disagree with the assertion that this family is misvalued. However, we are seeking comment, particularly updated information that could support a change in valuation for these services.

(7) Hyperbaric oxygen under pressure (HCPCS code G0277)

The RUC has requested the deletion of HCPCS code G0277 (*Hyperbaric oxygen under pressure, full body chamber, per 30-minute interval*), and recommended that CPT code 99183 be revised to be time-based as well to appropriately describe the treatment delivery, attendance and supervision. The RUC concluded that maintaining a separate G-code creates unnecessary coding complexity without adding clinical or administrative value and that one clear and consistent coding structure should exist for this service.

In 2015, CMS created HCPCS code G0277 to describe direct practice expense inputs associated with CPT code 99183 *(Physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy, per session)*. We noted that under the Outpatient Prospective Payment System (OPPS), the treatment used to be reported using separate treatment code C1300 (*Hyperbaric oxygen under pressure, full body chamber, per 30-minute interval*.) Therefore, we created HCPCS code G0277 to report the treatment delivery and to maintain consistency with the OPPS coding and PFS payment systems.

HCPCS code G0277 was identified as a high-volume growth code that has Medicare utilization of 10,000 or more. High utilization of this magnitude reflects that the code has been broadly adopted across multiple care settings and underscores its operational importance within the Medicare program. Deleting or replacing a high-volume code without an equivalent can disrupt billing practices, create reporting gaps, and impose unnecessary administrative burden on providers who have integrated it into their standard practice. As such, we believe there is a reason to continue to maintain the use of the G-code for hyperbaric oxygen therapy since HCPCS

code G0277 is utilized in multiple Medicare payment systems to report the time the patient uses the hyperbaric oxygen therapy. Accordingly, we are proposing to maintain HCPCS code G0277.

(8) Image-guided Robotic Linear Accelerator Stereotactic Radiosurgery (HCPCS code G0339 and G0340)

Image-guided robotic linear accelerator-based stereotactic radiosurgery services are currently reported by and paid for using HCPCS G-codes established the in CY 2007 PFS final rule HCPCS codes G0339 (*Image-guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session or first session of fractionated treatment)* and G0340 (*Image-guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment*). In April 2025, the RAW identified HCPCS code G0340 with 2023 Medicare utilization over 10,000 and Medicare status of "C" contractor priced. The Workgroup requested an action plan for G0340 for September 2025. In September 2025, the Workgroup reviewed the action plan and recommended that the RUC request that CMS delete G0339 and G0340 having identified a CPT code 77373 (*Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions)* that is available to report in lieu of G0339 and G0340.

A review of Medicare claims data shows that HCPCS codes G0339 and G0340 are billed frequently. HCPCS code G0339 was billed approximately 3,000 times and HCPCS code G0340 12,000 times in 2024 respectively. As such, we believe there is a reason to maintain the G codes for image-guided robotic linear accelerator-based stereotactic radiosurgery services since both sets of codes are billed so frequently, and we do not want to cause disruption in billing practice. Since the RUC plans on reviewing these codes during its September 2026 meeting if the codes are not deleted for CY 2027, we welcome the RUC's additional information regarding appropriate coding and payment for these services.

(9) Request for revaluation of physician work time based on empiric data (CPT codes 15734, 19318,19380, 23472, 27130, 27447, 37227, 37229, 43281, 43644, 47120, 88305, 88307)

An interested party nominated 13 CPT codes as potentially misvalued. These codes are listed in Table A-D14.

TABLE A-D14: CPT CODES NOMINATED FOR REVALUATION BASED ON CHANGES IN PHYSICIAN WORK TIME

CPT Codes	Description
Integumentary system (CPT codes 15734, 19318, 19380)	
15734	Muscle, myocutaneous, or fasciocutaneous flap obtained from the trunk
19318	Breast reduction
19380	Revision of reconstructed breast (eg, significant removal of tissue, re-advancement and/or re-inset of flaps in autologous reconstruction or significant capsular revision combined with soft tissue excision in implant-based reconstruction
Musculoskeletal system (CPT codes 23472, 27130, 27447)	
23472	Arthroplasty, total shoulder (glenoid and proximal humeral replacement (eg, total shoulder)
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft
27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)
Cardiovascular system (CPT codes 37227 and 37229)	
37227	with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed*
37229	with atherectomy, includes angioplasty within the same vessel, when performed*
Digestive system (CPT codes 43281, 43644, 47120)	
43281	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)
47120	Hepatectomy, resection of liver; partial lobectomy
Surgical pathology (CPT codes 88305 and 88307)	
88305	Level IV - Surgical pathology, gross and microscopic examination
88307	Level V - Surgical pathology, gross and microscopic examination

*Deleted as of CY 2026.

The nominator provided evidence that current physician work time values in the PFS do not accurately reflect real-world clinical practice for 13 CPT codes across five code families. Their methodology focused on codes involving large discrepancies between empirically derived intraservice estimates and intraservice times assigned in the PFS. The nominator did not assert that their research provided confirmatory evidence for every intraservice time discrepancy, which is why their analysis focused on coding families related to the 13 CPT codes listed previously (Table A-D14). They provided additional details on their findings related to the 13 CPT codes and other codes included in their coding families in this section.

Using the 2023 Maryland All-Payer Claims Database (MD-APCD), the nominator's analysis indicates that some of these codes are likely to be overvalued. In their nomination, their analysis reveals that the 88305 (Level IV Tissue Exam by Pathologist) code had the highest number of provider days with intraservice time exceeding an 8-hour workday, with more than

1,763 days, which was significantly higher than the other 12 CPT codes. There were 587 instances of physicians billing 88305 so many times in a single day that the total intraservice time exceeded 24 hours. For these 1,763 days, when they added up the total time spent on services (including other codes billed in a day, and pre-services times as well), the average time that services were billed for during these days was 2,217 minutes (approximately 37 hours). Additionally, despite the name of the code being "Tissue Exam by Pathologist," they found that gastroenterologists and dermatologists frequently billed this code while exceeding eight hours of work in a single day. According to the nominator, data from a 2016 Urban study[53] indicated that the median intraservice time for 88305 was only 2 minutes, compared to 25 minutes in the PFS, which is a 1,250 percent difference—larger than any of the empiric differences between NSQIP and the PFS intraservice times.

They also reviewed additional codes outside of the Urban study that are in the Level IV tissue exam by pathologist coding family, specifically CPT codes 88302, 88304, 88307, and 88309, to conduct a thorough check. As a result, they found that CPT code 88307 had 40 provider days where the total intraservice time exceeded 8 hours. The nominator suggested that CMS should consider reviewing the physician time for all codes within this family to address the existing PFS intraservice times.

In addition, they stated that several codes from the integumentary systems - CPT codes 15734 (*Muscle, myocutaneous, or fasciocutaneous flap; trunk*), 19318 (*Breast reduction*), and 19380 (*Revision of reconstructed breast (eg, significant removal of tissue, re-advancement and/or re-inset of flaps in autologous reconstruction or significant capsular revision combined with soft tissue excision in implant-based reconstruction)*) - are likely overvalued as clinicians spend 34, 90 and 14 days, respectively, performing these services, where the intraservice times

---

[53] *https://www.urban.org/research/publication/collecting-empirical-physician-time-data-piloting-approach-validating-work-relative-value-units*. Stephen Zuckerman, PhD, Katie Merrell, BA, Robert A. Berenson, MD, Susan Mitchell, RHIA, Divvy Upadhyay, MD, MPH, Rebecca Lewis, MPH, Collecting Empirical Physician Time Data: Piloting an Approach for Validating Work Relative Value Units. *https://www.urban.org/sites/default/files/publication/87771/2001123-collecting-empirical-physician-time-data-piloting-approach-for-validating-work-rel.ative-value-units_0.pdf*.

of these codes themselves were more than 8 hours. Over these days, clinicians spent an average of 32, 17, and 41 hours when the PFS times for all services they billed on these days were summed (including pre-service times). The RAND study[54] identified that 21 codes in the integumentary system had PFS intraservice times that were likely too long, and 3 codes had PFS intraservice times that were likely too short.

In the musculoskeletal system, they identified specific procedures with extended service times. For CPT codes 23472 (*Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))*), 27130 (*Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft*), and 27447 (*Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)*), there were 12, 10, and 26 Provider Days, respectively, that exceeded the 8-hour intraservice thresholds. These instances resulted in average total service times of 19, 19, and 21 hours, respectively. The NSQIP RAND study found that 97 musculoskeletal codes had intraservice times that were likely too long, while 14 had intraservice times that were likely too short.

According to the nominator, CPT codes 43281 (*Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh*), CPT 43644 (*Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)*), and CPT 47120 (*Hepatectomy, resection of liver; partial lobectomy*) were found to have 15, 14, and 10 practitioner days, respectively, where the intraservice time exceeded 8 hours. On these days, the providers recorded average total service times of 25, 33, and 52 hours, respectively. Additionally, the nominator stated that the 2015 NSQIP RAND study identified 86 digestive system codes that were likely too long and 12 codes that were likely too short.[55]

---

[54] *https://www.rand.org/pubs/research_reports/RRA3470-1.html.*
[55] *https://www.rand.org/content/dam/rand/pubs/research_reports/RR600/RR662/RAND_RR662.pdf.*

We appreciate the detailed information provided to us by external interested parties and welcome comments from the public regarding any potential actions for CY 2027 or for future rulemaking. We acknowledge the limitations associated with NSQIP data in terms of its applicability to other settings, as it is representative of the hospital setting, however we believe this empirical data may be a better input than limited survey data. Therefore, we are seeking comment on whether we should make these changes for CY 2027, or for future rulemaking, and whether we should consider making corresponding changes to the work RVUs for these services or if changes to the physician time would be sufficient.

(10) Request for reassessment of assigned RVUs for "Harvard-valued" codes (CPT codes 24515, 22216, 22210, 64721, 29824, 20610, and 20680).

We received notification from concerned interested parties about the "Harvard-valued" codes from 1992 that have not undergone a reassessment of assigned RVUs for over 20 years in some cases (see Table A-D15). We share their concerns about whether the current values for the CPT codes accurately reflect the resource inputs associated with furnishing the services. Because the CPT codes have not been recently reviewed and potentially significant technological changes have occurred during this time, we are proposing these CPT codes as potentially misvalued and requesting that the RUC and other interested parties review these services in terms of appropriate work RVUs, work time assumptions and direct PE inputs.

TABLE A-D15: [UNDER DEVELOPMENT]

CPT Codes	Description
24515	Open treatment of humeral shaft fracture, with or without internal fixation, includes repair of fracture fragments
22216	Spine, posterior or posterolateral technique, 3–6 vertebral segments, cervical or thoracic; includes all decompression and fusion work
22210	Spine, posterior or posterolateral technique, single vertebral segment, cervical or thoracic; includes all decompression and fusion work
64721	Neuroplasty and/or transposition; median nerve at carpal tunnel
29848	Endoscopy, wrist, surgical, with release of transverse carpal ligament
29824	Arthroscopy, shoulder, distal claviculectomy, includes debridement, limited capsular release as needed
20610	Arthrocentesis, large joint(s) (eg, shoulder, elbow, hip, knee, or wrist); with or without injection, including ultrasound guidance if performed
20680	Removal of deep implant, includes incision, dissection, and closure; eg, plates, rods, screws, or nails

(11) Allergy Immunotherapy (CPT Code 95165)

In the CY 2001 PFS final rule (65 FR 65393), we discussed the direct PE inputs for CPT code 95165 *(Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)*. As in the case of venoms, some non-venom antigens cannot be mixed together, that is, they must be prepared in separate vials. An example of this is mold and pollen. Therefore, some patients will be injected at one time from one vial - containing in one mixture all of the appropriate antigens - while other patients will be injected at one time from more than one vial. We extensively discussed how the practice expense component for mixing a multidose vial of antigens was computed, and how we observed that the most common practice at the time was to prepare a 10 cc vial; we also observed that the most common use was to remove aliquots with a volume of 1 cc. Therefore, a physician's removing 10 1cc aliquot doses captured the entire PE component for the service.

Recently we have received interested parties' communication from relevant specialties on the definition of a dose as it pertains to an allergy immunotherapy. They are concerned that clinical practice is not using this method of dosage to treat patients and the definition that Medicare is using is causing general confusion. They note that Medicare's 1cc aliquot dose is now creating reimbursement-driven changes to medical practice, rather than changes that align with clinical practice and is increasingly adopted by commercial payers and Medicaid plans, thereby negatively impacting the delivery of medically necessary and cost-effective patient care to Medicare beneficiaries. According to the specialty societies, when this Medicare policy was implemented, few Medicare beneficiaries received allergy immunotherapy – most practices report that less than 5 percent of patients receiving treatment at that time were Medicare beneficiaries. Today, specialty societies report, Medicare beneficiaries often comprise more than 20 percent of an individual practice's allergy immunotherapy patients.

We invite comment from the wider medical community, including analyses or studies, regarding CPT code 95165 and the definition of an allergy immunotherapy dose. In particular, we are interested in how these concepts are interpreted and implemented within clinical practice.

Additionally, Medicare utilizes a medically unlikely edit (MUE) of 30 doses per claim to flag potential overutilization. Specialty societies claim a more appropriate policy should use common clinical practice, by having an annual limit on doses of medically necessary treatment. For example, the annual limit of up to 160 doses per year during the first year of therapy would be higher to account for the build-up phase, then reduced to 130 or fewer doses per year thereafter when the beneficiary is receiving maintenance doses.

We welcome comments, including research or opinions from the medical community, on appropriate annual dose limits billed for CPT code 95165 based on clinical practice.

(12) Ultrasonic Wound Assessment (CPT code 97610)

An interested party nominated CPT code 97610 (*Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day*) as potentially misvalued due to an inflated supply costs direct PE input. The nominator stated that this inflation causes a site of service disparity where CMS pays significantly more for the non-facility practice expense compared to the hospital outpatient (OPPS) payment rate. The CY 2026 non-facility PE RVU of 11.51 for CPT code 97610 results in a payment of $384, compared to an OPPS payment rate of $205, representing a payment differential of $179. The nominator stated that this disparity is primarily driven by the $320 direct PE input, SA119 (kit, low frequency ultrasound wound therapy (MIST)). The nominator provided a hyperlink to the UltraMIST® system manufacturer's Investor Presentation[56] from December 2025 which states that "consumable costs = ~$100/procedure (list price)." On slide 13 of the presentation, it states that the single use applicators are $100 and that the pricing reflects manufacturer's suggested retail price (MSRP). The nominator also estimated

[56] *https://sanuwave.com/investors/presentations*.

an implied sales price of $86 per disposable kit on average using publicly available manufacturer disclosures and Medicare claims data. The nominator stated that the manufacturer reported $21.0 million in U.S. consumable and parts net revenue for CY 2024. The nominator was able to estimate the total volume of kits sold by the manufacturer by assuming each of the 745 unique billing NPIs in Medicare claims have approximately one of the ~1,000 UltraMist® systems in the field, such that the 181,851 Medicare claim lines account for 74.5 percent of total volume ($21.0 million / [181,851/{745/1,000}] = $86), noting that actual sales price would vary due to volume-based or other supplier discounts, commercial utilization, and other factors.

We agree with the nominator and are proposing CPT code 97610 as potentially misvalued. Additionally, we are proposing to change the cost of supply code SA119 to $100 in the direct PE database. We seek comment on this proposal and invite interested parties to submit paid invoices for supply code SA119 (kit, low frequency ultrasound wound therapy (MIST)). We also note that physician time may be currently overstated for CPT code 97610, as the December 2025 Investor Presentation asserts that the procedure takes about 3 to 20 minutes, with an average of 6 minutes. The current total physician time is nearly 26 minutes, with a work RVU of 0.39. Because the current intraservice time is over double the time asserted by the supply manufacturer in the Investor Presentation, we are seeking comment on whether the typical physician time to perform this service is closer to the manufacturer's assertion of 6 minutes or the current intraservice time of nearly 15 minutes.

(13) Autologous platelet rich plasma (HCPCS code G0465)

We received a request from a nominator to review HCPCS code G0465 *(Autologous platelet rich plasma (PRP) or other blood-derived product for diabetic chronic wounds/ulcers, using an FDA-cleared device for this indication, (includes as applicable administration, dressings, phlebotomy, centrifugation or mixing, and all other preparatory procedures, per treatment)* as potentially misvalued. The nominator requested that CMS update the work RVUs for HCPCS code G0465 from 1.78 to 5.50 based on the results of an independent survey of

physicians and qualified health professionals who have training and experience treating chronic, non-healing diabetic wounds that was performed by a third party in the Fall of 2025. The nominator also requested that CMS update its policy to state that multiple procedure payment adjustments do not apply to HCPCS code G0465. Additionally, in the CY 2025 PFS Final rule, we finalized crosswalking G0465 to CPT code 15275 (*Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area*), however, the nominator believes this is not an appropriate crosswalk for G0465.

We thank the nominator for submitting the information, including the survey conducted by the third party. However, we note the sample size of the survey shows only 34 respondents and so we have concerns as to whether this is a representative sample size of practitioners furnishing this service. Additionally, we continue to believe that the MPPR payment adjustment is applicable to multiple units of this service billed to the same beneficiary on the same day due to overlapping resource costs. Given that no additional information was submitted to support the increase in work RVU, we are not proposing this code as potentially misvalued.

E. Request for Information: Redesigning Primary Care to Make America Healthy Again

1. Introduction

Primary care is an essential component of the HHS Secretarial priority to "Make America Healthy Again" commonly known as MAHA.[57] Relatively and accurately valuing primary care appropriately is essential. It is the cornerstone of a high-functioning health care system, helping enable the shift in U.S. health care toward a focus of preventive rather than reactive medicine — for health care rather than "sick care."[58] Critical to this transition is incentivizing investment in high-value care that reduces health care costs (especially from chronic disease) in the long term. Building off recent HHS rulemaking that established such incentives for commercial health plans,[59] we are interested in how Original Medicare may similarly be able to incorporate more robust incentives to invest in high-value care, which will reduce costs of care in the long-term within the Physician Fee Schedule (PFS). More specifically, the agency is soliciting comment on how we might reconsider primary care service valuation to better support this objective amidst what may be a meaningful shift in how primary care is delivered given more recent technological innovation.

Primary care services delivered in the physician office were the locus for continuous, coordinated, and comprehensive care when the PFS was established in 1992. This definition of primary care as a beneficiary's first point of contact with the health care system[60] has been increasingly challenged by broader access to medical information through digital resources. This may accelerate as the increasing adoption of technology reshapes access to increasingly sophisticated sources of medical information before beneficiaries ever show up in the doctor's

---

[57] U.S. Department of Health and Human Services. *Make America Healthy Again (MAHA).* HHS.gov, *https://www.hhs.gov/maha/index.html*. Accessed 29 Apr. 2026.

[58] Kennedy, R. F., Jr. (2025). Remarks on the U.S. "sick-care system." *Fox News interview*. https://www.foxnews.com/health/rfk-jr-likely-confirmed-health-secretary-dr-siegel-saysAccessed 5/31/26.

[59] "Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program." *Federal Register*, vol. 91, 2026, p. 29683. U.S. Government, https://www.federalregister.gov/d/2026-10050/p-1540.

[60] O'Connor, S. M. "Citing Primary Care." *British Journal of General Practice*, vol. 61, no. 586, 2011, pp. 361–362. *https://pmc.ncbi.nlm.nih.gov/articles/PMC3133574*.

office.[61] Advances in technology, including generative and agentic artificial intelligence (AI), are poised to transform both beneficiary experience[62] and the role of the primary care clinicians.[63] These were not anticipated when defining the relative value units and time and intensity of services delivered by physicians, which are essential inputs to the PFS.[64]

To both support broader MAHA priorities and to reconcile with how technology is reshaping primary care delivery for beneficiaries and clinicians, we are seeking comment on how to re-imagine and improve the relative valuation of primary care services. We are focused on understanding how that re-imagination might occur within the current construct of office/outpatient (O/O) evaluation and management (E/M) services as well as via alternatives to fee-for-service payment, including through outcomes-based payment and/or the expansion of prospective primary care payment (PPCP). The latter, in particular, has long been a goal of external policy experts, including as a recommendation from the 2021 National Academy of Science, Engineering, and Medicine report '*Implementing High Quality Primary Care,*' which recommends team-based delivery supported by 'hybrid' payment models that combine prospective monthly and visit-based payments.[65] Over the past decade, the CMS Innovation Center tested PPCP in Medicare using a series of increasingly sophisticated hybrid payment approaches from the Comprehensive Primary Care initiative (CPC) to Primary Care First (PCF). The lessons learned from these Innovation Center model tests led Medicare to establish advanced primary care management (APCM) codes in the CY 2025 PFS final rule as a first step towards

---

[61] Rastogi, Namrata. "Healthcare's New Frontier: The Digital Front Door." *BMJ Innovations*, vol. 8, no. 2, 2022, *https://doi.org/10.1136/bmjinnov-2021-000874*.

[62] Yang, Betsy, et al. "Transforming the Primary Care Journey with Generative AI: A Foundation Model to Boost Efficiency, Quality, and Engagement." *Journal of General Internal Medicine*, 2026, *https://doi.org/10.1007/s11606-025-09716-y*.

[63] Sarkar, Urmimala, and David W. Bates. "Using Artificial Intelligence to Improve Primary Care for Patients and Clinicians." *JAMA Internal Medicine*, vol. 184, no. 4, 2024, pp. 343–344. *https://doi.org/10.1001/jamainternmed.2023.7965*.

[64] Berenson, Robert A., and Kevin J. Hayes. "Could Artificial Intelligence Affect Physician Payment for Nonprocedural Services? Part 1." *Health Affairs Forefront*, Health Affairs, 2025, *https://www.healthaffairs.org/content/forefront/could-artificial-intelligence-affect-physician-payment-nonprocedural-services-part-1*.

[65] National Academies of Sciences, Engineering, and Medicine. "Designing Interprofessional Teams and Preparing the Future Primary Care Workforce." *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*, National Academies Press, 2021.

PPCP.[66] The potential changes to primary care practice with increasing adoption of technology also raises concerns for increasing opportunity for fraud, waste, and abuse from malicious actors.[67] For these and other reasons, as the agency thinks about the re-imagination of primary care payment in the PFS, we are considering first establishing PPCP permanently in the Medicare Shared Savings Program. We would also like to better understand if there are suggestions on how to implement PPCP within the broader Original Medicare program with appropriate guardrails.[68]

We seek comment on three main topics:

- *Reconsidering relative primary care payment in the Medicare PFS*: We are increasingly concerned about the relative undervaluation of primary care services. We would like feedback on how to reconsider this relative undervaluation in the PFS under the current paradigm of O/O E/M visits, the Annual Wellness Visit (AWV), and care management codes. We seek comment on updating this code set, and how or if CMS should consider a 'two-track' approach to care management services with one track focused on technology enabled care and the other track focused on 'traditional' care management.

- *The payment implications of technology–enablement of primary care*: We are seeking comment on how technology and clinical AI are impacting primary care, both broadly and more narrowly within the care management codes and the AWV. We also would like to better understand how CMS might update its approach to paying for technology-enabled care given the potentially transformative effects on the beneficiary and clinician experience. If we were to approach paying for technology-enabled primary care differently, how should we consider the relative valuation, in terms of time and intensity of services? How else could these services be

---

[66] Agarwal, Sumit D., et al. "The Underuse of Medicare's Prevention and Coordination Codes in Primary Care: A Cross-Sectional and Modeling Study." *Annals of Internal Medicine*, vol. 175, no. 8, 2022, pp. 1100–1108. *https://doi.org/10.7326/M21-4770*.

[67] Gray, Jacob. "Strengthening Healthcare Program Integrity with AI." *ICF*, 2026, *https://www.icf.com/insights/health/healthcare-fraud-waste-abuse-ai*.

[68] Centers for Medicare & Medicaid Services. *Accountable Care Organization Operational System (ACO-OS)*. CMS, *https://security.cms.gov/pia/accountable-care-organization-operational-system*.

valued? How should we consider evidence of the impact or outcome of technology-enabled services in primary care?

- *Establishing Prospective Primary Care Payment in the Medicare Shared Savings Program*: Given the series of CMS Innovation Center PPCP model tests, how should CMS approach establishing PPCP in the Shared Savings Program, and more broadly across Original Medicare?

In short, this RFI seeks comment on how we should evaluate which of the payment models discussed previously in this section (FFS payment models, outcomes-based payments, or prospective payment) makes the most sense for primary care given the rapid changes that may arise for recent technological innovation.

2. Reconsidering Relative Primary Care Payment in the Medicare Physician Fee Schedule

a. O/O E/M Visits

Under the PFS, in accordance with section 1848 of the Act, we establish payment amounts for covered physicians' services and update payment policies to address changes, including those in medical practice, coding, or new data on relative value components. Original Medicare's fee-for-service payments for primary care services are overwhelmingly made through traditional O/O E/M visit codes. E/M codes describe a broad range of physician services that occur in an office setting, and do not distinguish between a one-time consultative visit and care that is part of a longitudinal care relationship, which may require additional time, coordination, and resources. We have previously described our concern that the complexity of services required to provide longitudinal care is not fully incorporated as part of the valuation of the work RVUs when the E/M code itself is used as the primary way to report the work of the professional (88 FR 78972). The physician community had previously supported this view when they highlighted that the existing E/M services, such as office visits, do not adequately describe the typical non-face-to-face care management work required by certain categories of beneficiaries

most often served by primary care practitioners (78 FR 43337).

As a result, specialties that do not routinely furnish procedural interventions or diagnostic tests and for which E/M visits represent a greater share of total allowed services are paid differently and generally less than their counterparts who routinely furnish procedural interventions and diagnostic tests. Section 1848 of the Act prohibits specialty-specific payment under the PFS, so we cannot vary the conversion factor or the number of relative value units for a physician's service based on the specialty type of the physician. Instead, in CY 2021, we adopted the RUC's recommendations for increased E/M work RVUs, based on their review of physician time for the E/M visit code set (84 FR 62851 through 62854). Next, in the CY 2024 PFS final rule, we took steps to better recognize the inherent complexity of visits associated with primary and longitudinal care of patients by finalizing Healthcare Common Procedure Coding System (HCPCS) code G2211 *(Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management service, new or established)).* HCPCS code G2211 is used by practitioners furnishing services as the continuing focal point for all the patient's needed health care services, including but not limited to primary care practitioners (88 FR 78969). In the CY 2026 PFS final rule (90 FR 49462 through 49464), we finalized our proposal to allow HCPCS code G2211 to be billed as an add-on code with the home or residence E/M visits, in addition to office/outpatient E/M visits. We are proposing changes to HCPCS code G2211 for CY 2027; see section II.D of this proposed rule for further discussion.

The current O/O E/M code set may still insufficiently reflect differences in the nature and intensity of care provided. As such, we are considering establishing distinct categories of O/O E/M visits in future rulemaking. Potential categories could be longitudinal care, acute care, or consultative visits, with distinctions based on the clinical purpose of the encounter and the associated resource costs of furnishing care. Longitudinal care visits involve care delivered both

during and between encounters as part of an ongoing comprehensive care relationship. During these visits, a beneficiary establishes, maintains, or updates that relationship. For example, a beneficiary returns to the clinic 3 months after their AWV for ongoing management of their diabetes, which requires an oral medication titration, and elevated blood pressure and hyperlipidemia, which includes a discussion about lifestyle modification. The practitioner also notices that they are overdue for an immunization, schedules them for a necessary screening test, and updates their plan of care accordingly. We would distinguish this visit (including the valuation of the pre- and post-service time and proximity to prior visits) from the care delivered in an acute care visit. In the future, we may consider valuing these visits as a combination of the E/M service furnished during the encounter and certain between-visit care management activities. In contrast, acute care visits are focused on the evaluation and management of a discrete, episodic problem that is generally resolved after treatment. For example, a beneficiary may seek care for a sore throat and suspected streptococcal pharyngitis, with no expectation of an ongoing care relationship related to that condition once it is resolved. While consultative visits are distinct from longitudinal and acute care visits because they are furnished in response to a referral to address a specific clinical question, consultative services could be considered similar in complexity to acute care, distinguished largely by consultative services typically including an evaluation of the patient and communication of findings or recommendations back to the referring practitioner.

We also note that CPT codes exist and are paid by private payers for consultative services (for example, CPT codes 99242 through 99245), although they are not paid by Medicare. We are seeking comment on whether to consider the complexity of these services to be closer to the acute care services versus the longitudinal care services. As a general matter, we would expect to consider consultative visits to be less complex than longitudinal care visits. We are seeking feedback on further actions we could take around appropriate valuation of primary care services:

- What updates to the HCPCS code G2211 policy (or the proposed modifiers, MOD1

and MOD2) should CMS consider to ensure the clinician billing HCPCS code G2211 (or proposed modifiers, MOD1 and MOD2) is serving as the focal point for beneficiaries, and that the practitioner is also considering preventive care, risk factor reduction, and other services necessary for coordinating the care of beneficiaries who have a complex condition?

- Given the broad range of changes CPT makes annually, we recognize updates to the CPT code set to reflect distinctions among O/O E/M visits by the function of the visit (longitudinal, acute, or consultative) may have significant advantages within the current billing and coding ecosystem. However, absent a change in CPT coding, should we consider the possibility of creating G codes to better recognize distinction between and among these kinds of visits? If so, what categories should we consider? How could we effectively differentiate longitudinal care visits from acute care visits? What number of levels would be needed and for which settings of care? Should we use existing CPT codes as templates? How should we consider valuing these potential G-codes under the PFS, including the basis for the standard inputs: work RVUs, time values, specialty mix for utilization crosswalks, direct PE inputs, etc.? How would practitioners balance and manage the increasing number and complexity of these codes?

- If CMS were to propose longitudinal or primary care visit types, what should the service period be? Should subsequent care management services be bundled in? If so, for what period of time? Which care management services might be included?

- Are there specific data on the resources used in furnishing longitudinal care, acute care, or consultative services CMS should consider for potential categorization of O/O E/M services?

3. Care Management Code 'Family'

We have for the last 14 years sought to unbundle services previously considered bundled into E/M services through separate coding and payment for care management services. In 2013,

the agency implemented a transitional care management code for post-discharge care (77 FR 68978). This was then followed by the creation of a broader family of codes for care management, including for beneficiaries with multiple chronic conditions or chronic care management (CCM) (78 FR 74414), for those requiring complex medical decision-making (for example, complex CCM, 81 FR 80349), and for those with a single or principal condition (principal care management (PCM), 85 FR 84697). In total, the CCM and PCM code families now include five sets of codes which are reported monthly on a timed basis, each set with a base code of 20 to 60 minutes and an add-on code for each additional 30 minutes. In the CY 2025 PFS final rule (89 FR 97859), we finalized three APCM codes (HCPCS codes G0556, G0557, and G0558) to recognize the evolving way primary care practices manage prevention and chronic condition management through interprofessional care teams. See Table A-E1 for more specificity on the purpose of each of the codes.

Despite these important steps to pay separately for care management services, uptake of the care management codes has been limited.[69] Interested parties cite cost-sharing and non-trivial documentation requirements as the primary barriers to broader adoption.[70] In response to these considerations, we removed the CCM requirement to count and document the minutes of care management services provided in the patients' medical record when billing APCM services. Interested parties had stated this was so burdensome it limited their use of the CCM Current Procedural Terminology (CPT) codes. At the same time, the agency was concerned about program integrity and therefore code auditability. In the absence of medical record documentation, we required that if a practitioner billed the APCM codes, they must report the Value in Primary Care MIPS Value Pathway (89 FR 97864). Despite these changes, uptake in the first year was less than anticipated. We seek feedback on whether a different payment

[69] Agarwal SD, Basu S, Landon BE. The Underuse of Medicare's Prevention and Coordination Codes in Primary Care : A Cross-Sectional and Modeling Study. Ann Intern Med. 2022 Aug;175(8):1100-1108. doi: 10.7326/M21-4770. Epub 2022 Jun 28. PMID: 35759760; PMCID: PMC9933078.

[70] Agarwal SD, Barnett ML, Souza J, Landon BE. Adoption of Medicare's Transitional Care Management and Chronic Care Management Codes in Primary Care. *JAMA.* 2018;320(24):2596–2597. doi:10.1001/jama.2018.16116

structure might be more appropriate as well as what might be done to further simplify the code set and associated requirements.

TABLE A-E1: CARE MANAGEMENT SERVICES PAID UNDER THE PFS

Service	Description
Care Management Services	
Chronic Care Management (CCM) (CPT Codes 99487, 99489, 99490, 99491, 99439, 99437)	Management of all care for patients with two or more serious chronic conditions, timed, per month.
Principal Care Management (PCM) (CPT Codes 99424, 99425, 99426, 99427)	Management of all care for patients with one serious chronic condition, timed, per month.
Transitional Care Management (TCM) (CPT Codes 99495, 99496)	Management of transition from acute care or certain outpatient stays to a community setting, with face-to-face visit (bundled into payment for the code), once per patient within 30 days post-discharge.
Advanced Primary Care Management (APCM) (HCPCS G0556, G0557, and G0558)	Management of all care for patients with or without chronic conditions, not timed, per month.
Communication Technology-Based Services	
Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM) (CPT codes 99453, 99445, 99454, 99470, 99457, 99458, 99091)	Remote monitoring and assessment of physiologic data or adherence and response to therapeutic treatment, timed, per month.

We are also asking for comment on how to reconfigure the care management code 'family' to better establish effective relative payment options for between visit care management services and how supervision requirements may need to change in technology-enabled care models where patients may initially engage with digital tools or receive care entirely in a digital environment. In addition, given our concerns about fraud, waste, and abuse in the care management code families, we would like to better understand how to ensure care management services are impacting care.

To improve the utilization of care management services where it is clinically appropriate, we seek comment on the following questions:

- What additional requirements should CMS consider to reduce fraud, waste, and abuse in care management services? Specifically on the following:

++ What is the appropriate 'trigger' or initiating visit for care management services? How would this change if it were an initiating visit vs. another event?

++ Should CMS consider changing supervision requirements in care management services to prevent fraudulent billing of care management services? What is the appropriate supervision requirement for care management services?

++ How should data submission to CMS change to verify services are received?

++ What guardrails should CMS consider to prevent inappropriate billing?

++ What proportion of care management services must be delivered by the supervising provider, versus auxiliary personnel?

- Are there specific data on the resources used in furnishing advanced primary care, which incorporates population health management, enhanced communication technology, and longitudinal care management? We welcome submission of any such data.

- To what extent are the current care management codes duplicative? Are there efficiencies to be gained in simplifying the current care management code 'family' into a more efficient code set? To what extent would this improve appropriate utilization of care management services?

- If reducing the number of care management codes would not increase efficiency or utilization of appropriate services, how else can CMS standardize the requirements across the care management codes?

- As care management becomes increasingly technology-enabled, how should CMS consider changing the code family and their relative valuations? How can CMS ensure that automated billing leveraging technology reflects actual care delivered to beneficiaries by care teams or practitioners?

- Should CMS create 'technology-enabled care management' codes or a 'two-track' approach to care management? How should we ensure these codes are appropriately differentiated?

4. Payment Implications of Technology Enablement of Primary Care

a. Changes to Primary Care and Care Management Due to Technology and Clinical AI

Adoption of new technology and AI tools in primary care has the potential to transform clinical care to such a degree that it may challenge how we traditionally think about care delivery. However, as of this request for information, clinician-facing AI tools that are currently in widespread use are more focused on administrative burden reduction and clinical decision-

support. For example, tools focused on *reducing clinician documentation burden* (e.g. AI scribes), have perhaps been the most widely taken up by clinicians,[71] with an estimated 25% penetration among all US physicians.[72] Early system-level evaluations demonstrate generally increased productivity among adopters along with decreases in perceived documentation burden.[73] The most widely used AI tool in primary care is likely a *clinical decision-support* application, Open Evidence, which more than forty percent of US physicians have self-reported using.[74] This software allows clinicians to ask an AI chat interface a wide variety of clinical questions and receive answers based on a large language model only drawing from well-known peer reviewed journals and guidelines (i.e. not the entire internet). *AI-assisted care delivery* agents have been deployed in a number of health systems but have not yet reached widespread use, to the best of CMS' knowledge.[75] In general, we note greater technological adoption may support a shift in care management from reactive, manual processes to proactive, data-driven, and personalized care.

In short, we believe technology is being used in increasingly innovative ways throughout primary care but would like to better understand that usage. Given this changing backdrop, we are seeking comment on how we develop a comprehensive and consistent approach to payment for technology-enabled care given likely lower cost-to-serve but potentially higher quality of care delivered. There are challenges in establishing appropriate valuation methodologies, due to the rapidly evolving nature, accuracy, impact, and scope of these technologies as well as the

---

[71] Littrell, A. (2026, May 19). *The AI tool physicians actually love: A conversation with Robert Wachter, M.D., chair of UCSF Medicine*. Medical Economics. https://www.medicaleconomics.com/view/the-ai-tool-physicians-actually-love-a-conversation-with-robert-wachter-m-d-chair-of-ucsf-medicine

[72] Doximity. (2026). *State of AI in medicine report 2026*. https://www.doximity.com/reports/state-of-ai-medicine-report/2026

[73] Holmgren AJ, Fenton CL, Thombley R, et al. Ambient Artificial Intelligence Scribes and Physician Financial Productivity. JAMA Netw Open. 2026;9(1):e2553233. doi:10.1001/jamanetworkopen.2025.53233

[74] OpenEvidence. (2025, July 15). *OpenEvidence, the fastest-growing application for physicians in history, announces $210 million round at $3.5 billion valuation*. https://www.openevidence.com/announcements/openevidence-the-fastest-growing-application-for-physicians-in-history-announces-dollar210-million-round-at-dollar35-billion-valuation

[75] Examples include "Cedars-Sinai Connect" , from https://www.cedars-sinai.org/csconnect.html or 'Hartford Healthcare GPT' https://www.aha.org/aha-center-health-innovation-market-scan/2026-05-19-hartford-healthcare-embraces-ai-patientgpt. Retrieved May 31, 2026

limited transparency into underlying costs and effect of these tools in primary care and other specialties.

One potential approach may be to link payment more directly to demonstrated clinical outcomes. We are seeking additional information on how to best structure payment for these technologies in a way that aligns with our agency's mission to increase quality, improve health, reduce costs, and strengthen the healthcare system. Clinical technology tools of interest would include those that provide clinical decision-making support that deliver AI-assisted (or augmented, etc.) primary care, or that are otherwise of note. We seek input on the following:

- Our understanding is that clinical documentation and clinical decision-support tools are currently the most commonly used applications of AI in primary care. Does this reflect current practice? In particular, are there additional *clinical* AI tools and new technologies that are frequently being used in primary care settings with high accuracy, demonstrated safety, and clinical outcomes reported? If so, please describe how they impact the clinical workflow and the beneficiary experience.

- If you are a physician furnishing primary care services, how has your practice been impacted or how do you expect it will be impacted by clinical AI tools?

- How has incorporating technology and AI tools impacted the resource costs associated with primary care practice, in terms of the time and intensity of services delivered?

- How has the implementation of clinical AI tools led to improvements in the quality of care, or reduced downstream costs? In general, please cite any evidence available for your comments.

- If these tools are increasing productivity, what are clinicians and other health professionals doing with the additional time/bandwidth created? Are you seeing more patients in visits, engaging more with population-health management or care management, accomplishing administrative tasks, or something else?

- How do you ensure patient data and privacy is adequately protected during use of

these tools?

- Please describe areas *where clinical AI tools in primary care are not well captured* in the current coding and payment system and suggest how these may be incorporated to facilitate *high-value,* technology-enabled primary care.

What lessons can CMS learn and adopt from private payors with respect to clinical AI? More specifically, we ask the following:

- What can CMS learn from how private payors have approached payment and coverage of clinical AI in primary care? How are they monitoring for safety, privacy, fraud, waste, and abuse?
- How could private payor coverage of clinical AI in primary care streamline or otherwise facilitate CMS coverage or payment?
- From an outcomes-based perspective, how should CMS evaluate and monitor the impact of technology-enabled care in primary care?
- What outcomes would accurately capture whether these technologies have improved or negatively affected primary care practice for both clinicians and beneficiaries? Are there different outcomes for short-term and long-term impacts?

What type of outcomes data should be shared with CMS? For example, to what extent would submission via Fast Healthcare Interoperability Resources (FHIR)-based APIs of clinical outcomes or activity sets be an appropriate approach by which to tie payment?

- What submission frequency and formats would be most appropriate?
- How can we collect those outcomes in a way that minimizes administrative burden?
- Are there other payment structures, beyond outcomes-based and prospective (which will be discussed in the next section), that would be more suited to the unique nature and impact of these technologies? If so, please describe.

5. Technology and AI-Augmentation in Primary Care via the Medicare AWV

As we at CMS endeavor to shift US health care toward a focus on preventive rather than

reactive medicine – for health care rather than 'sick care' – there may be no more obvious starting place for Medicare than the Initial Preventive Physical Exam (IPPE) and Medicare AWVs. The IPPE is a one-time preventive check-up where practitioners review the beneficiary's medical history, make sure they are up to date on important screenings and vaccines, and talk with the beneficiary about their family history and how to stay healthy.[76] Then every year following, beneficiaries have a conversation-focused visit to create a personalized prevention plan, called an Annual Wellness Visit (AWV).[77]

The IPPE and AWV were established under section 4103 of the Affordable Care Act which requires Medicare to cover an AWV in which a personalized prevention plan is created (Pub. L. 111– 148). The payment for AWVs has been updated to reflect the resource costs associated with advanced care planning (80 FR 70956), review of opioid use (85 FR 84713), and optionally physical activity and nutrition (90 FR 49483). The current requirements can be found on the CMS website.[78]

Section 1861(hhh)(4)(F) of the Act gives the Secretary the authority to experiment with the use of personalized technology focusing on health behavior change. We are interested in understanding whether advances in technology, including clinical AI, could improve the effectiveness, personalization, and both beneficiary and clinician experience for the AWV. Despite the importance of prevention and early identification of risk factors, evidence regarding the impact of the AWV on outcomes is mixed. Some studies have found that AWV receipt is associated with increased use of preventive services[79] but may not sufficiently close gaps in preventive care.[80] However, other studies have found no substantive association between AWV

---

[76] "Welcome to Medicare Preventive Visit." *Medicare.gov*, Centers for Medicare & Medicaid Services, https://www.medicare.gov/coverage/welcome-to-medicare-preventive-visit. Accessed 16 June 2026.
[77] "Yearly 'Wellness' Visits." *Medicare.gov*, Centers for Medicare & Medicaid Services, https://www.medicare.gov/coverage/yearly-wellness-visits. Accessed 16 June 2026
[78] Centers for Medicare & Medicaid Services. **"Medicare Wellness Visits."** *Centers for Medicare & Medicaid Services*, U.S. Department of Health and Human Services, https://www.cms.gov/medicare/coverage/preventive-services/medicare-wellness-visits. Accessed 7 July 2026
[79] Beckman AL, et al. The effect of Medicare's Annual Wellness Visit on preventive care for the elderly. *Prev Med*. 2018;116:126-133.
[80] Camacho F, Yao N, Anderson R. The Effectiveness of Medicare Wellness Visits in Accessing Preventive Screening. *Am J Health Promot*. 2017

adoption and improvements in evidence-based screening, acute care utilization, or spending,[81] or potentially increasing downstream low-value services.[82] Given the heterogeneity of these findings, we are interested in whether technology-enabled AWVs can improve not only the proportion of Medicare beneficiaries completing an AWV but also meaningful outcomes.

We are interested in whether clinical adoption of technology including clinical AI tools may facilitate transformation of the AWV from a point-in-time assessment to a more continuous, data-driven, and beneficiary-specific preventive care function. The function of these tools may support AWV completion from pre-visit activities as well as activities during and after the clinical encounter. As examples, clinical AI tools may support pre-visit collection of beneficiary reported information such as in the health risk assessment, adapting questions to a beneficiary's language or health literacy level.[83] For reviewing the medical and family history, AI tools have demonstrated superiority to even human experts in summarizing health information from structured and unstructured fields.[84] During the clinical encounter, AI tools may also support standardized clinical workflows embedded in the electronic health record environment,[85] identify beneficiaries who may warrant additional assessment, and generate suggested follow up steps for clinicians to review.[86] Following the encounter, AI tools may assist with developing post-encounter instructions in the language and health literacy level of the patient.[87]

We believe much of this can occur under current CMS billing guidance, and reiterate that

---

[81] Ganguli I, Souza J, McWilliams JM, Mehrotra A, et al. Association of Medicare's Annual Wellness Visit with Cancer Screening, Referrals, Utilization, and Spending. *Health Affairs*. 2019.
[82] Ganguli I, Lupo C, Mainor AJ, et al. Assessment of Prevalence and Cost of Care Cascades After Routine Testing During the Medicare Annual Wellness Visit. *JAMA Netw Open.* 2020;3(12):e2029891. doi:10.1001/jamanetworkopen.2020.29891
[83] Swisher AR, Wu AW, Liu GC, Lee MK, Carle TR, Tang DM. Enhancing Health Literacy: Evaluating the Readability of Patient Handouts Revised by ChatGPT's Large Language Model. Otolaryngol Head Neck Surg. 2024 Dec;171(6):1751-1757. doi: 10.1002/ohn.927. Epub 2024 Aug 6. PMID: 39105460.
[84] Van Veen D, Van Uden C, Blankemeier L, et al. Adapted large language models can outperform medical experts in clinical text summarization. *Nature Medicine*. 2024;30:1134-1142.
[85] Perkins SW, Muste JC, Alam T, Singh RP. Improving Clinical Documentation with Artificial Intelligence: A Systematic Review. Perspect Health Inf Manag. 2024 Jun 1;21(2):1d. PMID: 40134899; PMCID: PMC11605373.
[86] Yao, X., Rushlow, D.R., Inselman, J.W. *et al.* Artificial intelligence–enabled electrocardiograms for identification of patients with low ejection fraction: a pragmatic, randomized clinical trial. *Nat Med* **27**, 815–819 (2021). https://doi.org/10.1038/s41591-021-01335-4
[87] Young, Albert T., et al. "Patients and Dermatologists Are Largely Satisfied with ChatGPT-Generated After-Visit Summaries: A Pilot Study." *JAAD International*, vol. 15, 2024, pp. 33–35. Elsevier, https://doi.org/10.1016/j.jdin.2023.12.004

under current policy, the AWV must be performed by a physician or other health professional, or team of medical professionals directly supervised by a physician currently enrolled as a Medicare provider. We are interested in what barriers – if any – these requirements create to innovative AWV delivery models in which an AI technology company develops or operates these clinical AI tools and affiliates with a Medicare enrolled provider or supplier. We seek comment on the following:

- How can CMS improve the effectiveness, efficiency, personalization, and beneficiary experience of the IPPE and Medicare AWV?
- Which, if any, AWV components are being delivered (or could be) more efficiently delivered through technology and clinical AI-enabled tools? Please comment on how technology is being used today within the AWV, how that has changed over the last year, and how the community sees that changing over the next couple of years. Which activities require direct involvement by a physician, qualified non-physician practitioner, or medical professional under physician supervision?
- Could AI-enabled AWVs improve health outcomes that prior studies have found to be inconclusive?
- What evidence should CMS consider regarding whether technology or clinical AI-enabled AWVs improve clinical usefulness of visit and clinical outcomes, beneficiary reported outcomes, or utilization? In particular, research around changes in the use of preventive services, the application of preventive services to individual clinical risk factor assessment or in low-value downstream utilization are of specific interest.
- What existing statutory, regulatory, enrollment, billing, supervision, documentation, data-sharing or other requirements may create barriers to an AI technology company delivering AWV-related services while employing or contracting with appropriately licensed physicians or other medical professionals to perform AWVs? To what extent may program integrity concerns exist with these models?

- In what circumstances should CMS consider payment or policy changes that would allow technology-enabled organizations, including AI technology companies, to participate in AWV delivery models, either directly or through partnerships with Medicare-enrolled providers or suppliers?

- How should CMS evaluate whether AI-enabled AWVs are improving outcomes rather than merely increasing AWV volume, documentation completeness, coding intensity, or low-value care follow 'cascades' of services? Specifically, for which outcomes should CMS hold technology companies accountable?

- How could CMS optimize information sharing from AWV throughout the duration of the primary care relationship? Where could AI-enabled tools facilitate this process?

6. Developing Prospective Payment in the Shared Savings Program

a. Background

We stated at the beginning of this request for information that we are interested in further developing prospective primary care payment (PPCP) in Original Medicare, beginning with the Shared Savings Program. There is growing recognition that the fee-for-service (FFS) payment model has inherent limitations as a primary care payment mechanism, as it is not designed to support the comprehensive, coordinated care that primary care requires. In 2015, the Medicare Payment Advisory Commission (MedPAC) recommended a per beneficiary payment for primary care providers to support additional care coordination activities for Medicare beneficiaries.[88] MedPAC explained that while a per beneficiary payment in itself will not guarantee an increase in care coordination activities or even an increase in compensation for eligible primary care practitioners, it would be a first step in transitioning from FFS to a beneficiary-centered payment approach that encourages care coordination, including the non-face-to-face activities that are a

[88] Medicare Payment Advisory Commission. 2015. *Report to the Congress: Medicare Payment Policy*, page 106 Washington, DC: MedPAC. *https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-reports-mar2015_entirereport_revised-pdf/*.

critical component of care coordination.[89]

In a 2021 report on implementing high-quality primary care, the National Academies of Sciences, Engineering, and Medicine (NASEM) recommended that health care payers "pay for primary care teams to care for people, not doctors to deliver services" and encouraged payers to adopt a hybrid reimbursement model that combines FFS and capitation over time with an overarching goal to eventually pay for the majority of primary care services through risk-adjusted prospective payment.[90] NASEM recommended that a hybrid reimbursement model - with a mix of FFS and lump-sum or per-person payments – become the default method for paying for primary care teams.[91] NASEM found that with time, hybrid reimbursement models show improvements in care and reductions in use, particularly for people with multiple complex chronic conditions.[92]

Over the past 13 years, the CMS Innovation Center has tested a number of models that have progressively moved away from FFS billing, including: CPC, Comprehensive Primary Care Plus (CPC+), PCF, Next Generation ACO (NGACO), Global and Professional Direct Contracting (GPDC) Model, ACO REACH, and ACO Primary Care (PC) Flex. These models have focused on testing whether Medicare payment for primary care services through hybrid payments (a mix of FFS and capitated payments), population-based payments (PBPs), or total care capitation (TCC) improves quality of care for beneficiaries and reduces Medicare spend. Evidence from these models suggests that primary care capitation (PCC) is most effective when

---

[89] Medicare Payment Advisory Commission. 2015. *Report to the Congress: Medicare Payment Policy*, page 106 Washington, DC: MedPAC. *https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-reports-mar2015_entirereport_revised-pdf/.*

[90] National Academies of Sciences, Engineering, and Medicine. "Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care," pages 7-8. Washington, DC: The National Academies Press, 2021. https://doi.org/10.17226/3393 https://www.nationalacademies.org/read/25983/chapter/3#8.

[91] National Academies of Sciences, Engineering, and Medicine. "Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care," page 8. Washington, DC: The National Academies Press, 2021. https://doi.org/10.17226/3393 https://www.nationalacademies.org/read/25983/chapter/3#8.

[92] National Academies of Sciences, Engineering, and Medicine. "Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care," page 301. Washington, DC: The National Academies Press, 2021. https://doi.org/10.17226/3393 https://www.nationalacademies.org/read/25983/chapter/3#8.

it is embedded in an accountable care framework, such as the Shared Savings Program.[93] Model design and evaluations are available on the model-specific websites that can be found on *https://www.cms.gov/priorities/innovation/models#views=models*.

Previous Innovation Center primary care model tests have yielded lessons that shape current and future work, including the development of codes and payment for APCM services. Participants, namely clinicians, in primary care models have indicated, however, difficulties with investing in and maintaining primary care redesign activities due to a range of challenges. First, additional non-visit-based primary care payments have been generally layered upon base payments that are still predominantly FFS in structure. While payment for APCM services represents a meaningful step toward non-visit-based payments in concept, we do not view APCM as the end goal of primary care payment reform. The payment amounts associated with APCM are predicated on furnishing and billing APCM services. As such, APCM retains the fundamental structure of FFS billing and may not provide sufficient incentives for practices to focus on proactive, population-based non-visit care management activities.

Second, Innovation Center model funding that supports salaries for clinical and administrative staff, who are needed for advanced primary care coordination and population health functions, is contingent on continued participation in these models. Unlike APCM codes,[94] which are billing codes paid under the PFS and can be used to support ongoing primary care workforce investments, once the models end, practices are left without the funding that they received under the models for the clinical and administrative staff that had supported population health functions. Based on a review of internal CMS data related to billing for APCM services,

---

[93] *See, for example*, O'Malley A, Singh P, Fu N, et al. Independent Evaluation of the Comprehensive Primary Care Plus (CPC+): Final Report. Mathematica, page xviii. December 2023. *https://www.cms.gov/priorities/innovation/data-and-reports/2023/cpc-plus-fifth-annual-eval-report.*

[94] Three APCM codes and payment amounts were established in the CY 2025 Physician Fee Schedule final rule (89 FR 97859 through 97902). In the CY 2026 PFS final rule, CMS established three new G-codes (HCPCS codes G0568, an add-on code based on CPT code 99492, G0569, an add-on code based on CPT code 99493 for CoCM services delivered to patients also receiving APCM services, and G0570, an add-on code for general behavioral health integration services based on CPT code 99484) to be billed as add-on services to APCM base codes: HCPCS codes G0556, G0557, and G0558 (90 FR 49464 through 49471).

billing for APCM services is higher for Shared Savings Program ACO-assigned beneficiaries compared to Medicare beneficiaries outside of an ACO. This finding suggests that the accountability and care management infrastructure associated with ACOs may support more robust adoption of non-visit based primary care payment mechanisms.

Table A-E3 identifies recent Innovation Center models that tested capitated payment arrangements. As outlined in the table, the payment arrangements tested across these models reflect a progression from hybrid (FFS + capitation) payment structures to PBPs and TCC, with each successive model designed to build upon the experience of previous models. CPC+ and PCF relied on care management fees, performance-based incentive payments, and PBPs that partially replaced traditional FFS billing. While neither model reduced total Medicare expenditures or achieved net savings, the CPC+ evaluation found that independent practices who spent a longer time in the model, and those participating in the Shared Savings Program tended to have more favorable results.[95] This finding underscores the importance of embedding primary care payment reform within an accountable care framework.

Other Innovation Center models that have tested different kinds of cash flow and primary care capitated payments have focused on ACOs in models that build on the foundation of the Shared Savings Program. For example, ACOs in the NGACO model could select from four payment mechanisms: (1) traditional FFS; (2) FFS with a fixed per beneficiary per month (PBPM) infrastructure payment; (3) PBPs that gave ACOs a fixed percentage of expected FFS claims reductions in prospective monthly payments; or (4) all-inclusive PBPs, in which the ACO received expected FFS claim reductions in prospective monthly payments. Three quarters of NGACOs primarily chose FFS-based payment mechanisms such as the FFS or FFS with infrastructure payment (FFS+ISP). NGACOs electing PBP mechanisms had larger spending reductions of 3 percent ($409.1 per beneficiary per year (PBPY), $p<0.01$), compared with 1.3

[95] O'Malley A, Singh P, Fu N, et al. "Independent Evaluation of the Comprehensive Primary Care Plus (CPC+): Final Report," page 209. Mathematica. December 2023. *https://www.cms.gov/priorities/innovation/data-and-reports/2023/cpc-plus-fifth-annual-eval-report.*

percent ($172.9 PBPY, p<0.01) for NGACOs electing FFS-based payment mechanisms. Additionally, NGACOs, particularly the 35 that remained through PY 6, showed improvements in model reported quality measures over time for prevention and screening and for chronic disease management. Further, 25 of 35 NGACOs had reduced cumulative Medicare spending while maintaining or reducing rates of ambulatory care-sensitive conditions-related hospitalizations or 30-day unplanned readmissions, tended to reduce outpatient spending and Emergency Department visits, and tended to reduce skilled nursing facility spending and utilization. Over the course of the model, NGACOs invested in initiatives to better manage their patient populations, toward the goals of reduced spending and improved quality.[96]

Under the GPDC Model[97] (the successor to the NGACO model) and the ACO REACH model,[98] we offered two capitation options: (1) TCC (a PBPM capitated payment for all Medicare Part A and Part B services) and (2) PCC for primary care services equal to seven percent of the estimated total cost of care and composed of both a base amount and an enhanced amount designed to provide upfront revenue. Direct contracting entities and ACOs that selected PCC could also select an advanced payment option (APO), which provided upfront payments for services beyond primary care.

The ACO PC Flex model extends capitated payment arrangements to ACOs participating in the Shared Savings Program. The model is designed to test how prospective payments and increased funding for primary care in ACOs affects health outcomes, quality, and costs of care within the Shared Savings Program.[99] Model participants are limited to ACOs that participate in

---

[96] Lowell, K.H., and contributing authors. "Evaluation of the Next Generation Accountable Care Organization (NGACO) Model, Final Report," page 10. Bethesda, MD: NORC at the University of Chicago, 2024. *https://www.cms.gov/priorities/innovation/data-and-reports/2024/nextgenaco-sixthevalrpt*.

[97] Lowell, K.H., and contributing authors. "Evaluation of the Global and Professional Direct Contracting Model, Annual Report 2." Bethesda, MD: NORC at the University of Chicago, 2024. *https://www.cms.gov/priorities/innovation/data-and-reports/2024/gpdc-2nd-ann-report*.

[98] "ACO REACH Model, PY 2026 Financial Operating Policies: Capitation and Advanced Payment Mechanisms." Baltimore, MD: RTI International, 2025. *https://www.cms.gov/priorities/innovation/files/aco-reach-py26-financial-ops-capitation-payment-mechanisms.pdf*.

[99] ACO PC Flex (ACO Primary Care Flex) Model website: *https://www.cms.gov/priorities/innovation/innovation-models/aco-primary-care-flex-model*.

the Shared Savings Program and qualify as a "low revenue ACO" as defined by § 425.20.[100] ACOs participating in the ACO PC Flex Model receive two payments: a monthly PPCP and a one-time advanced shared savings payment. The PPCP is a PBPM payment for primary care services that replaces FFS payments for eligible primary care services with a monthly prospective payment composed of a county base rate (based on a county's average primary care spending), an ACO enhanced amount, and a population adjustment.[101] ACOs are required to spend at least 90 to 95 percent (depending on the performance year) of the total PPCP payment on the provision of care.[102] The ACO enhanced amount includes three types of payment enhancements: (1) the county enhancement, which is applied at the county level in counties designated as low spending counties relative to standardized spending nationally; (2) the flex enhancement, which is applied at the ACO level to all PC Flex ACOs, regardless of location or utilization, and (3) the enhancement add-on, which is a fixed amount PBPM for a performance year that may be used to increase the ACO enhanced amount for underlying changes in the Medicare PFS that are not reflected in the rate book. The enhanced amount will not be subject to recoupment in full by CMS based on the PC Flex ACO's performance in achieving shared savings.[103] Although interest in the ACO PC Flex model was robust, many eligible ACOs that expressed initial interest in the model ultimately did not submit applications, citing challenges associated with the application timeline. Additionally, several interested parties shared that

---

[100] Under § 425.20, a "low revenue ACO" is an ACO whose total Medicare Parts A and B fee-for-service revenue of its ACO participants, based on revenue for the most recent calendar year for which 12 months of data are available, is less than 35 percent of the total Medicare Parts A and B fee-for-service expenditures for the ACO's assigned beneficiaries, based on expenditures for the most recent calendar year for which 12 months of data are available.

[101] ACO Primary Care Flex Model Financial Methodology: Rate Book Development, Calculation of Monthly Prospective Primary Care Payment, and Financial Settlement, June 2025, version 2, pages 1-2. *https://www.cms.gov/files/document/aco-pc-flex-fin-meth-ratebook-dev.pdf*.

[102] ACO Primary Care Flex Model Financial Methodology: Rate Book Development, Calculation of Monthly Prospective Primary Care Payment, and Financial Settlement, June 2025, version 2, page 56. *https://www.cms.gov/files/document/aco-pc-flex-fin-meth-ratebook-dev.pdf*.

[103] ACO Primary Care Flex Model Financial Methodology: Rate Book Development, Calculation of Monthly Prospective Primary Care Payment, and Financial Settlement, June 2025, version 2, page 33. *https://www.cms.gov/files/document/aco-pc-flex-fin-meth-ratebook-dev.pdf*.

concurrent interest in the Making Care Primary model was a factor in their decision not to participate in ACO PC Flex.

The Innovation Center recently announced the Long-term Enhanced ACO Design (LEAD) model,[104] which is scheduled to begin on January 1, 2027. As currently designed, LEAD's capitated payment architecture builds directly on the framework used in ACO REACH and ACO PC Flex. Similar to ACO REACH and the ACO PC Flex model, participating ACOs will be required to select from either: (1) TCC payment or (2) PCC payment. The LEAD model plans to offer ACOs that elect PCC the option to receive additional payments to extend value-based arrangements beyond primary care. Specifically, ACOs may elect the non-primary care capitation (NPCC) or the APO to support alternative payment arrangements for non-primary care providers. It is anticipated that these options would allow ACOs to incrementally expand capitation beyond primary care without adopting full TCC.

TABLE A-E2: CAPITATED PAYMENT ARRANGEMENTS IN SELECT CMS INNOVATION CENTER MODELS

Model	Type	Capitated Payment Arrangement Options
Comprehensive Primary Care Plus (CPC+) 2017-2021	Hybrid (OM+ capitation)	FFS base + care management fees + performance-based incentive payments. Alternative payments to partially replace FFS billing available to Track 2 practices.
Primary Care First (PCF) 2021-2025	Population-based payments	Quarterly population-based payments that exceed FFS rates + flat visit fees replaced E/M billing + performance-based adjustment (based on performance measures) of -10 percent to 50 percent + payment accuracy adjustment to account for primary care furnished outside participating PCF practices.
Next Generation ACO (NGACO) 2016-2021	OM + Hybrid + Population-based payments	Four options: (1) FFS; (2) FFS + fixed per-beneficiary per-month infrastructure payment; (3) population-based payments as fixed percent of expected FFS claims; (4) all-inclusive population-based payments (prospective monthly payments based on expected FFS claim reductions).
Global and Professional Direct Contracting (GPDC) 2021-2022	Primary care capitation or Total Care Capitation	Two monthly payment options: (1) primary care capitation (PCC) payment or (2) total care capitation (for all Medicare Part A and Part B services). PCC includes a base primary care capitation amount + enhanced primary care capitation amount. Advanced payment option available for ACOs that select PCC.
ACO REACH 2023-2026	Primary care capitation or Total Care Capitation	Two monthly payment options: (1) primary care capitation (PCC) payment or (2) total care capitation. PCC consists of base primary care capitation amount + enhanced primary care capitation amount. Advanced payment option available for ACOs that select PCC.
ACO PC Flex 2025-2029	Primary Care Capitation	Monthly prospective primary care payment (PPCP) to replace FFS for eligible primary care services + one-time $250,000 advance shared savings payment. PPCP consists of: county base rate + ACO enhanced amount + population adjustment. Enhanced amount consists of: county enhancement + flex enhancement.
Long-term Enhanced ACO Design (LEAD) 2027-2036 (planned)	Primary Care Capitation or Total Care Capitation	Two monthly payment options are planned: (1) primary care capitation (PCC) payment or (2) total care capitation. As currently designed, PCC consists of: a base primary care capitation amount + enhanced primary care capitation amount. As currently designed, Advanced payment option and non-primary care capitation payment may be available for ACOs that select PCC.

b. Primary Care Capitated Payment Arrangements Considerations for the Shared Savings Program

[104] *https://www.cms.gov/priorities/innovation/innovation-models/lead.*

The goal of capitated payments is to give health care providers additional flexibility in how they deliver care and to reduce the volume-based incentives of Original Medicare (OM) payment. With capitated payments, health care providers receive steady, predictable cash flow that is not tied to the number of services they provide. This flexibility frees health care providers to deliver care in innovative and flexible ways, such as non-face-to-face care management, telehealth, and electronic messaging, without worrying about foregone OM revenue, tying these services to overall outcomes. We are interested in building on the experience of previous Innovation Center models that tested capitated payment arrangements. Section 1899(i)(2) of the Act authorizes the Secretary to use partial capitation in which an ACO is at financial risk for some, but not all, of the items and services covered under parts A and B, such as at risk for some or all physicians' services or all items and services under part B, provided that the partial capitation payments for a year made under the partial capitation model do not result in additional program expenditures than would otherwise be expended for such ACO for such beneficiaries for such year if the model were not implemented. The Secretary may limit a partial capitation model to ACOs that are highly integrated systems of care and to ACOs capable of bearing risk, as determined to be appropriate by the Secretary. Additionally, section 1899(i)(3) of the Act authorizes the Secretary to use other payment models instead of the one-sided model described in section 1899(d) of the Act as long as the Secretary determines that the other payment model will improve the quality and efficiency of items and services furnished to Medicare beneficiaries without additional program expenditures.

We have previously described how primary care teams are central to the relative success of Shared Savings Program ACOs.[105],[106] In 2024, as in previous years, ACOs comprised of larger proportions of primary care clinicians had significantly higher net per capita savings than

---

[105] "Medicare Shared Savings Program Continues to Deliver Meaningful Savings and High-Quality Health Care", October 29, 2024, Press Release. *https://www.cms.gov/newsroom/press-releases/medicare-shared-savings-program-continues-deliver-meaningful-savings-high-quality-health-care.*

[106] "Medicare Shared Savings Program Saves Medicare More Than $1.8 Billion in 2022 and Continues to Deliver High-quality Care", August 24, 2023, Press Release. *https://www.cms.gov/newsroom/press-releases/medicare-shared-savings-program-saves-medicare-more-1-8-billion-2022-continues-deliver-high-quality.*

ACOs comprised of smaller proportions of primary care clinicians (with $403 vs $224 in net per capita savings).[107] In recent years, we have received significant input from interested parties regarding opportunities to increase participation in ACO initiatives. One such option to increase participation would be to identify ways that the Shared Savings Program can support ACOs' efforts to strengthen primary care, such as by providing prospective monthly primary care capitated payments to primary care practices, to reduce reliance on OM payments and support innovations in care delivery that better meet beneficiary needs.

In the CY 2026 PFS proposed rule (90 FR 32502), we solicited comments on whether CMS should consider new payments to Shared Savings Program ACOs for prospective monthly APCM payments to be delivered to primary care practices that satisfy the APCM billing requirements, with the payments reconciled under the ACO benchmark. Nearly all commenters supported giving ACOs the option to receive prospective APCM payments. Only one commenter opposed prospective APCM payments, arguing that APCM delivery solely through ACOs risks undermining the core principles of CCM.

We are seeking feedback regarding potential primary care capitated payment arrangements in the Shared Savings Program. Specifically, we are requesting input on the following questions:

ACO and ACO Participant Readiness

- To what extent are Shared Savings Program ACOs and ACO participants, and their associated health care providers (referred to herein as "ACO providers/suppliers"), ready to take on capitated payment arrangements? Please describe ACO and ACO participant level of readiness for each of the following:

  ++ Hybrid capitation (a combination of capitated and OM payments).

---

[107] Medicare Shared Savings Program Accountable Care Organizations Updated Performance Year 2024 Financial and Quality Results Fact Sheet, September 29, 2025. *https://www.cms.gov/files/document/fact-sheet-ssp-py24-financial-quality-results.pdf*.

++ Full capitation for primary care services (that could enable ACOs to provide downstream payments to ACO participants).

++ PBPs as a fixed percentage of expected OM claims.

We are interested in understanding what operational changes ACOs would need to undertake to effectively receive, manage, and distribute capitated payments. Please describe any barriers or conditions – legal, financial, or operational - that could affect an organization's readiness to participate in each type of arrangement.

- If an ACO received capitated payments for primary care services furnished by ACO providers/suppliers billing through the TIN of an ACO participant (as defined in § 425.20), what organizational and programmatic goals would the ACO seek to advance with those payments? For example, we are interested in understanding whether ACOs would use capitated payments to expand the scope or capacity of existing care coordination and population health programs, or whether capitated payments would instead enable ACOs to operationalize new care delivery initiatives. Please describe the specific types of initiatives that ACOs would seek to implement, and how ACOs would ensure that these payments went to support primary care practices directly.

Eligibility for Participation

- Should CMS limit access to capitated payment arrangements exclusively to ACOs participating in two-sided risk tracks (BASIC tracks C, D, E or the ENHANCED track), or should all ACOs be eligible to receive some form of capitated payments, regardless of the ACO's participation track? ACOs participating in two-sided risk tracks must establish a repayment mechanism prior to the start of an agreement period, and we are interested in whether similar proof that an ACO could repay losses should be required as a condition for receiving capitated payments, even for ACOs in one-sided risk tracks.

- Should CMS limit capitated payment arrangements to ACOs with prior risk-bearing experience – either through participation in a previous Shared Savings Program agreement

period in a two-sided risk track (BASIC tracks C, D, E or the ENHANCED track) or through prior participation in a risk-bearing track in an Innovation Center model, such as ACO REACH – or should risk-bearing ACOs in their first Shared Savings Program agreement period also be eligible to participate in capitated payment arrangements? Why would commenters support one approach over the other? We are interested in whether prior experience with risk-bearing should be an explicit prerequisite for capitated payment eligibility or whether risk-bearing ACOs in their first agreement period should also be eligible to participate in capitated payment arrangements.

- Should CMS permit some, but not all, ACO participants within an ACO to participate in capitated payment arrangements, or should CMS require all ACO participants within an ACO to participate in capitated payment arrangements?

- Should CMS establish a minimum percentage of attributed beneficiaries[108] for whom eligible primary care practices must be furnishing care management services to receive capitated payments, either at the ACO level or at the individual ACO participant level?

- To what extent should the payment design and structure differ based on the level of risk or participation track of an ACO?

Payment Design and Structure

- What percentage of base year OM payments should be replaced by PCC, and what factors should guide this determination? For example, under the ACO REACH model, the PCC payment – including both the base PCC and the enhanced PCC - is set at 7 percent of the REACH ACO's prospective monthly performance year benchmark, a level designed to provide ACOs with a predictable, non-visit-based revenue stream for primary care services.

- What services should be included in primary care capitation (and reciprocally, in a fee reduction) to accurately capture an appropriate scope of primary care services furnished to beneficiaries, balancing the importance of providing up-front flexible payments, with the

[108] Specific Medicare beneficiaries for whom an ACO is responsible for the care and total cost of care. Generally determined based on care furnished during a specific calendar window and the clinicians that provided the care.

potential for risk to practices if service utilization grows? For example, under both the ACO REACH and ACO PC Flex models, the set of services eligible for primary care capitated payments is based on a specific list of CPT and HCPCS codes billed by primary care specialists (health care providers with specific specialty codes). In both models, the PCC bundle includes certain E/M office visits along with CCM, behavioral health integration, transitional care management, AWVs, advance care planning, and virtual communication services.

- We are interested in feedback about whether and in what form we should establish an enhanced primary care payment amount – in addition to the base primary care capitated payment amount – as a feature of primary care capitated payment arrangements in the Shared Savings Program. Specifically, we are interested in:

++ Calculation: For example, in ACO REACH, the enhanced primary care payment is calculated as a fixed percentage of the ACO's performance year benchmark, while in ACO PC Flex, the Flex Enhancement component of the primary care payment is calculated as a fixed dollar amount ($125) per eligible beneficiary per year, with additional enhancements (i.e. the County Enhancement) derived from county-level or regional spending benchmarks.

++ Reconciliation: In ACO REACH, enhanced primary care capitation (EPCC) is subject to recoupment at the end of the performance year. In ACO PC Flex the enhanced amount is included in total cost of care, subject to offsets from the prior savings adjustment and/or the regional adjustment.

- We are interested in whether CMS should consider offering an advanced payment option (APO) within the Shared Savings Program, similar to the APO offered by the ACO REACH model, to ACOs that have elected PCC. Specifically, we are interested in:

++ Does the availability of an APO enhance an ACO's ability to align specialist financial incentives with the ACO's total cost of care goals, or do the structural and administrative requirements of implementing an APO within the Shared Savings Program present barriers that outweigh the potential benefits?

++ Do Shared Savings Program ACOs have access to sufficient data – shadow bundles, claims data, public use files, and data from arrangements with other payers – to support the development and ongoing administration of an APO? If not, what data would be necessary?

- The ACO REACH model has offered TCC as a payment option for ACOs assuming the highest level of financial risk. The LEAD model also plans to offer TCC as a payment option for ACOs assuming the highest level of financial risk. We are interested in whether CMS should provide a full capitation option to Shared Savings Programs ACOs. Specifically, we seek feedback on:

++ Should CMS consider offering a full capitation option to Shared Savings Program ACOs that have demonstrated readiness to administer prospective payments, under which all Medicare Part A and Part B services furnished to assigned beneficiaries by ACO providers/suppliers billing through the TIN of ACO participants – but not services furnished to assigned beneficiaries by providers that are not on the ACO's participant list – would be paid through a TCC payment?

++ Should CMS limit full capitation to ACOs in tracks with the highest level of risk – ENHANCED track or BASIC track Level E – on the basis that full capitation should be reserved for ACOs that have already assumed downside financial risk and the organizational readiness to manage prospective payment for Medicare Part A and Part B services?

++ Are there other flexibilities that CMS should give ACOs to make TCC effective?

++ How should CMS calculate the per-beneficiary, per-month payment amount under a full capitation arrangement in the Shared Savings Program? Under ACO REACH, the monthly TCC payment amount paid to the ACO equals 1/12 of the performance year benchmark, adjusted by the TCC withhold.[109]

---

[109] Because it is expected that a portion of the total cost of care for aligned beneficiaries will be for services provided by providers and suppliers not participating in the TCC arrangement, CMS will withhold a portion of the monthly TCC amount to avoid the need for significant year-end recoupments from the REACH ACOs. *https://www.cms.gov/priorities/innovation/files/aco-reach-py26-financial-ops-capitation-payment-mechanisms.pdf*.

- Should CMS issue prospective capitated payments on a monthly or quarterly basis? Please describe the potential advantages, disadvantages, and operational implications of each approach.

- Should capitated payments be paid to ACOs and distributed downstream to ACO participants, or should CMS make payments directly to ACO participants that provide primary care services, similar to how CMS makes payments for APCM services, and what are the implications of each approach? Should CMS consider alternative mechanisms for delivering capitated payments directly to ACO Participants that are also primary care practices participating in Shared Savings Program ACOs? If so, what payment design, infrastructure, and policy considerations should guide the development of such alternative payment mechanisms?

- If capitated payments are issued directly to ACOs, should CMS require ACOs to provide a specific percentage of those payments to ACO participants that provide primary care services? How might this be audited? Additionally, should CMS require ACOs to have written capitated payment agreements with ACO participants to specify that a minimum percentage of the capitated payment will flow to ACO participants?

Care Delivery Requirements

- Should CMS require ACOs seeking to participate in capitated payment arrangements to make commitments to specific care delivery goals as a condition for participation? If so, what goals should be required and how should compliance be assessed and enforced? For example, we are interested in whether we should require ACOs to submit a primary care transformation plan – similar to the care delivery requirements under the CPC+ model, which required participating practices to demonstrate progress across five comprehensive primary care functions, including access and continuity, care management, comprehensiveness and coordination, patient and caregiver engagement, and planned care and population health – that specifies measurable targets for care delivery improvements, such as expanding after-hours

access, increasing care management for high-risk beneficiaries, or reducing avoidable emergency department utilization.

- How should CMS balance meaningful capitated payment levels with reduced administrative and reporting burdens for participating ACOs, and what primary care delivery requirements should CMS establish as conditions of eligibility for capitated payment arrangements in the Shared Savings Program? Should compliance with any care delivery requirements be monitored on a quarterly or annual basis, with the potential for payment recoupment in cases of noncompliance?

- Should CMS require that ACOs and ACO participants receiving capitated payments demonstrate the use of data-driven risk stratification methods to identify high-risk beneficiaries and target enhanced care management resources toward those beneficiaries? CMS provides Shared Savings Program ACOs with data that could be used for risk stratification, such as claims-based beneficiary data, risk scores, and quality performance reports. We are interested in whether CMS should require ACOs and ACO participants to use these data as a baseline input for their risk stratification methodologies or whether ACOs and ACO participants should be given the flexibility to design their own risk stratification approaches.

- Should care delivery requirements for capitated payment eligibility increase depending on the level/type of capitated payment selected by the ACO or ACO participants? For example, should ACOs that are receiving a higher percentage of capitated payments be subject to more comprehensive care delivery requirements or should a uniform set of care delivery requirements apply to all ACOs, regardless of the percentage of capitated payments they receive?

c. Primary Care Capitated Payment Arrangements Considerations outside of the Shared Savings Program

Though CMS is first exploring the development of PPCP within the guardrails of accountable care discussed in the third section of this RFI, we are also considering extending these efforts in future years to develop a bundled or capitated approach, called a ‘global period’

in the broader Original Medicare program (OM). In OM, many services, including surgical and maternity care services, are managed as 'global' periods by OM, where reasonable and necessary medical services are delivered throughout an episode. Primary care, once an initiating visit has occurred, could also be reimbursed over an interval of care consistent with the development of a trusting, longitudinal relationship between clinician and patient. We have not previously proposed a primary care 'global' period, in part because of the difficulty to ascertain where a primary care relationship starts, and where it stops, through claims data or other information readily obtained by CMS. We do attribute beneficiaries to organizations participating in alternative payment models, such as ACOs in the Medicare Shared Savings Program, based on a plurality of primary care services delivered and also maintain the possibility for beneficiaries to voluntarily align to a Shared Savings Program ACO through Medicare.gov where beneficiaries select a primary care provider.

To establish a primary care global period would require a number of services to be 'bundled' within the primary care global code family, including the IPPE or AWV, O/O E/M services, and care management services such as advanced primary care management services. Central to the challenge inherent in bundling together previously disparate services is ensuring beneficiaries would maintain access to care. CMS could monitor for any potential denials or limitations in care associated with the transition to a global period. We also would like to seek public input on which and how many of the services should be bundled, if they should be bundled entirely or through a 'hybrid' capitation with reduced FFS model, and how best to establish the payment levels for this global period. We seek input on the following: ● What would be the appropriate services to bundle in such a primary care global period (e.g. E/M, care management codes, AWV, etc.)? How should the agency consider the benefits and drawbacks regarding quality of care, patient safety, and evidence regarding care delivery changes in a fully or globally capitated approach with no per-visit payment vs. a hybrid payment approach with reduced per-visit payment and per-member per-month payment? ● For both a fully capitated

and hybrid payment approach, CMS has in past considered patient complexity (e.g. number of chronic conditions or HCC level) in our alternative payment models for primary care. How should CMS approach defining these levels or stratum for payments in a fully capitated or hybrid payment model for primary care? How many levels should be considered?

- In the absence of an encounter, is there another appropriate 'trigger' or initiation for a primary care global period? How long should it last? Is beneficiary receipt of an AWV in the previous 12 months sufficient?
- What necessary reporting requirements and accountability should CMS require for clinicians receiving primary care capitated payments? For example, should there be explicit minimum visit requirements for a clinician to be eligible to receive primary care capitated payments for their Original Medicare patients? Should we require specific clinical outcomes-based reporting? If so, what clinical outcomes should we measure?
- Broadly, to what extent should the approach Original Medicare takes to primary care payment differ between the Shared Savings Program and the broader program? If yes, how?
- In so much as the agency considers a prospective primary care payment (PPCP) for primary care, to what extent should the IPPE/AWV be the initiating visit for that global period?

F. Comprehensive Outpatient Rehabilitation Facility (CORF) Services and KX Modifier Threshold, and Medical Review Threshold

1. Technical Corrections of CORF Regulations

During rulemaking for CY 2008 (72 FR 66399), we made several regulation text revisions and redesignations at § 410.100 without changing a related regulatory provision of § 410.105 for the requirements for coverage of CORF services. We also created a new subpart M at 42 CFR 414.1105 for payment of CORF items and services that includes references to § 410.100 without making the corresponding revisions to the sections that were amended during CY 2008 PFS rulemaking.

We are proposing to revise § 410.105(b)(3)(ii) for the home environment evaluation to indicate that the home environment evaluation is specified at § 410.100(l) and not § 410.100(m) as it currently reads.

We are proposing to amend the regulation at § 414.1105(c) for CORF supplies and durable medical equipment to indicate that the supplies and durable medical equipment that are CORF services is specified at § 410.100(k) instead of § 410.100(l), as it currently reads. At the same time, we are also proposing to remove from § 414.1105(c) language that relates to CORF drugs and biologicals because the provisions relating to payment for drugs and biologicals that are CORF services are at § 414.1105(d), which was added in the CY 2008 PFS final rule.

We are requesting comments on these proposals.

2. KX Modifier Thresholds

The KX modifier thresholds were established through section 50202 of the Bipartisan Budget Act of 2018 (Pub. L. 115-123, February 9, 2018) (BBA) and were formerly referred to as the therapy cap amounts. These per-beneficiary amounts under section 1833(g) of the Act (as amended by section 4541 of the Balanced Budget Act of 1997) (Pub. L. 105–33, August 5, 1997) are updated each year based on the percentage increase in the Medicare Economic Index (MEI). Specifically, these amounts are calculated by updating the previous year's amount by the

percentage increase in the MEI for the upcoming calendar year and rounding to the nearest $10.00. Thus, for CY 2027, we propose to increase the CY 2026 KX modifier threshold amount by the most recent forecast of the 2017-based MEI. For CY 2027, the proposed MEI increase is estimated to be 2.5 percent and is based on the expected historical percentage increase of the 2017-based MEI. Multiplying the CY 2026 KX modifier threshold amount of $2,480 by the proposed CY 2027 percentage increase in the MEI of 2.5 percent ($2,480 x 1.025) and rounding to the nearest $10.00 results in a proposed CY 2027 KX modifier threshold amount of $2,540 for physical therapy and speech-language pathology services combined and $2,540 for occupational therapy services. We also propose to update the MEI increase for CY 2027 based on historical data through the second quarter of 2026, and we propose to use such data, if appropriate, to determine the final MEI percentage increase and the CY 2027 KX modifier threshold amounts in the CY 2027 PFS final rule.

Section 1833(g)(7)(B) of the Act describes the targeted medical review (MR) process for services of physical therapy, speech-language pathology, and occupational therapy services. The threshold for targeted MR is $3,000 through CY 2027. Effective beginning with CY 2028, the MR threshold levels will be annually updated by the percentage increase in the MEI, per section 1833(g)(7)(B) of the Act. Consequently, for CY 2027, the MR threshold is $3,000 for physical therapy and speech-language pathology services combined and $3,000 for occupational therapy services. Section 1833(g)(5)(E) of the Act states that CMS shall identify and conduct targeted medical review using factors that may include the following:

- The therapy provider has had a high claims denial percentage for therapy services under this part or is less compliant with applicable requirements under this title.
- The therapy provider has a billing pattern for therapy services under this part that is aberrant compared to peers or otherwise has questionable billing practices for such services, such as billing medically unlikely units of services in a day.

- The therapy provider is newly enrolled under this title or has not previously furnished therapy services under this part.
- The services are furnished to treat a type of medical condition.
- The therapy provider is part of a group that includes another therapy provider identified using the factors described previously in this section.

We track each beneficiary's incurred expenses for therapy services annually and count them towards the KX modifier and MR thresholds by applying the PFS rate for each service less any applicable multiple procedure payment reduction (MPPR) amount for services of CMS-designated "always therapy" services (see the CY 2011 PFS final rule at 75 FR 73236). We also track therapy services furnished by critical access hospitals (CAHs), applying the same PFS-rate accrual process, even though they are not paid for their therapy services under the PFS and may be paid on a cost basis (effective January 1, 2014) (see the CY 2014 PFS final rule at 78 FR 74406 through 74410).

When the beneficiary's incurred expenses for the year for outpatient therapy services exceed one or both of the KX modifier thresholds, therapy suppliers and providers use the KX modifier on claims for subsequent medically necessary services. Using the KX modifier, the therapist and therapy provider attest that the services above the KX modifier thresholds are reasonable and necessary and that documentation of the medical necessity for the services is in the beneficiary's medical record. Claims for outpatient therapy services exceeding the KX modifier thresholds without the KX modifier included are denied.

G. Supporting Beneficiaries Planning for Future Medical Decisions

1. Advance Care Planning (ACP) Services (HCPCS Codes GACP1 and GACP2)

a. Background

Medicare currently pays for ACP services as an optional element of the annual wellness visit (AWV) or a Part B medically necessary service (see 80 FR 70955 and https://www.cms.gov/files/document/mln-advanced-care-planning.pdf). While the Social Security Act covered a similar service as a voluntary part of the initial preventive physical exam under section 1861(ww)(3) of the Act since CY 2012, in CY 2016 we adopted new coding developed by the American Medical Association for payment of ACP services as a separate Part B medically necessary service or an optional element of the annual wellness visit (AWV). In this section of our proposed rule, we propose to create additional codes in this family that more explicitly describe and value the contributions of clinical staff in the provision of ACP services. We emphasize that clinicians must not, under any circumstances, attempt to influence their patients' decisions for ACP.

For CY 2015, the CPT Editorial Panel created two new codes describing ACP services by physicians and other qualified healthcare professionals (QHPs): CPT code 99497 (*Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed*), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate) and an add-on code, CPT code 99498 (*Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed*), by the physician or other qualified health care professional; *each additional 30 minutes (List separately in addition to code for primary procedure))* (80 FR 70955).

In the CY 2015 PFS final rule with comment period (79 FR 67670), we assigned a PFS interim final status indicator of ''I'' (Not valid for Medicare purposes. Medicare uses another code for the reporting and payment of these services. This code is not subject to a 90-day grace

period.) to CPT codes 99497 and 99498. We had received many public comments in response to the CY 2015 proposed rule recommending that we recognize and make separate payment for both CPT codes, in view of the time required to furnish the services and their importance for the quality of care and treatment of the patient. In the CY 2015 PFS final rule with comment period we responded that we would consider paying for CPT codes 99497 and 99498 after we had the opportunity to go through notice and comment rulemaking (80 FR 70955).

The following year, in the CY 2016 PFS final rule, we finalized our proposal to assign CPT codes 99497 and 99498 a PFS status indicator of ''A'' (Active) with RVUs based on the RUC recommended values. We adopted the RUC-recommended work RVU, physician time and direct PE inputs: 1.5 work RVUs and 1.4 work RVUs for CPT codes 99497 and 99498, respectively. We also added ACP as an optional element, at the beneficiary's discretion, of the AWV and made conforming changes to our regulations at § 410.15 that describe the conditions for and limitations on coverage for the AWV (80 FR 70959). In addition to adopting both CPT codes, we adopted CPT provisions regarding the reporting of timed services (80 FR 70956). We have also instructed practitioners that when reporting ACP as part of managing a beneficiary's illness, the condition discussed with the beneficiary is reported on the claim, whether or not an E/M visit is billed the same day (https://www.cms.gov/files/document/mln-advanced-care-planning.pdf). When ACP services are part of an AWV and furnished on the same day by the same practitioner as the AWV, an administrative exam or exam diagnosis is reported along with modifier 33 indicating the ACP services are preventive and not subject to cost sharing (https://www.cms.gov/files/document/mln-advanced-care-planning.pdf*).* In the CY 2016 PFS final rule, we also adopted CPT's coding guidance for ACP performed in conjunction with an E/M visit. CPT prefatory language indicates that when using CPT codes 99497 and 99498, no active management of the problem(s) is undertaken during the time period reported, and these

codes may be reported separately if performed on the same day as most E/M visits.[110] We cited a clinical vignette from the RUC recommendations, illustrating when the services described by CPT codes 99497 and 99498 could be reasonable and necessary for the diagnosis or treatment of illness or injury, stating that this could occur in conjunction with the management or treatment of a patient's current condition, such as a 68 year old male with heart failure and diabetes on multiple medications seen by his physician for the E/M of these two diseases, including adjusting medications as appropriate (80 FR 70955). In addition to discussing the patient's short-term treatment options, the patient might express interest in discussing long-term treatment options and planning, such as the possibility of a heart transplant if his congestive heart failure worsens, and advance care planning including the patient's desire for care and treatment if the patient suffers a health event that adversely affects the patient's decision-making capacity (80 FR 70956). In this case the physician would report a standard E/M CPT code for the E/M service and one or both of the CPT codes describing ACP, depending upon the duration of the ACP service (80 FR 70956). Moreover, the ACP service would not necessarily have to occur on the same day as the E/M service (80 FR 70956).

The CPT Codebook published by the American Medical Association contains prefatory language that describes CPT codes 99497 and 99498 as a "face-to-face service between a physician or other qualified health care professional and a patient, family member, or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms."[111] While this code descriptor language indicates that the time being billed is personally spent by the physician/QHP and the codes are valued accordingly, we finalized a provision in the CY 2016 PFS final rule that allowed the time of clinical staff to be counted if the billing physician or other billing practitioner managed, participated and meaningfully contributed to the provision of the services, because public commenters persuaded us that ACP was performed at

---

[110] Current Procedural Terminology, (CPT®) 2026 (CPT Codebook), Professional Edition, American Medical Association, page 61.

[111] CPT Codebook 2026, AMA, page 61.

times by a team of a treating physician or other treating practitioner and their staff. Therefore, in the CY 2016 PFS final rule (80 FR 70957), we stated that we believed the services described by CPT codes 99497 and 99498 could be appropriately provided by physicians or using a team-based approach where ACP would be provided by physicians, non-physician practitioners (NPPs), and other staff under the order and medical management of the beneficiary's treating physician or treating practitioner. To provide clarity on who could report the new codes, we noted that the CPT code descriptors described the services as furnished by physicians or other qualified health professionals, which for Medicare purposes, has been consistent with allowing these codes to be billed by the physicians and NPPs whose scope of practice and Medicare benefit category include the services described by the CPT codes and who are authorized to independently bill Medicare for those services. Therefore, we finalized that only these practitioners may report CPT codes 99497 and 99498, and ''incident to'' rules in § 410.26 would apply when these services would be provided incident to the services of the billing practitioner under a minimum of direct supervision. We stated that we expected the billing physician or NPP, in addition to providing a minimum of direct supervision, to manage, participate and meaningfully contribute to the provision of the services. Also, we noted that PFS payment rules would apply when ACP is furnished incident to other physicians' services, including where applicable, that State law and scope of practice must be met (80 FR 70959). Accordingly, even though CPT codes 99497 and 99498 describe (and are valued as) services performed only by the billing practitioner, we finalized a policy allowing the time of clinical staff to be included since we did not have G codes at that time that would have provided coding specific to that situation.

b. Proposals for CY 2027

Since 2016, we have heard from interested parties that ACP services may be under-utilized because some practitioners believe that only time they personally spend can count. While growth in ACP services utilization has been increasing, interested parties have communicated to CMS that the increase in utilization is not commensurate with the need for ACP services.

Utilization of ACP services has increased since 2016 from about 650,000 services to about 2.5 million per year in 2025. We note that for patients in critical care, advance care planning is bundled into payment for the critical care service codes (CPT codes 99291-2) and is therefore not separately billed, so these patients may receive ACP services that is not identifiable in the claims data. We believe that new coding could more accurately distinguish and value the work of the billing practitioners from time that is spent by their clinical staff in the provision of ACP services. Therefore, we are proposing to create two new HCPCS codes to describe ACP services furnished by clinical staff under the direct supervision of the billing physician or other practitioner (and incidental to their professional services), and proposing that the existing CPT codes 99497 and 99498 would only be used to report time personally spent by the billing practitioner. The proposed new codes would be: HCPCS G-code GACP1 (*Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), first 20 minutes of clinical staff time with the patient, family member(s), surrogate directed by a treating physician or other treating qualified health care professional) and* GACP2 *(Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), each additional 20 minutes with the patient, family member(s),* surrogate *directed by a treating physician or other treating qualified health care professional (List separately in addition to code for primary procedure)).*

We are proposing a work RVU of 1.00 for HCPCS code GACP1, based on a crosswalk to the work time of CPT code 99490 (*Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month*). For direct PE, we

are proposing 20 minutes of clinical labor (L037D) in the service period. We are proposing a work RVU of 0.7 for HCPCS code GACP2, based on a crosswalk to the work time of CPT code 99439 (*Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)).* For direct PE, we are proposing 20 minutes of clinical labor (L037D) in the service period.

Under this proposal, the new G codes and CPT codes 99497 and 99498 could be reported together, if time thresholds by the billing practitioner and clinical staff were each met with these respective code sets. We are seeking public comment on whether it would be better for the new G codes to represent, and be valued for, the combined time of a billing practitioner and their clinical staff within a single code, in case, for example, the billing practitioner and staff did not meet time thresholds for separate reporting of their respective times, but might meet the threshold for a code combining their time. For both the existing codes (describing physician time but allowing use for clinical staff time, as discussed previously) and newly proposed ACP codes (describing clinical staff time) to be paid "incident to," the reporting practitioner must furnish a prior professional service to which the services of the clinical staff are incidental, such as a prior E/M visit or ACP services personally performed by the billing practitioner the same day. Our manual provides that "[s]uch a service or supply could be considered to be incident to when furnished during a course of treatment where the physician performs an initial service and subsequent services of a frequency which reflect his/her active participation in and management of the course of treatment" (Medicare Benefit Policy Manual, Chapter 15, Section. 60.1.B, available at https://www.cms.gov/regulations-and-

guidance/guidance/manuals/downloads/bp102c15.pdf). We are seeking clarity from interested parties about whether these "incident to" criteria (the requirement for the billing practitioner to perform initial and subsequent services reflecting their participation in and management of the course of treatment) are typically met for beneficiaries needing ACP services, by a separately billed E/M visit (whether the same day as the ACP services or prior), or might best be included in a new code inclusive of combined time spent by both a reporting practitioner and their clinical staff. If the billing practitioner is by definition participating and managing by performing part of the ACP code itself, there would not be a need to require a prior initiating visit as we do for care management services provided "incident to." To help us craft new coding in a manner that reflects typical clinical practice as well as "incident to" rules governing payment for services by clinical staff, we are seeking public comments that specify or clarify for the alternative new coding, the typical care team structure; how much time is typically spent by the billing practitioner and spent by their staff, and when; and the clinical circumstances of patients, for example, the care settings and whether the patient is typically a well patient or is doing advance care planning in conjunction with a particular illness. This would inform how the coding structure reflects work that is personally performed by the billing practitioner in conjunction with ACP.

Medicare has not made a national coverage determination regarding ACP services; however, we note that in 2021 a Medicare Administrative Contractor made a Local Coverage Determination, revised in 2023. Contractors remain responsible for local coverage decisions in the absence of a national Medicare policy. We also note that direct supervision may be satisfied by audio visual technology. Furthermore, for CY 2027 we are proposing to add both HCPCS codes GACP1 and GACP2 to the Medicare Telehealth list.

Finally, we note that we are aware of additional factors beyond the scope of this rule that could be influencing uptake of the existing codes. Among these are: practitioner training for bringing ACP up for voluntary discussion, how to ensure that care planning that includes

delineation of patient goals, preferences and advance directives are available and actionable at the point of care (especially emergency care), enabling interoperable access to ACP information, lowering out-of-pocket costs for ACP services, and new quality measure that best capture meaningful ACP conversations and documented preferences.

2. Request for Information (RFI) on Community-based Palliative Care

a. Background

In the FY 2027 Hospice proposed rule, CMS solicited comment on the development of community-based palliative services outside of the hospice benefit (90 FR 17360). By community-based palliative care, we are broadly considering where palliative services can be delivered outside of the hospital, in outpatient clinics, in patients' homes, and other non-hospital settings. In this request for information we sought feedback on whether current evaluation and management (E/M) services, care management services, and ACP services reflected current billing and payment practices for physicians and other health professionals delivering palliative services, as well as on whether challenges in meeting documentation requirements, issues with compliance, or enhancements to current services could be considered to better enhance palliative care service delivery. In addition, in the 2027 ESRD proposed rule, concurrently, we are requesting information to advance payment policy and better understand the differences between maintenance dialysis and dialysis delivered in a comfort-focused context. Comments regarding either of these subjects are best delivered to their respective rules.

In coordination with these requests for information, we are additionally seeking comment on the specific requirements we should consider given the prior CMS Innovation Center model tests focused on complex and serious illness care. The evaluation findings from these prior tests are best summarized in the CMS Innovation Center white paper on '*Palliative care projects: Synthesis of Evaluation Results 2012-2021*'.[112] These results indicate that a comprehensive

[112] https://www.cms.gov/priorities/innovation/data-and-reports/2022/palliative-care-synthesis-2012-2021.

approach to palliative care services, including access to interdisciplinary teams, home visits, and shared-decision-making may improve care for Medicare beneficiaries.

We continue to prioritize reducing fraud, waste, and abuse throughout CMS programs, and have prioritized reducing fraud, waste, and abuse in hospice programs. While hospice care is not palliative care, in related disciplines and sites of care we are very interested in how to better address fraud, waste, and abuse.

Where should CMS focus on potential fraud, waste, and abuse in community-based palliative care? Please support your statements with peer-reviewed evidence or evidence from your institution with sufficient detail for review.

b. Eligibility for Serious Illness Care

Defining which beneficiaries are eligible for serious illness care is a principal challenge in palliative and supportive care. While many Medicare beneficiaries may benefit from additional supportive care to manage pain and symptom burden, understanding which beneficiaries should be eligible for this service is of central importance to Medicare. For example, complex chronic care management services require two or more chronic conditions placing the beneficiary at high risk for hospitalization, decline, or death, and requires moderate to high complexity medical decision-making. To elect the Medicare Hospice Benefit, two or more physicians must certify a beneficiary is within 6 months to the end of their life (or, if a beneficiary does not have an attending physician, then the hospice physician alone is permitted to provide the certification).

We are requesting feedback on eligibility and care management services, and for all comments please support your statements with peer-reviewed evidence or evidence from your institution (in sufficient detail for review):

- For any future supportive or palliative care service for Medicare beneficiaries, should eligibility be restricted to certification of a likely life expectancy duration?

- If eligibility is restricted to those beneficiaries with a terminal prognosis, is there evidence to suggest a reasonable interval (that is, less than 1 year of life expectancy as in some States' Medicaid programs)?

c. Eligibility for Palliative Services

Defining eligibility for palliative services beyond the potential criterion of a terminal prognosis is likely necessary to better understand who is eligible for serious illness care.[113] While for complex care management services we restrict eligibility to beneficiaries requiring moderate to complex medical decision making as well as a count of chronic conditions, common definitions of serious illness include not just chronic condition counts but also indicators of the impact on a person's daily function or excessive caregiver strain.[114]

We are requesting feedback on the following:

- For any future supportive or palliative care service for Medicare beneficiaries, how could we consider impact on the daily functions of life or activities of daily living as part of who is eligible for the service?
- Would eligibility best be based on impact on daily function, on caregiver strain, or both?
- How can we avoid overly burdensome requirements for defining eligibility for services?

d. The Future of the Care Management Services

In section II.E. of this proposed rule, we are explicitly reconsidering the future of the care management services that form the basis for payment adequacy for important between visit care (in addition to E/M services for outpatient or home visits). Care for the seriously ill involves

---

[113] Kelley AS, Covinsky KE, Gorges RJ, McKendrick K, Bollens-Lund E, Morrison RS, Ritchie CS. Identifying Older Adults with Serious Illness: A Critical Step toward Improving the Value of Health Care. Health Serv Res. 2017 Feb;52(1):113-131. doi: 10.1111/1475-6773.12479. Epub 2016 Mar 18. PMID: 26990009; PMCID: PMC5264106.

[114] https://pmc.ncbi.nlm.nih.gov/articles/PMC5756466/pdf/jpm.2017.0548.pdf.

interdisciplinary care teams and involves even greater coordination and between visit care than primary care services.[115]

We are requesting feedback on the following:

- How should we differentiate the care management requirements for seriously ill beneficiaries from other Medicare beneficiaries?

- What are the essential service elements that must be included? For example(s), continuity with a designated team member, access to timely clinical support, comprehensive symptom and caregiver assessment, electronic care plans, coordination with treating physicians, patient/caregiver education, timely follow up after ED/discharge. What other service elements should be included? Should any not be included?

e. Advanced Primary Care Management

Currently, for Advanced Primary Care Management (APCM) services (HCPCS codes G0556 through G0558), we require physicians to report to the MIPS Value Pathway for primary care as part of our safeguards for high quality primary care. If we elect to develop additional care management services for seriously ill beneficiaries, however we may define serious illness in the future, determining how best to report quality of care safeguards will be essential to ensure high quality care delivery.

We are requesting feedback on the following:

- Should care management services for seriously ill beneficiaries also require reporting to a MIPS Value Pathway? Which quality measures should be reasonably included?

- If no viable MIPS Value Pathway reporting mechanism is found, what are the essential quality elements required for palliative care management? Is sole reporting of ambulatory palliative care patients feeling heard and understood (CBE 3665) sufficient? Should other measures be considered?

[115] https://www.capc.org/toolkits/building-and-supporting-effective-palliative-care-teams/.

3. Request for Information on Intensive Lifestyle Interventions to slow progression of Alzheimer's disease

a. Background

In the CY 2026 Physician Fee Schedule proposed rule, CMS sought comment in a 'Prevention and Management of Chronic Disease' Request for Information (90 FR 32507), addressing management and self-management of chronic disease, services that address root causes of disease, social isolation and loneliness, improving physical activity, intensive lifestyle interventions, enhancing uptake of the annual wellness visit (AWV), supporting partnerships with AAAs and community care hubs, and addressing motivational interviewing and health coaching. For some topics, responses were of adequate depth for CMS to consider further action, addressed elsewhere in this rule, but as is not uncommon when CMS requests information across a broad range of topics, in other areas responses were limited in the depth and granularity necessary for CMS to address the resource costs to establish coding and payment options. Because of the overwhelming priority for CMS to support the aging processes, given that American older adults commonly cite their fear of Alzheimer's as an even greater health related fear than the development of cancer,[116] and the growing evidence base for using lifestyle changes to slow the progression of cognitive decline and the development of Alzheimer's disease and Alzheimer's disease-related dementias (AD/ADRD), CMS is requesting additional information to better understand the resource costs and requirements for developing intensive lifestyle interventions to reduce the risk of AD/ADRD for Medicare beneficiaries. Intensive lifestyle interventions would be in concert with but would not specifically include risk factor reduction in modifiable behaviors such as controlling contributing conditions (for example, hypertension, diabetes), eliminating tobacco use (in any form), and addressing hearing loss.[117] In other

---

[116] Ornish, Dean, et al. "Effects of Intensive Lifestyle Changes on the Progression of Mild Cognitive Impairment or Early Dementia Due to Alzheimer's Disease: A Randomized, Controlled Clinical Trial." *Alzheimer's Research & Therapy*, vol. 16, 2024, p. 122. https://link.springer.com/article/10.1186/s13195-024-01482-z.

[117] National Institute on Aging. *"Cognitive Health and Older Adults."* National Institutes of Health, https://www.nia.nih.gov/health/brain-health/cognitive-health-and-older-adults. Accessed 30 Apr. 2026.

countries, there is randomized controlled trial evidence that multi-domain approaches can slow cognitive decline amongst at-risk older adults,[118] which appear to be superior to individual domain interventions such as physical activity programming or diet changes.[119] In the U.S. there have also been a number of studies demonstrating the potential impact of diet changes on cognition (for example, the MIND trial demonstrated improved cognition for both groups undergoing diet changes, however one diet was not shown to be superior).[12, 13, 14, 120] To support high-value care, the payer assuming financial risk for an individual's health would do so over a long-term to give that payer an incentive to invest in high-value care that reduces health care costs over that long-term. As discussed in the recent HHS Notice of Benefit and Payment Parameters for 2027[121], creating these incentives for payers throughout the healthcare system is an HHS priority. Outside of these needed incentives exists Medicare fee-for-service, which has historically employed price-setting regimes that are not market-based and are slow to change with improvements and health innovations. As HHS continues to improve incentives for private payers to invest in preventive health care, we are interested in how to ensure fee-for-service Medicare is similarly able to benefit from better incentives to invest in high-value care.

To better understand resource costs associated with intensive, multi-domain interventions:

- Given the discussion of the evidence to date on the effectiveness of intensive lifestyle interventions for CMS to pursue, we are particularly interested in demonstrations of cost-savings associated with these and other interventions. Please cite any evidence available in your discussion.

---

[118] Ngandu, Tiia, et al. *"A 2 Year Multidomain Intervention of Diet, Exercise, Cognitive Training, and Vascular Risk Monitoring versus Control to Prevent Cognitive Decline in At-Risk Elderly People (FINGER): A Randomised Controlled Trial." The Lancet*, vol. 385, no. 9984, 2015, pp. 2255–2263. https://doi.org/10.1016/S0140-6736(15)60461-5.

[119] "2024 Lancet Commission Underscores the Potential for Dementia Risk Reduction, Identifying 14 Modifiable Risk Factors across the Life Course." *Alzheimer Europe*, 31 July 2024, https://www.alzheimer-europe.org/news/2024-lancet-commission-underscores-potential-dementia-risk-reduction-identifying-14-modifiable.

[120] Barnes, Lisa L., et al. *"Trial of the MIND Diet for Prevention of Cognitive Decline in Older Persons." The New England Journal of Medicine*, vol. 389, no. 7, 2023, pp. 602–611. https://www.nejm.org/doi/10.1056/NEJMoa2302368.

[121] https://www.govinfo.gov/content/pkg/FR-2026-05-20/pdf/2026-10050.pdf

- Given CMS' concern for addressing fraud, waste, and abuse throughout the Medicare program, please comment on any potential or observed FWA in diagnosis, treatment, or management of AD/ADRD.
- Given the emerging role of biomarker diagnostic testing (for example, p-tau217, et. al) for AD/ADRD leading to early diagnosis, please provide any evidence supporting earlier detection and its role in supporting improving AD/ADRD care and any potential role in identifying eligibility for an intensive lifestyle intervention focused on AD/ADRD.
- What are the essential domains to address in a multi-domain intensive lifestyle intervention to reduce the risk of cognitive decline for older adults at risk for developing AD/ADRD that would be appropriate to include under Medicare?
- Should these interventions be made available as a one-time service (that is, to teach older adults how to make changes in their lifestyle to help reduce AD/ADRD risk) or on a recurring (for example, annual) basis?
- Should the eligibility for these services be restricted to beneficiaries with a diagnosis of mild cognitive impairment (MCI), or early-stage dementia? If so, how should this diagnosis be made or confirmed?

Respondents to the general intensive lifestyle intervention question in the prior RFI focused on the differentiation between intensive lifestyle interventions (ILIs) and intensive behavioral therapy (IBT) where ILIs are more multi-domain, longitudinal, and comprehensive and typically incorporate a multi-disciplinary team and are delivered in a community setting, and noting these are needed flexibilities that current IBT coding does not currently accommodate. To better understand the resource costs and requirements for future AD/ADRD ILI services:

- Given ILI's are multi-domain, and likely include physical activity, nutrition, potentially additional domains such as sleep and stress management, who are the essential interdisciplinary team members that CMS should account for in developing appropriate resource costs for future services?

- How should supervision be determined for AD/ADRD ILI's? Is general supervision sufficient for ensuring clinical safety and oversight? Is direct supervision required?

While there are many variations of ILI's focusing on AD/ADRD that are delivered, the essential 'dose' of intervention or minimum frequency and duration of a future service, as well as the modality (that is, must this intervention be delivered purely in person, can it be delivered virtually) are all important to consider:

- What is the minimum frequency of sessions for an AD/ADRD ILI per week? What is the minimum number of weeks that will be necessary?
- Should CMS require a future AD/ADRD ILI to be delivered in person? Can it be delivered virtually?

Finally, while we are currently accepting applications for a CMS Innovation Center payment model to generate evidence associated with lifestyle interventions (MAHA ELEVATE),[122] including potentially intensive lifestyle interventions focused on reducing risk and/or slowing progression of AD/ADRD, currently CMS has no endorsement process for specific interventions. In development of the CMS Health Technology Ecosystem[123] and the library of applications:

- How should CMS support the development of our Health Technology Ecosystem to support older adults reducing their risk for developing AD/ADRD using intensive lifestyle changes?

Please note, this is a request for information (RFI) only. In accordance with the implementing regulations of the Paperwork Reduction Act of 1995 (PRA), specifically 5 CFR 1320.3(h)(4), this general solicitation is exempt from the PRA. Facts or opinions submitted in response to general solicitations of comments from the public, published in the **Federal Register**

---

[122] Centers for Medicare & Medicaid Services. *"MAHA ELEVATE (Make America Healthy Again: Enhancing Lifestyle and Evaluating Value-Based Approaches Through Evidence) Model."* CMS.gov, 2026, https://www.cms.gov/priorities/innovation/innovation-models/maha-elevate.

[123] Centers for Medicare & Medicaid Services. *"Health Technology Ecosystem."* CMS.gov, https://www.cms.gov/priorities/health-technology-ecosystem/overview. Accessed 30 Apr. 2026.

or other publications, regardless of the form or format thereof, provided that no person is required to supply specific information pertaining to the commenter, other than that necessary for self-identification, as a condition of the agency's full consideration, are not generally considered information collections and therefore not subject to the PRA.

H. Current Procedural Terminology (CPT) Request for Information (RFI)

The Current Procedural Terminology (CPT®) coding system is owned and copyrighted by the American Medical Association (AMA) and CMS uses CPT® under a royalty-free licensing agreement with the AMA.[124] The CPT® coding system was introduced by the AMA in 1966,[125] in part to "encourage the use of standard terms and descriptors to document procedures in the medical record" and "help communicate accurate information on procedures and services to agencies concerned with insurance claims," and it "provided the basis for a computer oriented system to evaluate operative procedures and contributed basic information for actuarial and statistical purposes."[126] The CPT® coding system went through a series of early version changes and in 1977 the AMA established the CPT-4 or 4th edition which established the current five-digit numeric structure of the CPT® coding system still used today.[127] The Health Care Financing Administration or HCFA, later renamed CMS,[128] in 1983 required the use of the Healthcare Common Procedure Coding System (HCPCS) for physician services and expanded to non-physician services in 1991.[129] and since this time HCPCS Level I services have been considerd synonymous with CPT, where Level II HCPCS refers to additional products, supplies, and services not included in the CPT® codes.130

---

[124] Centers for Medicare & Medicaid Services. *AMA Terms and Conditions*. Centers for Medicare & Medicaid Services, n.d., *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/AMA-Terms-Conditions.pdf*.

[125] American Medical Association. *History of CPT® Content*. American Medical Association, 5 Dec. 2025, *https://www.ama-assn.org/practice-management/cpt/history-cpt-content*.

[126] American Medical Association. *The Purpose of the CPT® Coding System & the CPT® Editorial Panel*. American Medical Association, 10 Sept. 2025*, https://www.ama-assn.org/about/cpt-editorial-panel/purpose-cpt-coding-system-cpt-editorial-panel*.

[127] American Medical Association. *The Purpose of the CPT® Coding System & the CPT® Editorial Panel*. American Medical Association, 10 Sept. 2025, *https://www.ama-assn.org/about/cpt-editorial-panel/purpose-cpt-coding-system-cpt-editorial-panel*.

[128] Centers for Medicare & Medicaid Services, Department of Health and Human Services. *Statement of Organization, Functions, and Delegations of Authority*. *Federal Register*, 5 July 2001, *https://www.federalregister.gov/documents/2001/07/05/01-16800/centers-for-medicare-and-medicaid-services-statement-of-organization-functions-and-delegations-of*.

129 *Medicare Program; Fee Schedule for Physicians' Services; Proposed Rule*. **Federal Register**, vol. 56, no. 108, 5 June 1991, pp. 25792–25978. U.S. Government Publishing Office, https://www.govinfo.gov/content/pkg/FR-1991-06-05/pdf/FR-1991-06-05.pdf

130 Centers for Medicare & Medicaid Services. **"Healthcare Common Procedure Coding System (HCPCS)."** *Centers for Medicare & Medicaid Services*, U.S. Department of Health and Human Services, https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system. Accessed 7 July 2026.

Following the passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) the Department of Health and Human Services (HHS) in subsequent regulation defined the combination of HCPCS, as maintained and distributed by HHS, and CPT-4, as maintained and distributed by the AMA, as the nationally required medical data code sets for physician services, physical and occupational therapy services, radiologic procedures, clinical laboratory tests, other medical diagnostic procedures, hearing and vision services, and transportation services including ambulance services (45 CFR 162.1002(a)(5)). This is commonly understood as a regulatory requirement for CPT-4 codes to be used to define physician services. While this is HHS' current regulatory interpretation of the HIPAA (Pub. L. 104-191), it is important to note that HHS has only specified in regulation that HCPCS and CPT-4 to be used in combination. There is no specification in the HIPAA statute regarding the manner in which these national coding sets may be used or how they may be combined, and only HHS interpretation, not the Act itself, mentions CPT®.

New CPT® codes are introduced by the CPT® Advisory Committee. This committee was established following the initial publication of the CPT® coding system in 1966, which provides advice on procedure coding and appropriate nomenclature as relevant to the committee member's specialty and consists of "members of national medical specialty societies seated in the AMA House of Delegates."[131] When a new CPT® code is defined by the CPT® Advisory Committee, it is then assigned a payment value by the AMA Relative Value Scale Update Committee or RUC.[132]

The AMA RUC was established in 1992, after CMS transitioned to the resource-based relative value scale (RBRVS) to provide recommendations on the valuation of physician services. As established in section 1848 of the Act, CMS began paying for physician services in

---

[131] American Medical Association. *CPT® Nominations & Opportunities*. American Medical Association, 11 Feb. 2025, *https://www.ama-assn.org/about/cpt-editorial-panel/cpt-nominations-opportunities*.

[132] American Medical Association. *RVS Update Committee (RUC)*. American Medical Association, 4 Mar. 2026, *https://www.ama-assn.org/about/rvs-update-committee-ruc/rvs-update-committee-ruc*.

1998 on the basis of a product of the relative value of the physician service, incorporating the physician work, the practice expense, and the malpractice component. These elements form the basis for the RBRVS. The components of physician services were originally established by a team of Harvard researchers (William Hsiao, et al.) and CMS has occasionally referenced the 'Harvard' valuations making reference to these original contributions.[133] According to the AMA, the AMA RUC "*provides medicine a voice in shaping Medicare relative values*," and by all published estimates this has been an effective mechanism.[134]

There has also been longstanding concern expressed over the Federal reliance on a private organization with such an obvious conflict of interest as providing information on the time and resource requirements to conduct physician services when this information may influence their own payment. For nearly 20 years, MedPAC has expressed concern over the influence of the AMA RUC to value services, specifically noting that CMS has "*over-relied on specialty societies with a financial stake in the process*" and has recommended that CMS establish a separate group of experts to make payment recommendations.[135] Further, we note the historic reliance on the CPT and RUC process as a potential contributor to the development of US health care as a 'sick care' system with limited emphasis on prevention and lifestyle modifications and which may inhibit progress on the Secretarial priority to Make America Healthy Again. Additionally, we note a recent National Academies of Sciences, Engineering, and Medicine (NASEM) report recommending RUC alternatives for establishing primary care payment valuation and recommendations for alternative sources for data collection.[136]

---

[133] Hsiao WC, Braun P, Kelly NL, Becker ER. Results, Potential Effects, and Implementation Issues of the Resource-Based Relative Value Scale. *JAMA.* 1988;260(16):2429–2438. doi:10.1001/jama.1988.03410160105013.
[134] American Medical Association. *RVS Update Committee (RUC)*. American Medical Association, 4 Mar. 2026, *https://www.ama-assn.org/about/rvs-update-committee-ruc/rvs-update-committee-ruc*.
[135] Medicare Payment Advisory Commission. *Testimony: Options to Improve Medicare's Payments to Physicians*. 8 May 2007, *https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/congressional-testimony/051007_Testimony_MedPAC_physician_payment.pdf*.
[136] National Academies of Sciences, Engineering, and Medicine. *Improving Primary Care Valuation Processes to Inform the Physician Fee Schedule*. National Academies Press, 2025, https://doi.org/10.17226/29069.

Given these longstanding concerns, we are seeking comment on a number of areas regarding the influence of the CPT® coding system and AMA process on physician payment policy as part of the Secretarial priority to Make America Healthy Again.

1) What, if any, evidence is there for CMS to consider regarding the harms or challenges associated with AMA's monopoly over CPT-4 licenses for health care entities? Please cite potential improvements to patient care diverted or delayed due to AMA'S monopoly over CPT codes, including inhibited innovations and acquisition or maintenance costs of CPT® licensure.

2) What, if any, evidence is there that the generation of CPT-4 codes follows a process of identification of medical necessity? What opportunities or examples from other populations, sites of care, or international health systems could instruct a process of identification of medical necessity in the CPT-4 code development process?

3) A combination of CPT-4 and HCPCS codes were formally adopted by HHS as the legal standard for national coding for physician and other services as part of implementing HIPAA (45 CFR 162.1002(a)(5)). If CMS were to revisit this standard in future rulemaking, which if any alternatives exist to CPT-4 for CMS to consider as part of the national coding standard for physician services? Would CMS need to specify a separate legal standard, or could CMS allow for private competition to supplement the existing CPT-4 coding standard?

4) What objective alternatives exist, or could be developed, to maintain a more objective process to the current AMA CPT and RUC committee processes? How would these alternatives support or inhibit innovation?

5) What are the benefits and drawbacks of paying for physician procedural services on the basis of the underlying International Classification of Diseases, 10th Revision (ICD-10) procedure code, as an alternative to CPT-4 code? How could the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) services be grouped or bundled into payment categories, similar to Medicare Severity Diagnosis Related Groups (MS-

DRGs), or Outpatient Prospective Payment System (OPPS) Ambulatory Payment Classifications (APCs)? What other alternatives exist for bundling or grouping procedural services?

III. Other Provisions of the Proposed Rule

A. Drugs and Biological Products Paid Under Medicare Part B

1. Requiring Manufacturers of Certain Single-Dose Container or Single-Use Package Drugs to Provide Refunds with Respect to Discarded Amounts (§§ 414.902 and 414.940)

a. Background

Section 1847A(h) of the Act requires manufacturers to provide a refund to CMS for certain discarded amounts from a refundable single-dose container or single-use package drug (hereinafter referred to as "refundable drug") for calendar quarters beginning January 1, 2023.

The calculation of the refund is codified at § 414.940(c). For a new refund quarter (as defined at § 414.902) beginning on or after January 1, 2023, an amount equal to the estimated amount (if any) by which:

- The product of the total number of units of the billing and payment code for such drug that were discarded during such new refund quarter; and the amount of payment determined for such drug or biological under section 1847A(b)(1)(B) or (C) of the Act, as applicable, for such new refund quarter.
- Exceeds an amount equal to the applicable percentage of the estimated total allowed charges for such drug for the new refund quarter.

Section 1847A(h)(3)(B)(i) of the Act establishes an applicable percentage of 10 percent, but provides that, in the case of a refundable drug that has unique circumstances involving similar loss of product as that described in section 1847A(h)(8)(B)(ii) of the Act, the Secretary, through notice and comment rulemaking, may increase such applicable percentage as determined appropriate by the Secretary. Section 1847A(h)(8)(B)(ii) of the Act describes a drug or biological approved by the Food and Drug Administration (FDA) for which dosage and administration instructions included in the labeling require filtration during the drug preparation process, prior to dilution and administration, and require that any unused portion of such drug

after the filtration process be discarded after the completion of such filtration process. Drugs with an increased applicable percentage are listed on the CMS website.[137]

For previous rulemaking in which we finalized to increase the applicable percentage of a drug with unique circumstances involving similar loss of product as that described in section 1847A(h)(8)(B)(ii) of the Act, we explained specifically why the loss of product met the statutory requirements. In the CY 2023 Physician Fee Schedule (PFS) final rule (87 FR 69729), we finalized an increase in the applicable percentage for a drug reconstituted with a hydrogel and administered via ureteral catheter or nephrostomy tube into the kidneys, where a substantial amount of reconstituted hydrogel adheres to the vial wall during preparation and cannot be withdrawn for administration. Because this unavoidable preparation-related loss is similar to the loss described in section 1847A(h)(8)(B)(ii) of the Act, we stated that such a drug that is reconstituted with a hydrogel and has variable dosing based on patient-specific characteristics (for example, Jelmyto® (mitomycin for pyelocalyceal solution)) should be considered to have unique circumstances as described in section 1847A(h)(3)(B)(ii) of the Act that would warrant an increased applicable percentage.

In the CY 2024 PFS final rule (88 FR 79052), we increased the applicable percentage for certain drugs with low volume doses and stated that such drugs have unique circumstances because certain FDA-labeled amounts on the vial or package are unused and discarded after administration of the labeled dose and these amounts are not available to be administered. The unique circumstances described for such drugs are similar to loss of product from filtration described in section 1847A(h)(8)(B)(ii) of the Act because in both circumstances, such amounts lost are amounts that are not part of the recommended dose and are not available to be administered to the patient (one being loss due to labeled amounts remaining in the filter and the other due to labeled amounts remaining in other areas such as the vial or syringe).

---

[137] *https://www.cms.gov/medicare/payment/part-b-drugs/discarded-drugs.*

In the CY 2024 PFS final rule, we also finalized an increased applicable percentage for certain orphan drugs furnished to fewer than 100 unique beneficiaries per calendar year. We explained (88 FR 79053 through 79057) that because of the substantial statistical variation (based on demonstrated JW modifier claims data from 2021 and 2022) from quarter to quarter for such drugs, we believe it would be difficult to optimize the presentation of the drug to consistently minimize the discarded amounts to less than 10 percent given the small number of patients receiving the drug. We considered the higher percentage of unused and discarded amounts from such drugs as unavoidable loss due to both the low number of unique beneficiaries receiving the drug contributing statistically higher variability in discarded amounts. Also, due to the low numbers of patients available to study for rare disease, it may be more difficult to determine the most efficient vial size for the patient population who receive the drug post-marketing. We stated this is similar to the loss of product due to filtration described in section 1847A(h)(8)(B)(ii) of the Act because the loss is unavoidable in both circumstances. In the case of filtration described in statute, the loss is unavoidable because certain amounts of product will be left within the filter and unavailable for administration; in the case of rarely utilized orphan drugs, the loss is unavoidable because of the variability of potential doses (and low number of patients receiving the drug) leading to an inability to develop a package size that will result in a consistent average percentage of discarded units.

We stated in the CY 2024 PFS final rule (88 FR 79057) that we do not consider the following to be unique circumstances warranting an increased applicable percentage at this time: weight-based doses, body surface area (BSA)-based doses, varying surface area of a wound, loading doses, escalation or titration doses, tapering doses, and dose adjustments for toxicity because we believe manufacturers can optimize the availability of products for these circumstances to limit the percentage of discarded units for a drug, unlike the circumstances of manufacturers of drugs that require filtration during the preparation process, as described in section 1847A(h)(8)(B)(ii) of the Act.

We also explained in the CY 2024 PFS final rule (88 FR 79060) that, while we cannot anticipate future drug development or what unique circumstances might arise, we can offer our analysis of the unique circumstances we consider involving similar loss of product as that described in section 1847A(h)(8)(B)(ii) of the Act for drugs that are reconstituted in hydrogel and with variable dosing based on patient-specific characteristics (87 FR 69727 through 69731), drugs with low volume doses, and rarely utilized orphan drugs (88 FR 79052 through 79057). Regarding examples of evidence, we noted minimum vial fill studies and dose preparation studies in the CY 2024 PFS proposed rule, both of which are suitable for justifying increased applicable percentages because they can establish that certain unusable amounts of a product are necessarily included in a container to safely and consistently administer the labeled therapeutic dose to a patient.

b. Application for Increased Applicable Percentage

Section 1847A(h)(3)(B)(ii) of the Act permits the Secretary to increase the applicable percentage for a refundable drug that has unique circumstances through notice-and-comment rulemaking. In the CY 2024 PFS final rule (88 FR 79057 through 79060), we finalized an application process (CMS-10835, OMB 0938-1435) by which manufacturers can apply for an increased applicable percentage for a drug and may request that we consider an individual drug to have unique circumstances for which an increased applicable percentage is appropriate. Under § 414.940(e)(2), an application must be submitted by February 1 of the CY prior to the year the increased applicable percentage would apply; for a drug that is not FDA-approved by February 1, the application must have FDA approval by August 1, and the manufacturer must notify CMS and submit the FDA-approved label by September 1 of that year. The application must include a written request that the drug be considered for an increased applicable percentage based on its unique circumstances; FDA-approved labeling for the drug (or, if the drug is not approved by the February 1 application deadline described in paragraph (e)(2) of this section, documentation of FDA acceptance of the application for review); justification for the

consideration of an increased applicable percentage based on such unique circumstances; and justification for the requested increase in the applicable percentage. Following review of timely applications, CMS will summarize its analyses of applications and propose appropriate increases in rulemaking. If adopted, the increased applicable percentage will be the applicable percentage beginning January 1 of the following calendar year.

We received one application requesting an increased applicable percentage for consideration for CY 2027 from the manufacturer of Leukine® (sargramostim),[138] who resubmitted a request for a 72 percent applicable percentage after applying the previous 2 years. The applicant submitted the information required at § 414.940(e)(1), including, as applicable, FDA-approved labeling for the drug, justification for consideration of an increased applicable percentage, and justification for the requested applicable percentage.

Leukine® is a leukocyte growth factor with five FDA-approved indications related to hematological conditions and hematopoietic recovery, as well as one indication to increase survival following acute exposure to myelosuppressive doses of radiation. The applicant's submitted FDA-approved labeling for the drug does not include the adjuvant uses described in the application (further described later in this paragraph) due to ongoing cancer vaccine adjuvant trials. The applicant reemphasized that multiple sponsors are in late-stage development, with a total of 27 Phase II and Phase III clinical trials, an increase from 22 reported in the previous year, investigating Leukine® as a vaccine adjuvant for oncology indications, specifically to stimulate the immune response of dendritic cells when used alongside these vaccines. We note that cancer treatment vaccines differ from the vaccines that protect against viruses, such as the influenza virus. Instead of preventing disease, cancer treatment vaccines aim to stimulate the immune system to attack existing cancer cells in the body.[139] The applicant stated that it has no ownership stake in the development of these cancer treatment vaccines and does not possess

[138] *https://www.accessdata.fda.gov/drugsatfda_docs/label/2022/103362s5249lbl.pdf*.
[139] *https://www.cancer.org/cancer/managing-cancer/treatment-types/immunotherapy/cancer-vaccines.html*.

control or influence over the design and execution of the clinical trials. The applicant further explained that the estimated completion dates for Phase III clinical trials vary, with the earliest expected in late 2026[140,141] and the latest in March 2029.[142]

The adjuvant use of Leukine® in predetermined dosage is distinct from its six FDA-approved indications, all of which have dosages that are based on body weight or body surface area (BSA). The adjuvant use dosages of Leukine® in clinical trials are generally much smaller than dosages for indications in the FDA-approved labeling. The smallest dose of Leukine® used for vaccine adjuvant purposes of which the applicant is aware (that is, 70 mcg) would lead to as much as 72 percent of the drug being discarded from a single-dose 250 mcg lyophilized vial, which is the only size available commercially. The applicant suggests that if use of these small doses were to become more common for an approved indication, the percentage of discarded units could increase the discarded drug refund amount that could be owed by the applicant, even though the applicant lacks control or knowledge of the potential variability of the discarded amounts that may occur if Leukine® were used for such purposes. The applicant notes that if another manufacturer were to seek FDA approval for adjuvant use of sargramostim but was not involved in its production, the available single-dose 250-mcg vial presentation of Leukine® would likely not be optimized for the small doses being studied in these trials. The applicant also expresses concern about potential refund liability if small-dose adjuvant use becomes more common.

The application builds on prior submissions by reiterating that Leukine® appears on FDA's list of essential medicines,[143] that the Administration for Strategic Preparedness and Response (ASPR) has documented a requirement to procure and stockpile Leukine® as a medical countermeasure for neutropenia resulting from acute radiation syndrome,[144] and that the

---

[140] *https://clinicaltrials.gov/study/NCT04229979*.
[141] *https://clinicaltrials.gov/study/NCT05232916*.
[142] *https://clinicaltrials.gov/study/NCT05100641*.
[143] *https://www.fda.gov/media/143406/download?attachment*.
[144] *https://sam.gov/opp/f4735f1f235847a0bb138c13333097de/view*.

applicant continues to collaborate with the Biomedical Advanced Research and Development Authority (BARDA). In this application, the applicant also newly states that Leukine® has been designated a "Medical Product Priority" by the Department of Defense (DoD) under Pub. L. 115-92 (enacted December 12, 2017).[145] DoD maintains a Medical Product Priority list as part of the DoD-FDA coordination framework established following Pub. L. 115-92 and formalized in the FDA-DoD Memorandum of Understanding.[146] Under this framework, DoD identifies and maintains a list of its highest-priority medical products to support focused, recurring engagement with FDA; however, we could not corroborate a Leukine® designation using resources available for public review. The applicant's 2022 public announcement of an Other Transaction Agreement with the DoD references Leukine® as a potential medical countermeasure for sulfur mustard gas exposure,[147] but it does not reference a "Medical Product Priority" designation. Additionally, a study published in 2025 comparing essential medicines across U.S. Federal agencies and the World Health Organization did not identify Leukine® on DoD's operational medicines list. The study noted that the DoD operational medicines list is a subset of FDA's essential medicines list—meaning medicines on the DoD list also appear on FDA's list, but not all medicines on FDA's list appear on the DoD list.[148] Nevertheless, these emergency-response and preparedness-related listings or designations do not, by themselves, demonstrate unique circumstances related to discarded amounts for purposes of an increased applicable percentage because they are designed to support Federal planning, procurement, and interagency coordination to ensure adequate supply of essential products, rather than to provide evidence of drug-specific, unavoidable product loss similar to loss of product as described in section

---

[145] To amend the Federal Food, Drug, and Cosmetic Act to authorize additional emergency uses for medical products to reduce deaths and severity of injuries caused by agents of war, Pub. L. 115-92, 131 Stat. 2023 (2017).
[146] *https://www.fda.gov/about-fda/domestic-mous/mou-225-19-001*.
[147] *https://www.partnertx.com/partner-therapeutics-announces-contract-with-u-s-department-of-defense-for-advanced-development-of-leukine-to-treat-sulfur-mustard-gas-hd-exposure/*.
[148] ML Janvrin, A Kanagaratnam, VA Suarez et al. A comparison of the essential medicines lists of the U.S. Department of Health and Human Services, the U.S. Department of Defense, the U.S. Food and Drug Administration, and the World Health Organization, Journal of the American Pharmacists Association, 65(5),2025.

1847A(h)(8)(B)(ii) of the Act.

As part of CMS' review of the application, we analyzed existing claims data from the first quarter of 2018 through the last quarter of 2025 and found the percentage of units discarded for Leukine® (HCPCS code J2820) ranged from 1.1 percent to 4.9 percent, which is below the applicable percentage of 10 percent. The quarterly discarded percentages during this time frame were stable, with a standard deviation of less than 1 percentage point and values tightly clustered around a mean of approximately 2.4 percent. This is notably lower than the 6.21 percent average standard deviation observed for rarely utilized orphan drugs, as reported in the CY 2024 PFS final rule (88 FR 79053). Accordingly, the applicant's requested applicable percentage relies on assumptions about hypothetical future dosing and utilization that are not evident in Part B claims data available to date.

At the time of the CY 2026 PFS proposed rule, the impact of a potential adjuvant indication with a type of immunotherapy commonly referred to as cancer vaccines[149] on the current percentage of units discarded was uncertain. Additionally, it was not yet known whether sargramostim would be approved for additional indications and dosages described by the applicant, and the available data was insufficient for CMS to determine whether Leukine® had unique circumstances prompting an increase in the applicable percentage. Therefore, we did not propose to increase the applicable percentage in the CY 2026 PFS proposed rule. The applicant agreed with CMS' rationale for this decision.

Although the applicant agreed with CMS's rationale in the CY 2026 PFS proposed rule, they submitted a new application for CY 2027 with updated information on oncology vaccine-adjuvant clinical trials and projected timing for potential FDA approvals, as well as an asserted DoD "Medical Product Priority" designation. However, the core uncertainties identified in the CY 2026 PFS proposed rule persist: the absence of FDA-approved labeling for the asserted adjuvant indication(s) or dosage(s) and uncertainty regarding whether such uses would be

[149] *https://www.cancerresearch.org/treatment-types/cancer-vaccines*.

utilized to an extent that discarded amounts would exceed the applicable percentage in a calendar quarter.

The existing claims data and trends for discarded amounts of sargramostim discussed earlier do not support a determination that Leukine® has qualifying unique circumstances that would support an increased applicable percentage under section 1847A(h)(3)(B)(ii) of the Act. Unlike the analysis leading to an increased applicable percentage for certain orphan drugs as described earlier in the Background section III.A.1.a. of this proposed rule, which relied on evidence indicating that certain orphan drugs have unavoidable loss of drug similar to the loss of product described in section 1847A(h)(8)(B)(ii) of the Act, the justification presented by the applicant for an increased applicable percentage for their product is based largely on projections regarding potential future oncology vaccine-adjuvant use at smaller doses. These projections assume a utilization scenario in which sargramostim use would shift predominantly to the studied indications at the lowest study dose discussed earlier in this section, rather than remaining primarily under the FDA-approved indications, for which claims data currently demonstrate very low discarded amount percentages with no trending increase. In the absence of qualifying unique circumstances, we do not reach the question of whether the requested applicable percentage would be appropriate.

Accordingly, we are not proposing an increase in the applicable percentage for Leukine® for CY 2027. The applicant may reapply in a future application cycle when more information, such as FDA-approved labeling reflecting new indications or dosages, becomes available. We welcome comments on the application for increased applicable percentage.

B. Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

1. Background on RHC and FQHC Payment Methodologies

As provided in 42 CFR part 405, subpart X of our regulations, RHC and FQHC visits generally are defined as face-to-face encounters between a patient and one or more RHC or FQHC practitioners during which one or more RHC or FQHC qualifying services are furnished. RHC and FQHC practitioners are physicians, nurse practitioners (NPs), physician assistants (PAs), Certified Nurse Midwives (CNMs), clinical psychologists (CPs), licensed marriage and family therapists, mental health counselors, and clinical social workers, and, subject to certain conditions, a registered nurse or licensed practical nurse that is furnishing care to a homebound RHC or FQHC patient in an area verified as having shortage of home health agencies. Transitional Care Management (TCM) services can also be paid by Medicare as an RHC or FQHC visit. In addition, Diabetes Self-Management Training (DSMT) or Medical Nutrition Therapy (MNT) services furnished by a certified DSMT or MNT program may also be considered FQHC visits for Medicare payment purposes. Only medically necessary medical, mental health, or qualified preventive health services that require the skill level of an RHC or FQHC practitioner are RHC or FQHC billable visits. Services furnished by auxiliary personnel acting under the supervision of the RHC or FQHC practitioner, are considered incident to the visit and are included in the per-visit payment.

RHCs generally are paid an all-inclusive rate (AIR) for all medically necessary medical and mental health services and qualified preventive health services furnished on the same day (with some exceptions). The AIR is subject to a payment limit, meaning that an RHC will not receive any payment beyond the specified limit amount per visit. As of April 1, 2021, all RHCs are subject to statutory upper payment limits determined in accordance with section 1833(f) of the Act, as amended by section 130 of the Consolidated Appropriations Act, 2021 (Pub. L. 116-260).

FQHCs were paid under the same AIR methodology until October 1, 2014. Beginning on that date, in accordance with section 1834(o) of the Act (as added by section 10501(i)(3) of the Patient Protection and Affordable Care Act (Pub. L. 111-148, March 23, 2010)), FQHCs began to transition to the FQHC PPS system, in which they are paid based on the lesser of the FQHC PPS rate or their actual charges. The FQHC PPS rate is adjusted for geographic differences in the cost of services by the FQHC PPS geographic adjustment factor (GAF). The rate is increased by 34 percent when an FQHC furnishes care to a patient that is new to the FQHC, or to a beneficiary receiving an initial preventive physical examination (IPPE) or has an annual wellness visit (AWV). Section 1834(o)(2)(B)(ii) requires the FQHC PPS base rate be updated annually by the percentage increase in a market basket of Federally qualified health center goods and services as promulgated through regulations, or if such an index is not available, by the percentage increase in the Medicare Economic Index (MEI) (as defined in section 1842(i)(3)) for the year involved. See section III.B.4 of this proposed rule, for the proposed CY 2027 updates.

Under the general authority of section 1834(o) of the Act, CMS codified at §§405.2462 and 405.2464 to pay historically excepted tribal FQHCs using the Medicare outpatient per visit rate established annually by IHS, rather than the FQHC PPS rate (80 FR 71089). These rates are set by IHS under sections 321(a) and 322(b) of the Public Health Service (PHS) Act based on prior-year cost reports. The outpatient per visit rate applies only to provider-based IHS or tribal facilities (§413.65(m)) and historically excepted tribal FQHCs. For CY 2026, the rate is $733 per visit in the lower 48 States.

Both the RHC AIR and FQHC PPS payment rates were initially designed to reflect the cost of all services and supplies that an RHC or FQHC furnished to a patient in a single day. These nearly all-inclusive rates are not adjusted at the individual level for the complexity of individual patient health care needs, the length of an individual visit, or the number or type of practitioners involved in the patient's care. Instead for RHCs, all costs for the facility over the course of the year are aggregated, and an AIR is derived from these aggregate expenditures.

Section 1834(o)(2)((B)(ii) of the Act requires the FQHC PPS base rate be updated annually by the percentage increase in a market basket of Federally qualified health center goods and services as promulgated through regulations, or if such an index is not available, by the percentage increase in the MEI (as defined in section 1842(i)(3)) of the Act for the year involved.

RHCs and FQHCs are also paid for non-face-to-face care management work involved in coordinating care outside of the RHC AIR and FQHC PPS (§ 405.2464(c)). That is, payment is based on the PFS national non-facility payment rate and is made in addition to the otherwise billable visit for patients utilizing chronic care management (CCM), principal care management (PCM), general behavior health integration (BHI), chronic pain management (CPM), remote physiologic monitoring (RPM), remote therapeutic monitoring (RTM), community health integration (CHI), principal illness navigation (PIN), PIN-peer support services, advanced primary care management (APCM), and psychiatric collaborative care model (CoCM). In addition, payment is based on the PFS national non-facility payment rate and is made in addition to the otherwise billable visit for communication technology-based services (CTBS) and remote evaluation services (§ 405.2464(e)).

In the CY 2026 PFS final rule (90 FR 49556 through 49558), we finalized a policy that effective January 1, 2026, services that are established and paid under the PFS and designated as care management services would be considered "care coordination services" for purposes of separate payment for RHCs and FQHCs. The care coordination codes can be found in the PFS table entitled "Designated Care Management Services", which is published annually with the PFS Final Rule Addenda on the CMS website.

2. Payment for Certain Preventive Services

a. Background

Medicare Part B covers a comprehensive set of preventive services aimed at promoting early detection and reducing the risk of chronic disease.[150] These services include wellness visits (such as the IPPE and AWV), evidence-based screenings for cancer and chronic conditions, behavioral health and risk factor screenings, certain vaccinations, and preventive counseling interventions. Coverage for many of these services was expanded under sections 4103 and 4104 of the Affordable Care Act; the services are covered without beneficiary cost-sharing when furnished according to Medicare requirements. Collectively, they are designed to support proactive, patient-centered care and improve long-term health outcomes, particularly when delivered in primary care settings. CMS has implemented these statutory provisions through regulations at 42 CFR part 410, which define, among other things, the coverage, eligibility, and frequency requirements for preventive services.

CMS also establishes and updates coverage of preventive services through the National Coverage Determination (NCD) process, if such services are recommended with a grade of A or B by the U.S. Preventive Services Task Force (USPSTF). These processes specify the conditions under which preventive services are considered reasonable and necessary for Medicare beneficiaries.

Payment for preventive services is made in accordance with applicable Medicare payment systems, for example, the PFS under 42 CFR part 414. CMS provides additional operational guidance through subregulatory instructions, including manuals and program transmittals, to ensure consistent implementation of coverage and payment policies. Beneficiary copayment and deductible (where applicable) is waived by the Affordable Care Act for the IPPE and AWV, and for Medicare-covered preventive services recommended by the USPSTF with a grade of A or B.

---

[150] *https://www.cms.gov/medicare/prevention/prevntiongeninfo/medicare-preventive-services/mps-quickreferencechart-1.html*.

When statutorily permissible, we pay for covered preventive services under Medicare Part B to RHCs and FQHCs pursuant to such facilities' encounter-based payment methodologies, rather than as PFS separately billable services, except where otherwise specified.

RHCs are paid under the AIR methodology for a limited number of qualified preventive health services furnished by an RHC practitioner. FQHCs are paid under the FQHC PPS for qualified preventive health services and preventive primary health services required under section 330 of the PHS Act.[151] A qualified preventive health service refers to a Medicare-covered preventive service that also meets the requirements for a billable RHC or FQHC visit, including a face-to-face encounter with a RHC or FQHC practitioner (that is, the service is at a level that requires the expertise of a RHC or FQHC practitioner). Specifically, RHCs and FQHCs are paid for the professional component of allowable preventive services when the program requirements are met and frequency limits (where applicable) have not been exceeded.[152] In this context, professional component refers to the practitioner's clinical service associated with a preventive service, as opposed to the technical or ancillary elements of the service. Preventive services furnished in other settings, for example, physician offices, are generally paid on a service-by-service basis. However, preventive services that do not constitute a separate billable RHC or FQHC visit must be furnished as part of a qualified RHC or FQHC visit (for example, an evaluation and management (E/M) visit) to be billable to Medicare. If a preventive service, that does not constitute a billable RHC or FQHC visit, is furnished and is not part of a qualified RHC or FQHC visit, it may not be payable under Medicare.

b. Federal Initiatives to Improve Health Outcomes and Access to Care

(1) The Make America Healthy Again (MAHA) Commission

---

[151] Section 1861(aa)(3) of the Act (42 U.S.C. 1395x(aa)(3)) defines Federally Qualified Health Center (FQHC) services to include services and supplies furnished by an FQHC, including preventive primary health services required under section 330 of the Public Health Service Act (42 U.S.C. 254b).

[152] Pub. 100-02, Chapter 13, Section 220 – Preventive Health Services.

On February 13, 2025, the President signed an Executive Order establishing the MAHA Commission within the Department of Health and Human Services (HHS).[153] The Commission is chaired by the Secretary of HHS and includes representatives from multiple Federal agencies. The Commission was directed to assess contributing factors to chronic disease and to develop a coordinated Federal strategy to improve population health outcomes, with an initial focus on pediatric populations.

In 2025, the Commission released an assessment identifying a range of factors associated with chronic disease, including dietary patterns, environmental exposures, physical inactivity, and other behavioral and upstream drivers of health. The Commission subsequently issued a strategy outlining potential Federal actions to address these factors through cross-agency coordination, research, and programmatic initiatives.[154]

Although the Commission's initial focus is on childhood health, its findings are relevant to Federal health programs serving other populations, including Medicare beneficiaries. Chronic conditions associated with the factors identified by the Commission are prevalent among Medicare beneficiaries and are significant drivers of program expenditures.

(2) The Rural Health Transformation (RHT) Program

The RHT Program was authorized by section 71401 of the Working Families Tax Cut (WFTC)(Pub. L. 119-21, July 4, 2025) legislation and empowers States to strengthen rural communities across America by improving healthcare access, quality, and outcomes by transforming the healthcare delivery ecosystem. On September 15, 2025, we announced the availability of funding under the RHT Program and program objectives for States seeking to participate in this initiative, among other information. The RHT Program represents a $50 billion Federal investment over 5 Federal fiscal years (FY 2026 to FY 2030), with $10 billion available

---

[153] Exec. Order No. 14212, Establishing the Make America Healthy Again Commission, 90 FR 9833 (Signed, February 13, 2025).

[154] *https://www.usda.gov/about-usda/news/press-releases/2025/09/09/maha-commission-unveils-sweeping-strategy-make-our-children-healthy-again*.

annually, intended to strengthen health care infrastructure, expand access to care, and improve health outcomes in rural communities across the United States.

The program has five strategic goals, grounded in the permissible uses of funds under the statute: Make Rural America Healthy Again — Support rural health innovations and new access points to promote preventive health and address the root causes of disease; Sustainable Access — Improve the efficiency and long-term sustainability of rural health care providers as enduring access points for care; Workforce Development — Strengthen recruitment and retention of qualified health care professionals in rural communities; Innovative Care — Advance innovative care models that improve health outcomes, coordinate care, and promote flexible care arrangements; and Technology Innovation — Foster the adoption of innovative technologies that promote efficient care delivery, data security, and access to digital health tools for rural facilities, providers, and patients.[155]

c. Increasing Access to Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT) Services in RHCs

Section 4105 of the Balanced Budget Act of 1997 added section 1861(qq) of the Act to permit Medicare coverage of outpatient DSMT services when these services are furnished by a certified provider who meets certain quality standards. This program is intended to educate beneficiaries in the successful self-management of diabetes. The program includes instructions in self-monitoring of blood glucose; education about diet and exercise; an insulin treatment plan developed specifically for the patient who is insulin dependent; and motivation for patients to use the skills for self-management. DSMT services may be covered by Medicare only if the treating physician or treating qualified non-physician practitioner who is managing the beneficiary's diabetic condition certifies that such services are needed. The referring physician or qualified non-physician practitioner must maintain the plan of care in the beneficiary's medical record and documentation substantiating the need for training on an individual basis when group training is

[155] *https://www.cms.gov/priorities/rural-health-transformation-rht-program/overview*.

typically covered, if so ordered. A designated certified provider bills for DSMT provided by an accredited DSMT program. Certified providers must submit a copy of their accreditation certificate to the contractor. The statute states that a "certified provider" is a physician or other individual or entity designated by the Secretary that, in addition to providing outpatient self--management training services, provides other items and services for which payment may be made under title XVIII of the Act, and meets certain quality standards.

We designated all providers and suppliers that bill Medicare for other individual services such as hospital outpatient departments, renal dialysis facilities, physicians and durable medical equipment suppliers, as eligible to be certified providers. All suppliers/providers who may bill for other Medicare services or items and who represent a DSMT program that is accredited as meeting quality standards can bill and receive payment for the entire DSMT program.

Registered dietitians are eligible to bill on behalf of an entire DSMT program on or after January 1, 2002, if the provider employing or contracting with the dietitian has obtained a Medicare provider number. A dietitian may not be the sole practitioner of the DSMT service.[156] Under our regulations at § 410.144(a)(4)(ii), there is an exception for dietitians working in rural areas. In a rural area, an individual who is qualified as a registered dietitian and as a certified diabetic educator who is currently certified by an organization approved by us may furnish training and is deemed to meet the multidisciplinary team requirement. DSMT requirements for coverage, beneficiary eligibility, services and frequency of services and provider certification and accreditation are codified in 42 CFR 410 subpart H and the National Coverage Determination (NCD) 40.1.[157]

Section 1861(s)(2)(V) of the Act authorizes Medicare Part B coverage of MNT for certain beneficiaries who have diabetes or a renal disease. Regulations for MNT were established

---

[156] *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/b02062.pdf.*

[157] *https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=251&ncdver=1&keyword=DSMT&keywordType=starts&areaId=all&docType=NCA,CAL,NCD,MEDCAC,TA,MCD,6,3,5,1,F,P&contractOption=all&sortBy=relevance&bc=1.*

effective January 1, 2002, at 42 CFR 410 subpart G (66 FR 55246 and 55331). An NCD establishes the duration and frequency limits for the MNT benefit and coordinates MNT and DSMT.[158] MNT services are defined in section 1861(vv) of the Act as nutritional diagnostic, therapeutic, and counseling services provided by a registered dietitian or nutrition professional for the purpose of managing diabetes or a renal disease under a referral by a physician. The provider qualifications for registered dieticians and nutrition professionals are defined in § 410.134.

Effective January 1, 2022, coverage of MNT, for the first year a beneficiary receives MNT, with either a diagnosis of renal disease or diabetes as defined at 42 CFR 410.130 is 3 hours of administration. Coverage in subsequent years for renal disease or diabetes is 2 hours. The dietitian/nutritionist may choose how many units are administered per day as long as all of the other requirements of the NCD and §§ 410.130 through 410.134 are met. Under the exception at § 410.132(b)(5), additional hours are considered to be medically necessary and covered if the physician determines that there is a change in medical condition, diagnosis, or treatment regimen that requires a change in MNT and orders additional hours during that episode of care. If the physician determines that receipt of both MNT and DSMT is medically necessary in the same episode of care, Medicare will cover both DSMT and MNT initial and subsequent years without decreasing either benefit as long as DSMT and MNT are not provided on the same date of service.

Section 5114 of the Deficit Reduction Act of 2005 amended section 1861(aa)(3) of the Act to add DSMT and MNT services as covered and paid under the FQHC benefit, effective January 1, 2006. Then the Affordable Care Act further expanded the scope of FQHC services to include preventive services defined under section 1861(ddd)(3) of the Act, however, RHCs were not similarly addressed. Under this statutory authority, DSMT and MNT services furnished by certified providers are stand-alone billable visits in FQHCs when all of the requirements are met.

---

[158] *https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=252*.

If DSMT or MNT services are provided on the same day as another qualified visit, the FQHC is paid for one visit, and the charges associated with DSMT or MNT are waived from coinsurance obligations (79 FR 25447). We note, group DSMT is not payable in FQHCs because Medicare payment is limited to individual, face-to-face encounters under the FQHC PPS, and group training does not meet the definition of a billable visit.

For RHCs, DSMT services and MNT services rendered by registered dietitians or nutrition professionals are included under the RHC benefit, if all relevant program requirements are met. Separate payment under Part B to RHCs for these services provided by these practitioners is precluded as set forth in regulations at §§ 414.63 and 414.64. However, RHCs are permitted to become certified providers of DSMT and MNT services and bundle the cost of such services into their clinic payment rates. The provision of these services would not generate an RHC visit, though their costs may be included in the cost report and used for determining the AIR. [159] Consequently, RHCs are not paid for encounters where only DSMT or MNT services are provided.

For several years, interested parties have expressed concern about access to DSMT and MNT services in RHCs. Commenters stated that because these are preventive services, not treating these services as a separate encounter is impacting access to care for rural beneficiaries. They state that there are additional concerns regarding the payment for DSMT and MNT services between RHCs and FQHCs and rural interested parties have requested aligning payment for these services. They believe that we should recognize DSMT and MNT services as a qualified visit for RHCs when these services are provided by a certified provider and all the requirements are met. They believe that the utilization rate is low for beneficiaries receiving care in RHCs and explained that if we allow RHCs to receive payment for furnishing DSMT and MNT services, then this rate may increase.

Recent studies highlight a continued need for DSMT and MNT services in rural areas,

---

[159] *https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/a03021.pdf.*

driven by rising diabetes prevalence and significant access disparities. Some of the barriers identified for people living in rural communities, especially for getting access to diabetes education and prevention programs, include limited number of providers, longer distance to medical facilities, higher costs, outdated cultural beliefs, lack of transportation, and limited community resources. More efforts to reduce these barriers may help reduce the overall high burden of diabetes in the rural US.[160] The necessity of DSMT and MNT in rural areas is supported by findings such that, they are clinically essential, diabetes control is improved, complications are reduced, lower costs, rural populations have equal or greater need, there are higher diabetes burden (widely established in rural health literature), access is systematically worse in rural areas, there are fewer providers, geographic maldistribution, and lower utilization despite need. Therefore, expanding DSMT and MNT in rural areas is not just beneficial, it is necessary to address documented health differences in access and outcomes.[161] In addition, we have observed that utilization for these services is low in rural settings. That is, an analysis of Medicare claims data from 2024 indicate that utilization of DSMT and MNT in RHC settings is substantially lower than in comparable care settings. In CY 2024, DSMT services were furnished to approximately 125 RHC beneficiaries, representing 0.005 percent of the total RHC beneficiary population of approximately 2.3 million. MNT services were furnished to approximately 439 RHC beneficiaries, representing 0.019 percent of the total RHC beneficiary population. On a claims basis, DSMT accounted for 0.002 percent and MNT for 0.007 percent of total RHC claims in CY 2024. By comparison, FQHCs, showed DSMT utilization rates approximately 22 times higher and MNT utilization rates approximately 28 times higher than RHCs on a per-beneficiary basis. On a claim basis, FQHC utilization of DSMT and MNT exceeded RHC utilization by approximately 31 times and 32 times, respectively. Rural physician offices, which

---

[160] Khavjou O, Tayebali Z, Cho P, Myers K, Zhang P. Rural-Urban Disparities in State-Level Diabetes Prevalence Among US Adults, 2021. Prev Chronic Dis. 2025 Jan 16;22:E05. doi: 10.5888/pcd22.240199. PMID: 39819894; PMCID: PMC11870018.

[161] Rhudy, C., Schadler, A., & Talbert, J. C. (2020). *Rural/urban disparities in utilization of diabetes self-management training to the fee-for-service Medicare population.* Rural and Underserved Health Research Center, University of Kentucky.

share the geographic and demographic characteristics of RHC patient populations, showed DSMT and MNT utilization rates approximately 17 times and 7 times higher than RHCs, respectively, on a per-beneficiary basis. The analysis further demonstrated that within the PFS setting where DSMT and MNT are most readily identifiable in claims data, these services represent a very small share of total Medicare spending — less than 0.01 percent and 0.02 percent of total PFS line payments, respectively, in CY 2024. This could suggest that beneficiaries receiving care in RHCs may have disproportionately lower participation due to potential provider shortages and structural payment barriers when compared to other settings of care. participation due to potential provider shortages and structural payment barriers when compared to other settings of care.

As such, we believe that we should attempt to align access and payment for RHCs and FQHCs to the extent possible, given the statutory differences in benefit design between the two settings of care. Because DSMT and MNT are affirmatively covered Medicare Part B benefits under sections 1861(s)(2)(S) and 1861(s)(2)(V) of the Act, respectively, and are defined under sections 1861(qq) and 1861(vv) of the Act, there is a compelling basis for ensuring these clinically essential services are payable under the RHC benefit. Continuing to exclude these services from RHC payment limits access for rural Medicare beneficiaries and would be inconsistent with both the statutory coverage framework and the foundational purpose of the RHC program. Reducing differences between RHCs and other settings in which DSMT and MNT are furnished and paid, such as in FQHCs and physician office, may help expand access to care for Medicare beneficiaries in rural areas. This policy would strengthen access to services that address chronic conditions prevalent among Medicare beneficiaries which are significant drivers of program expenditures.

Since DSMT and MNT services may be furnished by certified providers other than RHC practitioners as defined in §§ 410.141 and 410.134, respectively, these services could be furnished by certified providers under the direct supervision of an RHC practitioner. Direct

supervision does not require the physician (or other supervising practitioner) to be present in the same room. However, the physician (or other supervising practitioner) must be in the RHC or FQHC and immediately available to provide assistance and direction throughout the time the incident to service or supply is being furnished. See definitions at § 405.2401(b) "Direct Supervision."

We propose to recognize DSMT and MNT services as qualified preventive services that are covered and paid the AIR as stand-alone billable visits under the RHC benefit. To constitute as a billable RHC visit, these services would need to be furnished by a certified provider under the direct supervision of RHC professional staff. We believe aligning payment policies in RHCs with other settings, for example FQHCs and physician offices, would help expand access to care for Medicare beneficiaries in rural areas while supporting Federal initiatives to strengthen rural healthcare. As such, we are proposing to revise § 405.2463(a) and (b)(2) to allow DSMT and MNT services to be stand-alone billable visits in RHCs. Similar to FQHCs, when DSMT or MNT is furnished on the same day as another qualified visit, the RHC would be paid one AIR for that encounter. We consider these policies to align an incongruency between FQHC and RHC access to preventive services and do not expect in future rulemaking to propose additional preventive services beyond which are currently paid for in FQHCs and physician offices. We invite public comments on these proposals.

3. Services Furnished Using Telecommunication Technology

a. Background

Section 3704 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) (Pub. L. 116-136, March 27, 2020) directed the Secretary to establish payment for RHC and FQHC services that are provided as Medicare telehealth services by RHCs and FQHCs serving as a distant site (that is, where the practitioner is located) during the PHE for COVID-19. Specifically, section 1834(m)(8)(B) of the Act, as added by section 3704 of the CARES Act, required that, for the duration of the PHE for COVID-19, the Secretary develop and implement

payment methods for FQHCs and RHCs that serve as a distant site. The payment methodology outlined in the CARES Act requires that rates be based on rates that are similar to the national average payment rates for comparable telehealth services under the Medicare PFS. Accordingly, we established payment rates for these services furnished by RHCs and FQHCs based on the average PFS payment amount for all Medicare telehealth services, weighted by volume in a Special Edition Medicare Learning Network Article (SE20016). Congress has extended this payment flexibility beyond the PHE for COVID-19 through a series of statutory amendments, most recently under section 6209(c) of the CAA, 2026, which extended this payment flexibility through December 31, 2027.

We codified this payment policy at 42 CFR 405.2464(g). As amended in the CY 2025 PFS final rule (89 FR 98554), § 405.2464(g) states that for an encounter furnished using interactive, real-time, audio/visual telecommunications technology or for certain audio-only interactions in cases where the patient is not capable of, or does not consent to, the use of video technology services that are not described in § 405.2463(b)(3), payment to RHCs and FQHCs are subject to the national average payment rates for comparable services under the PFS and costs associated with these services shall not be used in determining payments under the RHC all-inclusive rate or the FQHC prospective payment system.

In the CY 2022 PFS final rule (86 FR 65210 and 65211), we revised payment for mental health visits in RHCs and FQHCs furnished via interactive, real-time, audio/visual or audio-only telecommunications technology. Instead of paying for these services under the national average payment rates for comparable services under the PFS, as is done for non-behavioral health services, we amended the regulation at § 405.2463 to permit mental health visits in RHCs and FQHCs furnished via audio/visual or audio-only telecommunication to be paid under the RHC AIR and FQHC PPS rates. In addition, to align with the Medicare telehealth statutory requirements for mental health services, we finalized at §§ 405.2463(b)(3) and 405.2469(d) that there must be an in-person mental health service furnished within 6 months prior to the

furnishing of the telecommunications service and that an in-person mental health service (without the use of telecommunications technology) must be provided at least every 12 months while the beneficiary is receiving services furnished via telecommunications technology for diagnosis, evaluation, or treatment of mental health disorders, unless, for a particular 12-month period, the physician or practitioner and patient agree that the risks and burdens outweigh the benefits associated with furnishing the in-person item or service, and the practitioner documents the reasons for this decision in the patient's medical record.

However, beginning with section 304 of the Consolidated Appropriations Act, 2022 (CAA, 2022) (Pub. L. 117–103, March 15, 2022), the in-person visit requirements for mental health visits were delayed. These requirements were further delayed through various laws that included extension of the telehealth flexibilities. Following the publication of the CY 2026 PFS final rule, section 6208 of the Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026 (Pub. L. 119-37, November 12, 2025) extended the delay until January 30, 2026. Most recently, section 6209(d) of the CAA, 2026 extended the abeyance of the RHC/FQHC mental health in-person requirements through December 31, 2027.

b. Proposal for Conforming Regulatory Text Changes

Because section 6209(c) of the CAA, 2026 extended authority for CMS to pay for FQHC and RHC non-behavioral health telecommunication technology services as Medicare telehealth services, we are not proposing any modifications for this provision to § 405.2464(g).

Because section 6209(d) of the CAA, 2026 extended the abeyance of the RHC and FQHC mental health in-person requirements through December 31, 2027, we are proposing to make conforming regulatory text changes at §§ 405.2463(b)(3) and 405.2469(d). This provision, as proposed, would require that the in-person visit requirements not apply to any services furnished through December 31, 2027.

4. Proposed CY 2027 FQHC PPS Market Basket Update

Section 1834(o)(2)(B)(ii) of the Act requires the FQHC PPS base rate be updated annually by the percentage increase in a market basket of Federally qualified health center goods and services as issued through regulations, or if such an index is not available, by the percentage increase in the MEI (as defined in section 1842(i)(3) of the Act) for the year involved. For CY 2027 (that is, January 1, 2027, through December 31, 2027), we propose to use an estimate of the percentage increase in the 2022-based FQHC market basket to update payments to FQHCs based on the best available data. Consistent with CMS practice, we propose to use the update based on the most recent historical data available at the time of publication of the final rule. For example, the final CY 2027 FQHC update would be based on the four-quarter moving-average percent change of the 2022-based FQHC market basket through the second quarter of 2026 (based on the final rule's statutory publication schedule). At the time of this proposed rule, we do not have the second quarter of 2026 historical data, and therefore, the proposed CY 2027 FQHC update is based on the most recent projection available at this time. As finalized in the CY 2025 final rule (89 FR 98032), a productivity adjustment is included in the 2022-based FQHC market basket.

For CY 2027, we propose to update the CY 2026 FQHC PPS base rate by the historical percentage increase through the second quarter of 2026 of the productivity-adjusted FQHC market basket (which we refer to as the FQHC market basket update). For CY 2027, the proposed FQHC market basket update is estimated to be 2.5 percent and is based on the expected historical percentage increase of the productivity-adjusted 2022-based FQHC market basket (referred to as the FQHC market basket update). Multiplying the CY 2026 FQHC PPS base rate amount of $207.72 by the proposed CY 2027 FQHC market basket update of 2.5 percent ($207.72 x 1.025) results in a proposed CY 2027 FQHC PPS base rate amount of $212.91. For the final rule, we propose that the CY 2027 market basket update and the productivity adjustment will be updated to reflect historical data through the 2nd quarter of 2026.

5. Proposed Technical Changes

a. Section 405.2464(b)(1) and (2)

We propose revisions at § 405.2464(b)(1) and (2) to correct the references within these paragraphs so that they reference the appropriate paragraph or sections under subpart X of part 405. We propose to revise § 405.2464(b)(1) by replacing "paragraphs (d) and (e)" with "paragraphs (c) and (h)" since the payment discussed under these paragraphs are not based on the FQHC PPS per diem rate. We propose to revise § 405.2464(b)(2)(i) and (ii) to reference § 405.2462(e). This reference should have been revised when we redesignated this section in the CY 2022 PFS final rule (86 FR 65660).

b. § 405.2464(g)

In the CY 2025 PFS final rule (89 FR 98015 through 98017) we discussed medical visit services furnished via telecommunications technology. We revised § 405.2464 by adding new paragraph (g) to reflect our payment policy for these services. That is, for non-behavioral health services, an encounter furnished using telecommunications technology, payment to RHCs and FQHCs are subject to the national average payment rates for comparable services under the PFS and costs associated with these services shall not be used in determining payments under the RHC AIR or the FQHC PPS. During a recent review of our regulation, we noticed that we inadvertently used the term "an encounter" instead of "services." We are proposing to revise § 405.2464(g) to be consistent with the authority under section 1834(m)(8) of the Act.

c. Section 405.2469(d)

In the CY 2022 PFS final rule (86 FR 65210 and 65211), we explained that § 405.2469(d) was revised to describe the same in-person mental health visit requirement applicable under § 405.2463. In subsequent PFS rulemaking, as discussed previously in this section, we described revisions to both provisions as technical changes intended solely to conform the regulations to the applicable statutory delay of the in-person requirement. Because the current text of § 405.2469(d) separately restates the technology modalities and in-person requirement language, it creates an unnecessary risk of divergence from § 405.2463(b)(3). Accordingly, we propose to revise the regulatory text at § 405.2469(d) to align the description of

permissible telecommunications modalities with the language used in § 405.2463. Specifically, § 405.2469(d) currently refers to audio-only interactions in cases where beneficiaries do not wish to use, or do not have access to, devices that permit two-way, audio/video communication. In contrast, § 405.2463 permits the use of audio-only interactions in cases where the patient is not capable of, or does not consent to, the use of video technology. To ensure consistency across these provisions we are proposing to revise the descriptions to match what is described at § 405.2463, namely that the use of audio-only interactions is permissible in cases where the patient is not capable of, or does not consent to, the use of video technology. We are also proposing to revise § 405.2469(d) to align the description of the in-person visit requirement for mental health services with the requirements set forth in § 405.2463(b)(3). We believe that these amendment are non-substantive and clarifying because they do not alter payment policy; they merely align duplicative regulatory text and eliminate any potential internal inconsistency.

C. Clinical Laboratory Fee Schedule (CLFS): Consolidated Appropriations Act (CAA), 2026

1. Background on the Clinical Laboratory Fee Schedule

Prior to January 1, 2018, Medicare paid for clinical diagnostic laboratory tests (CDLTs) on the Clinical Laboratory Fee Schedule (CLFS) under section 1833(a), (b), and (h) of the Act. Under the previous payment system, CDLTs were paid based on the lesser of: (1) the amount billed; (2) the local fee schedule amount established by the Medicare Administrative Contractor (MAC); or (3) a national limitation amount (NLA), which is a percentage of the median of all the local fee schedule amounts (or 100 percent of the median for new tests furnished on or after January 1, 2001). In practice, most tests were paid at the NLA. Under the previous payment system, the CLFS amounts were updated for inflation based on the percentage change in the Consumer Price Index for All Urban Consumers (CPI-U), and reduced by a productivity adjustment and other statutory adjustments, but were not otherwise updated or changed. Coinsurance and deductibles generally do not apply to CDLTs paid under the CLFS.

Section 1834A of the Act, as established by section 216(a) of the Protecting Access to Medicare Act of 2014 (PAMA), required significant changes to how Medicare pays for CDLTs under the CLFS. In a final rule that appeared in the June 23, 2016 **Federal Register** (81 FR 41036)**,** entitled Medicare Clinical Diagnostic Laboratory Tests Payment System (hereinafter referred to as the CLFS final rule), we established requirements to implement section 1834A of the Act at 42 CFR part 414, subpart G.

Under the CLFS final rule, "reporting entities" must report to CMS during a "data reporting period" "applicable information" collected during a "data collection period" for their component "applicable laboratories." The first data collection period occurred from January 1, 2016, through June 30, 2016. The first data reporting period occurred from January 1, 2017, through March 31, 2017. On March 30, 2017, we announced a 60-day period of enforcement discretion for the application of the Secretary's potential assessment of civil

monetary penalties for failure to report applicable information with respect to the initial data reporting period.[162]

In the CY 2018 PFS proposed rule (82 FR 34089 through 34090), we solicited public comments from applicable laboratories and reporting entities to better understand the applicable laboratories' experiences with data reporting, data collection, and other compliance requirements for the first data collection and reporting periods. We discussed these comments in the CY 2018 PFS final rule (82 FR 53181 through 53182) and stated that we would consider the comments for potential future rulemaking or guidance.

As part of the CY 2019 Medicare PFS rulemaking, we finalized two changes to the definition of "applicable laboratory" at § 414.502 (see 83 FR 59667 through 59681, 60074; 83 FR 35849 through 35850, 35855 through 35862). First, we excluded Medicare Advantage plan payments under Part C from the denominator of the Medicare revenues threshold calculation to broaden the types of laboratories qualifying as an applicable laboratory. Second, consistent with our goal of obtaining a broader representation of laboratories that could potentially qualify as an applicable laboratory and report data, we also amended the definition of applicable laboratory to include hospital outreach laboratories that bill Medicare Part B using the CMS-1450 14x Type of Bill.

2. Payment Requirements for Clinical Diagnostic Laboratory Tests

In general, under section 1834A of the Act, the payment amount for each CDLT on the CLFS furnished beginning January 1, 2018, is based on the applicable information collected during the data collection period and reported to CMS during the data reporting period and is equal to the weighted median of the private payor rates for the test. The weighted median is calculated by arraying the distribution of all private payor rates, weighted by the volume for each payor and each laboratory. The payment amounts established under the CLFS are not subject to

---

[162] *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/2017-March-Announcement.pdf*.

any other adjustment, such as geographic, budget neutrality, or annual update, as required by section 1834A(b)(4)(B) of the Act. Additionally, section 1834A(b)(3) of the Act, implemented at § 414.507(d), provides for a phase-in of payment reductions, limiting the amounts the CLFS rates for each CDLT (that is not a new advanced diagnostic laboratory test (ADLT) or new CDLT) can be reduced as compared to the payment rates for the preceding year. Under the original provisions enacted by section 216(a) of PAMA, for the first 3 years after implementation (CY 2018 through CY 2020), the reduction could not be more than 10 percent per year. For the next 3 years after implementation (CY 2021 through CY 2023), section 216(a) of PAMA stated that the reduction could not be more than 15 percent per year. Under sections 1834A(a)(1) and (b) of the Act, as enacted by PAMA, for CDLTs that are not ADLTs, the data collection period, data reporting period, and payment rate update were to occur every 3 years. As such, the second data collection period for CDLTs that are not ADLTs was originally scheduled to take place from January 1, 2019, through June 30, 2019, and the next data reporting period was originally scheduled to take place from January 1, 2020, through March 31, 2020, with the next update to the Medicare payment rates for those tests based on that reported applicable information scheduled to take effect on January 1, 2021.

Section 216(a) of PAMA established a new subcategory of CDLTs known as ADLTs, with separate reporting and payment requirements under section 1834A of the Act. The definition of an ADLT is set forth in section 1834A(d)(5) of the Act and implemented at § 414.502. Generally, under section 1834A(d) of the Act, the Medicare payment rate for a new ADLT is equal to its actual list charge during an initial period of 3 calendar quarters. After the new ADLT initial period, ADLTs are paid using the same methodology based on the weighted median of private payor rates as other CDLTs. However, under section 1834A(d)(3) of the Act, updates to the Medicare payment rates for ADLTs occur annually instead of every 3 years.

Additional information on the private payor rate-based CLFS is detailed in the CLFS final rule (81 FR 41036 through 41101) and is available on the CMS website.[163]

3. Previous Statutory Revisions to the Data Reporting Period and Phase-In of Payment Reductions

Beginning in 2019, Congress repeatedly extended the data reporting periods for CDLTs that are not ADLTs and revised the phase-in of CLFS payment reductions through multiple laws, including: section 105 of the Further Consolidated Appropriations Act, 2020 (FCAA) (Pub. L. 116-94, December 20, 2019); section 3718 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) (Pub. L. 116-136, March 27, 2020); section 4 of the Protecting Medicare and American Farmers from Sequester Cuts Act (PMAFSCA) (Pub. L. 117-71, December 10, 2021); section 4114 of the Consolidated Appropriations Act, 2023 (CAA, 2023) (Pub. L. 117-328, December 29, 2022); section 502 of the Further Continuing Appropriations and Other Extensions Act, 2024 (FCAOEA, 2024) (Pub. L. 118-22, November 17, 2023); and section 221 of the Continuing Appropriations and Extensions Act, 2025 (CAEA, 2025) (Pub. L. 118-83, September 26, 2024). For a detailed discussion of these statutory revisions, please see the CY 2025 PFS final rule (89 FR 98038 through 98043) and the prior PFS rules referenced in the CY 2025 discussion.

4. Additional Statutory Revisions to the Data Reporting Period, Phase-In of Payment Reductions and Data Collection Period

Section 6209 of the Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026 (Pub. L. 119-37, enacted November 12, 2025) made further revisions to the CLFS requirements for the next data reporting period for CDLTs that are not ADLTs and to the phase-in of payment reductions under section 1834A of the Act. Specifically, section 6209(b) of the Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026

[163] *https://www.cms.gov/medicare/payment/fee-schedules/clinical-laboratory-fee-schedule/clfs-history.*

delayed the next data reporting period for CDLTs that are not ADLTs so that reporting would be required during the period of February 1, 2026 through April 30, 2026, instead of the data reporting period of January 1, 2025, through March 31, 2025 established under the FCAOEA, 2024.

Section 6209 of the Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026 did not modify the data collection period that applies to the next data reporting period for these tests. Thus, under section 1834A(a)(4)(B) of the Act, as amended by section 105(a)(1) of the FCAA, the next data reporting period for CDLTs that are not ADLTs (February 1, 2026, through April 30, 2026) continued to be based on the data collection period of January 1, 2019, through June 30, 2019, as defined in § 414.502.

Section 6209(a) of the Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026 amended the provisions in section 1834A(b)(3) of the Act regarding the phase-in of payment reductions under the CLFS. First, it extended the statutory phase-in of payment reductions resulting from private payor rate implementation by an additional year, that is, through CY 2029. It further amended section 1834A(b)(3)(B)(ii) of the Act to specify that the applicable percent for CY 2026 was 0 percent, meaning that the payment amount determined for a CDLT for CY 2026 shall not result in any reduction in payment as compared to the payment amount for that test for CY 2025. Section 6209(b) of this law further amended section 1834A(b)(3)(B)(iii) of the Act to state that the applicable percent of 15 percent would apply for CYs 2026 (January 31, 2026 through December 31, 2026), 2027, and 2028.

Most recently, section 6226 of the Consolidated Appropriations Act, 2026 (CAA, 2026) (Pub. L. 119-75, February 3, 2026) amended section 1834A of the Act to revise the data reporting period, data collection period, and requirements for the phase-in of payment reductions. Specifically, section 6226 of the CAA, 2026 revised the next required data reporting

period for CDLTs that are not ADLTs to be May 1, 2026, through July 31, 2026, and specified that the applicable data collection period is January 1, 2025, through June 30, 2025.

Section 6226 of the CAA, 2026 also amended section 1834A(b)(3) of the Act to specify that the applicable percent was 0 percent for all of CY 2026, meaning that the payment amount determined for a CDLT for CY 2026 shall not result in any reduction in payment as compared to the payment amount for that test for CY 2025, and to extend the statutory phase-in of payment reductions resulting from private payor rate implementation by an additional year, that is, through CY 2029. Therefore, the applicable percent of up to 15 percent would apply for CYs 2027 through 2029. Section 6226 of the CAA, 2026 further provided that, notwithstanding any other provision of law, the Secretary may implement the amendments made by this section by program instruction or otherwise.

5. Proposed Conforming Regulatory Changes

In accordance with section 6226 of the CAA, 2026, we are proposing to make certain conforming changes to the data reporting and payment requirements at 42 CFR part 414, subpart G. Specifically, we are proposing to revise § 414.502 to update the definitions of both the "data collection period" and "data reporting period," specifying that the data collection period is the 6-month period from January 1 through June 30, during which applicable information is collected and that precedes the data reporting period, and that the data reporting period for CDLTs that are not ADLTs is the 3-month period, May 1 through July 31, and for ADLTs is the 3-month period, January 1 through March 31, during which a reporting entity reports applicable information to CMS and that follows the preceding data collection period. We are also proposing to revise § 414.504(a)(1) to indicate that initially, data reporting begins January 1, 2017, and is required every 3 years beginning May 1, 2026. In addition, we are proposing to make conforming changes to our requirements for the phase-in of payment reductions to reflect the amendments in section 6226 of the CAA, 2026. Specifically, we are proposing to revise § 414.507(d) to indicate that for CY 2026, payment may not be reduced by more than 0.0 percent as compared to the

amount established for CY 2025, and for CYs 2027 through 2029, payment may not be reduced by more than 15 percent as compared to the amount established for the preceding year.

We note that the CYs 2018 through 2026 CLFS payment rates for CDLTs that are not ADLTs are based on applicable information collected in the data collection period of January 1, 2016 through June 30, 2016. Under current law, the CLFS payment rates for those tests for CY 2027 through CY 2029 will be based on applicable information collected during the data collection period of January 1, 2025 through June 30, 2025, and reported to CMS during the data reporting period of May 1, 2026 through July 31, 2026.

6. Technical Correction (§ 414.523(a)(1))

a. Background

Section 1833(h)(3)(A) of the Act generally requires the Secretary to provide for and establish a nominal fee to cover the appropriate costs in collecting the sample on which a CDLT was performed and for which Medicare payment is made, in addition to the amounts provided under the Medicare CLFS. In addition, section 1834A(b)(5) of the Act requires that, when the sample is collected from an individual in a skilled nursing facility (SNF) or by a laboratory on behalf of a home health agency (HHA), the otherwise applicable nominal specimen collection fee be increased by $2.00.

In the CY 2023 PFS final rule (87 FR 69744 through 69760), we finalized a policy to codify specimen collection fee provisions at § 414.523(a)(1), including updating the base specimen collection fee amount and establishing an annual CPI–U update. In that rulemaking, we also stated that the statutory $2.00 increase for specimens collected from a Medicare beneficiary in a SNF or by a laboratory on behalf of an HHA would continue to apply, consistent with section 1834A(b)(5) of the Act. However, due to a drafting or codification error, the operative regulatory text implementing this increase in the CY 2023 PFS final rule (87 FR 70225 through 70226) was not fully included in § 414.523(a)(1), and only a partial introductory clause remains in paragraph (a)(1)(v). Specifically, the introductory text to § 414.523(a)(1) states that

payment is made "[e]xcept as provided in paragraph (a)(1)(v)," but § 414.523(a)(1)(v), as codified, consists only of the fragment: "For a specimen collected from a Medicare beneficiary." This text is incomplete and does not contain operative language establishing an exception or alternative payment methodology. In addition, other provisions within § 414.523(a)(1), including paragraph (a)(1)(ii), already specify that the specimen must be collected from a Medicare beneficiary, creating an apparent internal inconsistency when read together with the introductory exception clause.

b. Proposed Technical Correction

To resolve this internal inconsistency and accurately reflect the statutory provisions and longstanding policy, we are proposing to revise § 414.523(a)(1) to restore the complete and operative language implementing the statutory $2.00 increase. That is, we propose revising § 414.523(a)(1)(v) to state that for a specimen collected from a Medicare beneficiary in a skilled nursing facility or on behalf of a home health agency, the specimen collection fee otherwise paid under paragraph (a)(1) of this section is increased by $2.00.

We do not believe that this proposal reflects a substantive policy change. In the CY 2023 PFS proposed rule (87 FR 46043), we proposed to codify existing specimen collection fee policies and to incorporate the statutory $2.00 increase for SNF and HHA collections into § 414.523(a)(1) as a discrete paragraph. Specifically, we proposed that, beginning April 1, 2014, for a specimen collected from a Medicare beneficiary in a SNF or on behalf of an HHA, the specimen collection fee otherwise paid under § 414.523(a)(1) would be increased by $2.00, consistent with section 1834A(b)(5) of the Act. In the CY 2023 PFS final rule (87 FR 69744 through 69760), we finalized policies consistent with this framework, including the continued application of the statutory $2.00 increase.

We note that it has been, and continues to be, CMS' policy to pay the specimen collection fee only for qualifying specimens collected from Medicare beneficiaries, and to apply the additional $2.00 increase for specimens collected from a Medicare beneficiary in a SNF or by a

laboratory on behalf of an HHA, as required by statute. We have consistently implemented this policy operationally through claims processing systems, subregulatory guidance, and annual payment updates.

D. Proposed Changes to the Ambulatory Specialty Model (ASM)

1. Executive Summary and Background

a. Executive Summary

(1) Purpose

We are proposing to make changes to the Ambulatory Specialty Model (ASM or model) effective on the model start date of January 1, 2027.

(2) Summary of Major Provisions

ASM is a mandatory alternative payment model tested by the CMS Center for Medicare and Medicaid Innovation (Innovation Center) under section 1115A of the Act. ASM will have 5 performance years that begin January 1, 2027 and end December 31, 2031 with performance-based payment adjustments occurring 2 calendar years (CYs) following the end of each ASM performance year.

We finalized ASM through notice-and-comment rulemaking in the Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program final rule (hereinafter "CY 2026 PFS final rule") (90 FR 49562 through 49720). However, based on the feedback we received after the publication of the CY 2026 PFS final rule and our own internal review, we are proposing several technical refinements and adjustments to the model. As described in detail in section III.D.2 of this proposed rule, we propose the following modifications:

- Revising select ASM definitions and adding new ASM definitions.
- Clarifying ASM participant exceptions from specified model requirements due to taxpayer identification number (TIN) changes before or during an ASM performance year.
- Excepting certain ASM heart failure participants from specified model requirements due to a redesignated specialty type.
- Incorporating an option to terminate ASM participants under certain circumstances.

- Incorporating an option for data submission for the improvement activities ASM performance category at either the individual or group level.
- Clarifying the scoring of multiple quality measure data submissions from ASM participants in small practices.
- Adding an administrative claims-based low back pain imaging quality measure and replacing the patient-reported outcome measure for low back pain with a functional status outcome process measure.
- Adjusting benchmarking and scoring policies for quality measures.
- Adding a quality ASM performance category scoring incentive for the voluntary submission of patient-reported outcome (PRO) data to support the development of patient-reported outcome performance-based measures (PRO-PM) under ASM.
- Revising requirements of the Promoting Interoperability ASM performance category to align with proposed changes to the Merit-based Incentive Payment System (MIPS) Promoting Interoperability performance category and adding a Promoting Interoperability measure suppression policy.
- Incorporating a rural scoring adjustment for ASM participants in rural areas.
- Revising the contents of the ASM performance report to include additional information related to scoring-related proposals in this proposed rule.
- Clarifying language on the application of ASM payment adjustments when an ASM participant reassigns billing rights to a new TIN during an ASM payment year.
- Clarifying the availability of the CMS-sponsored model arrangements and patient incentives safe harbor and applicability of programmatic waivers for ASM to reflect that such flexibilities are associated with active performance under ASM and would not be available or applicable during an ASM performance year in which an ASM participant is either ineligible for, or excepted from, specified model requirements.

- Revising provisions establishing collaborative care arrangement (CCA) requirements to improve clarity and update the permissible parties, remuneration conditions, documentation requirements, and compliance terms.

- Clarifying and reorganizing select regulatory text to improve readability and flow.

The proposals in this proposed rule reflect our commitment to ensuring ASM's incentives help drive quality of care improvements for beneficiaries and reductions in Medicare spending.

b. Background

(1) Statutory Authority

Section 1115A of the Act authorizes the Secretary to test innovative payment and service delivery models to reduce program expenditures under Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) while preserving or enhancing the quality of care furnished to beneficiaries. Under this authority, we may test models that modify payment methodologies, establish accountability for quality and cost outcomes, and incorporate financial risk arrangements. Under the authority of sections 1115A and 1871(a)(2) of the Act, through notice-and-comment rulemaking, we finalized ASM in the CY 2026 PFS final rule that appeared in the November 5, 2025, **Federal Register** (90 FR 49562 through 49720).

(2) Background

ASM will test whether holding physician specialists accountable for the quality and cost of care associated with the longitudinal management of specific chronic conditions, heart failure and low back pain, can reduce Medicare expenditures while preserving or enhancing quality of care for Original Medicare beneficiaries. Clinical decisions made by specialists in ambulatory settings can meaningfully influence disease progression as well as downstream utilization and spending. ASM's design, in its goal to reduce Medicare expenditures while preserving or enhancing the quality of care, aims to: (1) improve the management of chronic disease and slow disease progression through more effective risk assessment; (2) increase active collaboration between specialists and primary care providers, and (3) reduce avoidable hospitalizations and

low-value procedures (that is, procedures that provide little clinical benefit or the risk of harm outweighs its potential benefit).

In developing ASM, we considered specialist-managed conditions that often require ongoing outpatient management, diagnostic evaluation, medication management, coordination by specialists with other clinicians across different care settings, and, in some cases, procedural or surgical intervention (90 FR 49562 through 49564). Based on these factors, ASM selects individual specialists who manage one of two ASM targeted chronic conditions, heart failure or low back pain. As we designed ASM's participation criteria and performance evaluation framework to cover multiple conditions and associated specialists, we continue to explore whether including additional conditions and specialists would be appropriate.

Our goal with the model test is to select specialists who have a meaningful level of engagement in the care of Original Medicare beneficiaries with ASM targeted chronic conditions as ASM participants. Under the provisions finalized in the CY 2026 PFS final rule (90 FR 49571 through 49596), we select ASM participants by a combination of a TIN and a National Provider Identifier (NPI). ASM participants are clinicians who meet four ASM participant eligibility criteria: (1) bill claims under the Medicare Physician Fee Schedule, (2) have a selected physician specialty type relevant to an ASM targeted chronic condition, (3) meet a historical volume threshold of condition-specific episode-based cost measure (EBCM) episodes, and (4) have a service location in a selected mandatory geographic area (that is, selected Core-Based Statistical Areas (CBSAs) and metropolitan divisions). ASM heart failure participants include cardiologists, and ASM low back pain participants include physicians with specialty types of anesthesiology, interventional pain management, neurosurgery, orthopedic surgery, pain management, and physical medicine and rehabilitation.

ASM evaluates ASM participants across four ASM performance categories: quality, cost, improvement activities, and Promoting Interoperability. The evaluation of ASM participant performance leverages the MIPS Value Pathways (MVP) framework, which utilizes a cohesive

set of measures and activities focused on performance in furnishing care for a particular specialty or clinical condition. ASM participants must meet each ASM performance category's requirements and report required data. We use data reported by ASM participants and other administrative data, such as inputs gathered from claims, to evaluate each ASM participant's performance on an annual basis. We determine a composite final score for each ASM participant based on performance across the four ASM performance categories and adjust final scores to account for beneficiary medical and social complexity as well as practice size.

Based on performance relative to other specialists treating the same ASM targeted chronic condition in an ASM cohort, ASM participants will receive a positive, neutral, or negative payment adjustment on all Medicare Part B claims for covered professional services during the CY 2 years following the applicable ASM performance year (for example, performance during the 2027 ASM performance year results in the application of ASM payment adjustments during the 2029 ASM payment year). Payment adjustments will range from negative 9 percent to positive 9 percent in the first 2 ASM payment years, gradually increasing to 12 percent in the final ASM payment year.

We refer readers to the CY 2026 PFS final rule (90 FR 49562 through 49720) and ASM's provisions at 42 CFR part 512, subpart G, for additional information on all finalized provisions.

2. Proposed Changes to Provisions of the Ambulatory Specialty Model (ASM)

a. Definitions

In the CY 2026 PFS final rule, we finalized certain terms for ASM. We described these finalized definitions in context throughout section III.C.2 of the CY 2026 PFS final rule and codified them at § 512.705 (90 FR 49569).

After internal review of ASM's provisions, we believe minor modifications to select definitions would improve the readability and overall clarity of ASM's provisions.

Accordingly, we propose at § 512.705 to modify the definition of "ASM beneficiary" to clarify this term means a Medicare FFS beneficiary who is being treated by an ASM participant

for an ASM targeted chronic condition. We believe this edit would improve the precision of the definition by using the finalized definition of "ASM targeted chronic condition" that is used throughout ASM's provisions, rather than just "targeted chronic condition" as the definition currently reads.

We also propose to revise the definition of "Dual eligible proportion" at § 512.705 for clarity. Specifically, we propose to clarify that the definition of "Dual eligible proportion" means "the share of an ASM participant's beneficiaries who are dually eligible Medicare beneficiaries". This revision would more clearly refer to an ASM participant.

We refer readers to section III.D.2.f.(3) of this proposed rule for the proposed definition of "Rural area" as it is described in context of the proposed rural scoring adjustment.

We seek comment on the proposed revisions to the "ASM beneficiary" and "Dual eligible proportion" definitions at § 512.705.

b. Participation

(1) Background

As discussed in the CY 2026 PFS final rule (90 FR 49571 through 49596), we designed ASM with a focus on clinicians who commonly treat Original Medicare beneficiaries in an ambulatory setting, develop longitudinal relationships with patients, and co-manage beneficiaries with primary care providers (PCP). In addition, we believe clinicians who treat ASM targeted chronic conditions are well-positioned to benefit from improved integration between specialty and primary care, creating greater opportunities to incentivize high-value care and tertiary prevention.

We determined the model would assess quality of care provided at the individual clinician level, as identified by a combination of TIN and NPI, rather than at the level of a group practice or facility, with limited exceptions, to align accountability with individual clinical decision-making and to better capture variation in individual clinical practice patterns among clinicians within the same organization (90 FR 49574). As a result, each ASM participant is

individually responsible for meeting model requirements and is evaluated independently for the purposes of ASM performance category scoring, final scoring, and determining an ASM payment adjustment factor and corresponding ASM payment multiplier.

(2) Mandatory Participation

In the CY 2026 PFS final rule (90 FR 49571 through 49574), we finalized that once a clinician meets the ASM participant eligibility criteria and is selected as an ASM participant, they remain an ASM participant for the duration of the ASM test period. Once selected as an ASM participant, there may be circumstances where the ASM participant does not meet the ASM participant eligibility criteria for a specific ASM performance year. Accordingly, we developed a policy whereby an ASM participant is only subject to certain ASM requirements for the ASM performance year(s) in which they meet ASM participant eligibility criteria. We also finalized provisions that describe the effect of not meeting ASM participant eligibility criteria for an ASM performance year (90 FR 49571 through 49574). Specifically, under existing provisions, an ASM participant who does not meet ASM participant eligibility criteria for an ASM performance year is: (1) not subject to the requirements for performance assessment described at § 512.715, data submission described at § 512.720, and final scoring described at § 512.745; (2) not subject to payment adjustment described at § 512.750 for the corresponding ASM payment year; and (3) not eligible for Medicare program waivers described at § 512.775 provided under the model for the applicable ASM performance year

To clarify and better incorporate policies related to exceptions of specific ASM performance requirements and ASM participant terminations discussed later in this section of this proposed rule, we are proposing to revise our regulatory text describing mandatory ASM participation and the effects of not meeting ASM participant eligibility criteria for an ASM performance year.

Specifically, we propose at § 512.710(a)(1) that a clinician who we select as an ASM participant for at least one ASM performance year is considered an ASM participant for the

duration of the ASM test period unless we (1) terminate ASM in accordance with Standard Provisions for Mandatory Innovation Center Models described at § 512.165, or (2) terminate the ASM participant as described under proposed § 512.710(h). We believe this proposed revision is consistent with our original policy finalized in the CY 2026 PFS final rule describing that an ASM participant, once selected, remains an ASM participant for the ASM test period. Our proposal also incorporates the effect of a possible ASM participant termination, which we propose later in this section of this proposed rule.

We also propose to add a paragraph heading and revise § 512.710(a)(2) to clarify that this paragraph describes the effects of not meeting ASM participant eligibility criteria for an ASM performance year. We propose to move select regulatory text at current § 512.710(a)(2)(i) to § 512.710(a)(2) to improve readability and to incorporate new proposals on the effects of not meeting ASM participant eligibility criteria for an ASM performance year.

First, we propose to separate select regulatory text included in current § 512.710(a)(2)(i) into separate paragraphs by revising paragraph § 512.710(a)(2)(ii) and adding new paragraph § 512.710(a)(2)(iii). Under this proposal, § 512.710(a)(2)(i) would describe the specified model requirements that an ASM participant would not be required to meet for the applicable ASM performance year, § 512.710(a)(2)(ii) would describe the specific model requirements not applicable for the corresponding ASM payment year, and § 512.710(a)(2)(iii) would describe an ASM participant's ineligibility for waivers provided under the model for the applicable ASM performance year. These revisions do not introduce substantive changes to finalized provisions describing the effects of an ASM participant not meeting ASM participant eligibility criteria for an ASM performance year; rather, we believe such revisions help clarify that not meeting ASM participant eligibility criteria would not nullify the application of ASM payment adjustments on Medicare Part B claims for covered professional services during the corresponding ASM payment year based on performance in a prior ASM performance year. For example, a clinician may be selected for mandatory participation for the 2027 ASM performance year. If that ASM

participant does not meet the ASM participant eligibility criteria for the 2029 ASM performance year, the revisions here help clarify that while the ASM participant would not be subject to the applicable performance assessment, data reporting, and scoring requirements during the 2029 ASM performance year (that is, CY 2029), but that ASM payment adjustments based on the ASM participant's performance from the 2027 ASM performance year would still be applied in CY 2029.

Second, we propose at § 512.710(a)(2)(iv) that an ASM participant who does not meet ASM participant eligibility criteria for an ASM performance year would not be eligible for the CMS-sponsored model arrangements and patient incentives safe harbor described at § 512.765 for the applicable ASM performance year. We believe this proposal is consistent with our intent to make this safe harbor available for ASM performance years where the ASM participant is actively performing in the model (90 FR 49709). We refer readers to section III.D.2.h. of this proposed rule for further explanation of this proposal.

We seek comment on our proposed revisions to §§ 512.710(a)(1) and 512.710(a)(2).

(3) Specialty Type

Participation is limited to clinicians who are within specialties and furnish covered professional services related to ASM targeted chronic conditions—heart failure or low back pain. As finalized in the CY 2026 PFS final rule, we determine specialty type based on the specialty code most frequently reported on a clinician's Medicare Part B claims (90 FR 49583 through 49585). Medicare Administrative Contractors (MACs) derive specialty codes on claims from clinician-reported specialty types provided during Medicare enrollment. Physicians report their specialty type as part of their Medicare enrollment application through the Provider Enrollment, Chain, and Ownership System (PECOS) or through submission of the CMS 855I paper application.[164] The Medicare enrollment form is also used for revalidations and ad hoc changes to certain information. We use data from the CY 2 years prior to each ASM performance year to

[164] *https://www.cms.gov/medicare/cms-forms/cms-forms/cms-forms-items/cms019477*.

determine whether a clinician meets the model's specialty type criteria. For example, we use CY 2025 data, including specialty type data, to select final ASM participants for the 2027 ASM performance year.

For the ASM heart failure cohort, we finalized inclusion of physicians with a specialty type of cardiology. Our rationale for including cardiologists as ASM heart failure participants, as explained in the CY 2026 PFS final rule, is that they commonly provide care to Original Medicare beneficiaries with heart failure and are well-positioned to manage outcomes by ensuring patients are optimized on guideline-directed medical therapy to prevent exacerbation of their condition (90 FR 49576). We did not finalize the inclusion of other cardiac-related specialties (for example, cardiac electrophysiology, intensive cardiac rehabilitation, cardiac surgery, interventional cardiology, and advanced heart failure and transplant) as these clinicians are often proceduralists and not commonly involved in the longitudinal management of patients with heart failure (90 FR 49576). Because one of ASM's goals is to measure the performance of clinicians with similar patterns of heart failure care, we include cardiologists, but not other cardiac-related specialties, even though those cardiac-related specialists may be attributed patients with heart failure as measured through the heart failure EBCM (90 FR 49577).

For the ASM low back pain cohort, we finalized inclusion of physicians who have a specialty of anesthesiology, pain management, interventional pain management, neurosurgery, orthopedic surgery, or physical medicine and rehabilitation. In the CY 2026 PFS final rule (90 FR 49577 through 49580), we emphasized that specialty types for the ASM low back pain cohort include physicians who are most directly involved in the evaluation and management of low back pain and whose clinical decision-making is expected to meaningfully influence downstream utilization and spending. We explained that the included specialists commonly furnish services to Original Medicare beneficiaries with low back pain and play a central role in determining the use of imaging, injections, procedures, and surgical interventions. We also noted that we did not include certain other specialties that may occasionally treat low back pain but are

not typically responsible for its longitudinal management. By focusing on a defined set of specialties with similar roles in managing low back pain, we aim to support more meaningful comparisons of performance and to align model incentives with opportunities to improve care coordination, reduce unnecessary procedures, and promote evidence-based treatment.

We are not proposing any adjustments to the specialty types included in each ASM cohort as finalized at § 512.710(d) in the CY 2026 PFS final rule (90 FR 49576 through 49580). As part of this proposed rule, we are proposing to correct small typographical errors in the regulatory text at §§ 512.710(d)(1) and 512.710(d)(2). These revisions do not introduce substantive changes to existing provisions.

We seek comment on the proposed correction of the typographical errors at §§ 512.710(d)(1) and 512.710(d)(2).

(4) ASM Participant Exceptions

We recognize that there may be limited circumstances in which an ASM participant selected for participation for an ASM performance year should be excepted from certain ASM requirements for that ASM performance year and should consequently be excepted from the application of an ASM payment multiplier to the ASM participant's Medicare Part B payments for covered professional services during the corresponding ASM payment year. Accordingly, we finalized a narrow set of ASM participant "exclusions," or situations in which an ASM participant is excepted from specified ASM requirements in the CY 2026 PFS final rule to balance operational feasibility with the need for robust evaluation and generalizable findings (90 FR 49582 through 49583). As finalized at § 512.710(c), an ASM participant who stops reassigning billing rights to the TIN we used to select the ASM participant and begins reassigning billing rights to a new TIN during an ASM performance year is not subject to certain ASM requirements—specifically the requirements for performance assessment described at § 512.715, data submission described at § 512.720, final scoring described at § 512.745, and payment adjustment described at § 512.750—and is no longer eligible for Medicare program

waivers provided under the model described at § 512.775 for the applicable ASM performance year. An exception from specified ASM requirements for one ASM performance year does not apply for the entire ASM test period because we consider clinicians who meet ASM participant eligibility criteria for at least one ASM performance year to be an ASM participant for the remainder of the ASM test period. This means that an ASM participant will receive payment adjustments during a corresponding ASM payment year based on performance from an ASM performance year for which they were required to meet these specified ASM requirements (90 FR 49571 through 49574). In other words, if an ASM participant meets the ASM participant eligibility criteria for the 2027 and 2028 ASM performance years, but not the 2029 and 2030 ASM performance years, by continuing to remain an ASM participant, the ASM payment multipliers calculated based on the ASM participant's performance during the 2027 and 2028 ASM performance years would continue to be applied to the ASM participant's Medicare Part B payments for covered professional services during the corresponding ASM payment years (that is, CY 2029 and CY 2030).

After internal review, we believe it would be more precise to refer to the situations in which an ASM participant is not required to meet specified ASM requirements for applicable ASM performance year(s) as "exceptions" to ASM requirements rather than ASM participant "exclusions." We believe this revision to the terminology will better capture the intended policy to not require an ASM participant to meet certain ASM requirements for an ASM performance year under certain circumstances. Accordingly, throughout this section of this proposed rule, we are proposing revisions to existing regulatory text to clarify the current circumstances under which an ASM participant may be excepted from certain ASM requirements and are proposing new provisions to include additional circumstances under which an exception would apply.

In the remainder of this section of this proposed rule, we propose, in addition to the current exception due to a change in the reassignment of billing rights (that is, change in TIN), to recognize a new exception. Specifically, we propose that ASM heart failure participants who

meet certain specialty type redesignation requirements may be excepted from specified model requirements. For each exception, we discuss proposals around the requirements and process for notifying us of a change that may warrant an exception. Finally, in accordance with the proposed revisions to § 512.710(a)(2) discussed earlier in this section of this proposed rule, we make proposals at § 512.710(c) to describe the effect and duration of an exception due to a change in TIN or redesignation of primary specialty type.

(a) Exceptions Due to TIN Changes

In the CY 2026 PFS final rule (90 FR 49582 through 49583), we finalized that an ASM participant who stops reassigning billing rights to the TIN used to select the ASM participant and begins reassignment to a new TIN during the same ASM performance year would no longer be subject to specified ASM requirements for that ASM performance year under either TIN if the ASM participant notifies us of the reassignment change within 30 days. We explained that a TIN change during an ASM performance year may limit our ability to determine continued ASM participant eligibility and assess performance under the model using consistent claims history and EBCM data.

Since the finalization of the CY 2026 PFS final rule, interested parties have shared examples with us of additional circumstances, beyond changes in reassignment, that impact a clinician's affiliation with a particular TIN (for example, retirement from practice) and inquired whether those circumstances would qualify an ASM participant for exception from specific ASM requirements. Our finalized provisions also do not account for situations when an ASM participant reassigned their billing rights to a new TIN before the start of an ASM performance year. After internal review, we believe that it would be appropriate to address such circumstances in ASM's provisions.

Accordingly, we are making multiple proposals to simplify the exception from specified model requirements based on TIN changes including to recognize additional TIN change scenarios for possible exception from specified ASM requirements.

First, we are proposing to redesignate the provisions at current § 512.710(c)(1), which describes the notification process for TIN changes that occur during an ASM performance year, as new § 512.710(c)(1)(i)(B). We propose to revise § 512.710(c)(1) to describe how we may determine an exception applies. Specifically, we propose that an ASM participant who demonstrates the circumstances described by an exception apply (that is, change in TIN or approved primary specialty type redesignation) would be excepted from specified ASM requirements, subject to CMS determination for the duration specified for each exception. For each of these exception situations, we discuss the proposed requirements that an ASM participant would be required to meet and, later in this section of this proposed rule, the duration of the exception.

Second, we propose at new § 512.710(c)(1)(i) that an ASM participant who (1) stops reassigning billing rights to the TIN we used to select them as ASM participant for an applicable ASM performance year and (2) satisfies the TIN change notification requirements at proposed § 512.710(c)(1)(i)(A) or § 512.710(c)(1)(i)(B), as applicable, may be excepted from specified ASM requirements. We believe the addition of this provision provides additional clarity on how the notification processes proposed at §§ 512.710(c)(1)(i)(A) and 512.710(c)(1)(i)(B) could lead to an exception.

Third, we propose new provisions related to ASM participant TIN changes that occur before the start of an ASM performance year. At § 512.710(c)(1)(i)(A), we propose that an ASM participant who stops reassigning billing rights to the TIN we used to select them as an ASM participant before the applicable ASM performance year must notify us in writing no later than 60 days after the start of the applicable ASM performance year; after receiving such notice, we may determine an exception to specified ASM requirements applies for the ASM performance year. We recognize that ASM participants may change organizational affiliations between the time we select ASM participants and the start of an ASM performance year. Based on our previously finalized provisions related to the TIN change exception in the CY 2026 PFS final

rule, we believe that the same challenge of having consistent claims history and EBCM data to evaluate ASM participant eligibility criteria under the new TIN would apply in this circumstance and thus an exception would be appropriate. We believe that requiring the ASM participant to notify us in writing no later than 60 days after the start of the ASM performance year would provide an adequate window to provide us with notice of such change after we release the list of ASM participants for a given ASM performance year.

Finally, we propose at § 512.710(c)(1)(i)(B) that an ASM participant who stops reassigning their billing rights to the TIN we used to select them for participation in ASM during an ASM performance year is not required to reassign billing rights to a new TIN during the same ASM performance year to be potentially eligible for an exception from specified ASM requirements. We believe the proposed modification would capture additional organizational affiliation changes, such as retirements, that merit an exception from specified ASM requirements. We further believe this proposal is consistent with the original intent of the TIN change exception policy we finalized in the CY 2026 PFS final rule. We are also proposing that an ASM participant who changes their TIN during an ASM performance year must provide written notice of the change in a form and manner determined by us within 30 days of stopping reassignment to that TIN. We believe that adding this additional detail on the form of the notification and required timing clarifies the notification process for ASM participants.

We seek comment on our proposal at § 512.710(c)(1) describing the notice and determination process for an exception from specified model requirements. We also seek comment on our proposal at § 512.710(c)(1)(i) to describe the requirements for an exception from specified model requirements for an ASM participant who stops reassigning billing rights to the TIN we used to select them as an ASM participant. We also seek comment on: (1) our proposed notification process for TIN changes that occur before the start of an ASM performance year described at § 512.710(c)(1)(i)(A); (2) our proposal to remove the requirement that an ASM participant who no longer reassigns their billing rights to the TIN we used to select

them as an ASM participant during an ASM performance year must begin reassigning billing rights to a new TIN to be eligible for exception as described at § 512.710(c)(1)(i)(B); and (3) our proposal that an ASM participant must provide written notice of the change in TIN within 30 days of stopping reassignment of billing rights to the ASM participant's TIN as described at § 512.710(c)(1)(i)(B).

(b) Exceptions Due to Heart Failure-Related Specialty Type Redesignations

In the CY 2026 PFS final rule, we did not propose or consider an exception based on redesignations of specialty type made through Medicare enrollment before or during an ASM performance year.

Since publication of the CY 2026 PFS final rule, we have received interested parties' feedback that we should consider adjustments to ASM participant eligibility determinations based on more recent Medicare enrollment information related to specialty type, which is used to derive the Medicare Part B claims-based specialty type that we use to evaluate ASM participant eligibility criteria.

We believe that using historical data to evaluate ASM participant eligibility criteria for each ASM performance year is still appropriate. In the CY 2026 PFS final rule (90 FR 49583 through 49585), we explained that determining a clinician's specialty type based on historical data from 2 CYs before an ASM performance year provides an objective and consistent approach because it allows us to use historical claims data to evaluate clinician specialty type, as well as the EBCM episode threshold, as part of the ASM participant eligibility criteria. This approach also supports operational feasibility because it enables us to provide advance notification for ASM participants to prepare for the start of an ASM performance year.

However, we recognize that clinicians may not have had sufficient time to formally update an out-of-date specialty type before the end of CY 2025 because ASM was not finalized until November 2025. For example, specialty type redesignations made in CY 2026 would not be reflected in the CY 2025 data used to select final ASM participants for the 2027 ASM

performance year. Setting an appropriate scope of ASM participant exceptions is important in a mandatory model such as ASM to preserve the integrity of the model design and evaluation, and to ensure a representative ASM participant population. While allowing unrestricted ASM participant exceptions due to specialty type redesignations could introduce selection bias and undermine the model test, we believe that certain limited and clinically appropriate redesignations may warrant consideration based on the timing of ASM's announcement and selection of ASM participants.

Accordingly, we are proposing that ASM heart failure participants who officially redesignate their primary specialty type through an approved Medicare enrollment application (either PECOS or CMS-855 form paper application) to a limited set of specialty types and demonstrate proof of board certification would be excepted from specified ASM requirements and ineligible for Medicare program waivers and the safe harbor provisions available in the model for the applicable ASM performance year and for all remaining ASM performance years in the ASM test period. We further discuss the proposed duration of this specific exception later in this section of this proposed rule.

Specifically, we propose at § 512.710(c)(1)(ii) that we may approve an exception from specified model requirements for an ASM heart failure participant upon receipt of written notification of updated Medicare enrollment to the following redesignated primary specialty types described at § 512.710(c)(1)(ii)(A): cardiac electrophysiology, cardiac surgery, interventional cardiology, advanced heart failure and transplant cardiology, and adult congenital heart disease. We propose at § 512.710(c)(1)(ii)(B) that an ASM heart failure participant who redesignated their primary specialty type through an approved Medicare enrollment application (either PECOS or CMS-855 form paper application) would need to provide us written notification of the approved redesignation, along with verification of board certification in the newly designated primary specialty type described under § 512.710(c)(1)(ii)(A) within 30 days of the effective date of the approved redesignation.

Recognizing an exception for ASM heart failure participants that redesignate their specialty type to one of the proposed specialty types would be appropriate because these specialty types reflect highly specialized or procedure-focused practice areas that are distinct from the broader management of cardiovascular disease and heart failure captured under the cardiology specialty. Excepting cardiac electrophysiology, cardiac surgery, and interventional cardiology would be appropriate because these specialties are predominantly procedure-focused and are generally organized around the performance of invasive or technical interventions rather than the longitudinal medical management of cardiovascular disease. Cardiac electrophysiology primarily involves the diagnosis and treatment of cardiac arrhythmias through procedures such as ablation and device implantation; interventional cardiology centers on catheter-based interventions (for example, percutaneous coronary intervention). Cardiac surgery involves operative treatment for cardiac conditions. Advanced heart failure and transplant cardiology specialists primarily manage patients with end-stage heart failure, mechanical circulatory support, or transplant-related care, while adult congenital heart disease specialists treat individuals with complex congenital conditions that persist into adulthood. Because the specialty types proposed for exception represent narrower scopes of practice than general heart failure management, their exception from specified requirements helps ensure that ASM remains focused on specialists who manage heart failure in a comprehensive and ongoing manner, thereby improving the specificity and consistency of the ASM heart failure cohort.

To be excepted from the specified ASM requirements under this proposal, we believe that the ASM participant must (1) officially redesignate their primary specialty type to one of the specialty types described earlier through an approved Medicare enrollment application and (2) provide evidence of board certification in the redesignated specialty to ensure that an exception to specified ASM requirements is valid and appropriate. While Medicare enrollment requirements stipulate a clinician must supply documentation supporting eligibility for Medicare enrollment under § 424.510(d), these enrollment regulations do not specify a mechanism for

substantiating specialty type. Initial enrollment, revalidation, and any interim changes to an existing enrollment require a physician to select a primary specialty and attest that they meet all state or Federal requirements for their selected primary specialty. Physicians must meet the same requirements for any secondary specialty selected. They must also provide information on the active certification relating to their selected primary specialty type, specifically certification number, effective data, certifying entity, and state where issued. If no certification is associated with the selected primary specialty, then the physician must report the certification relevant to the secondary specialty.[165] MACs have operational authority to validate reported information, including requesting supporting documentation, if needed. In addition to requiring the redesignation through a Medicare enrollment application, we believe that requiring an ASM participant to report additional proof of board certification in one of the proposed specialty types eligible for exception would promote a more accurate approach to the exception process while avoiding unrestricted or unverified exceptions that could introduce selection bias into the model test. Further, all of the proposed specialty types for exception have a certifying entity that provides evidence of board certification. The American Board of Internal Medicine provides board certification for cardiac electrophysiology, interventional cardiology, advanced heart failure and transplant cardiology, and adult congenital heart disease specialty types. The American Board of Thoracic Surgery provides board certification for the cardiac surgery specialty type. Therefore, we believe that an ASM heart failure participant seeking an exception would be able to produce evidence of board certification for all specialty types proposed for exception.

We considered an alternative proposal whereby we would only recognize specific specialty type redesignation-based exceptions that occur during 2027 and 2028 ASM performance years to limit the number of ASM participants potentially excepted. Based on the announcement of ASM in the CY 2026 PFS final rule in November 2025, we believe that

---

[165] *https://www.cms.gov/medicare/cms-forms/cms-forms/cms-forms-items/cms019477*.

potential ASM participants may not have had adequate time to officially redesignate their primary specialty type such that it is reflected in the Medicare Part B claims used to select ASM participants for these ASM performance years. For example, a 2027 ASM participant who redesignated their primary specialty type in CY 2026 would not have that change reflected in the CY 2025 claims data used to evaluate their eligibility. A similar timing challenge could occur for the 2028 ASM performance year because we will use CY 2026 data to select ASM participants for the 2028 ASM performance year. We believe that finalization of ASM in the CY 2026 PFS final rule provided potential ASM participants advanced notice to redesignate their specialty type, if appropriate, for CY 2027, which is the year of data that we will use to select ASM participants for the 2029 ASM performance year. However, we recognize that appropriate specialty type redesignations could occur after the 2028 ASM performance year and that allowing the potential for an exception based on specific specialty type redesignations for a longer period would retain consistency in the application of the proposed exception for specified ASM requirements.

We considered but are not proposing exceptions based on specialty type redesignations for ASM low back pain participants. Unlike cardiac specialties, the specialty types included in the ASM low back pain cohort typically do not have Medicare specialty types that reflect further specialization that would be appropriate for excepting ASM low back pain participants. We also believe that the larger number of specialty types in the ASM low back pain cohort would naturally capture common changes in specialty type by ASM low back pain participants over time. For example, we would capture an anesthesiologist ASM low back pain participant who redesignates their primary specialty type to pain management or interventional pain management over the course of the ASM test period through our existing use of historical Mediare Part B claims to identify specialty type. Our rationale for recognizing exceptions based on specialty type redesignation is to ensure each ASM cohort represents specialists who can be appropriately held accountable for longitudinal management of heart failure or low back pain. Accordingly, we

believe that the existing ASM low back pain participant specialty type criteria, together with the minimum episode attribution volume for the low back pain EBCM, accomplishes this objective and allowing unrestricted exceptions based on specialty type redesignations in the ASM low back pain cohort could introduce selection bias into the model test.

We seek comment on the proposed timeline and documentation requirements for notifying us of an ASM heart failure participant specialty type redesignation for the purpose of determining an exception proposed under § 512.710(c)(1)(ii). We also seek comment on the proposed specialty types—cardiac electrophysiology, cardiac surgery, interventional cardiology, advanced heart failure and transplant cardiology, and adult congenital heart disease—to which an ASM heart failure participant may redesignate their primary specialty type through an approved Medicare enrollment application to be considered for an exception from specified ASM requirements. We further seek comment on the proposed requirement to provide us with direct evidence of board certification in one of the proposed specialty types eligible for exception. We also seek comment on our alternative to only consider exceptions for specific specialty type redesignations based on notifications that occur during the 2027 and 2028 ASM performance years. Finally, we seek comment on whether we should consider ASM low back pain participant exceptions based on primary specialty type redesignations, including rationale on specific specialty type redesignations that we could consider for ASM low back pain participants.

(c) Effect and Duration of Exceptions to Specific ASM Performance Requirements

We propose at § 512.710(c)(2) to define the effect of an approved exception on an ASM participant. Specifically, we propose that the ASM participant with an approved exception would: (1) not be subject to performance assessment described at § 512.715, data submission described at § 512.720, and final scoring described at § 512.745 for the applicable ASM performance year; (2) not be subject to payment adjustments described at § 512.750 for the corresponding ASM payment year; (3) not be eligible for Medicare program waivers available under the model described at § 512.775 for the applicable ASM performance year, and (4) not be

eligible for the CMS-sponsored model arrangements and patient incentives safe harbor described at § 512.765 for the period for which we determine an exception applies. We believe that the proposed effect of an exception retains the intent of the finalized provisions related to ASM participant exclusions due to TIN changes in the CY 2026 PFS final rule while adding new elements that strengthen program integrity. This proposal is also similar to the effect of an ASM participant not meeting the ASM participant eligibility criteria for an ASM performance year discussed earlier in this section of this proposed rule

We propose at § 512.710(c)(3)(i) that an exception related to a TIN change would be effective on the CMS-determined date and would only apply for the applicable ASM performance year. We believe that limiting an exception to a single ASM performance year would allow us to select the ASM participant with the exception (that is, the same TIN/NPI combination) for a future ASM performance year should the NPI again reassign billing rights to that same TIN and meet ASM participant eligibility criteria under that TIN.

We considered whether to extend an exception related to a TIN change for the remainder of the ASM test period. However, we believe that this approach could lead to unnecessary exceptions for later ASM performance years, particularly in the case that an excepted ASM participant begins reassigning billing rights to the same TIN under which we previously selected them as an ASM participant, and excepted them, for a previous ASM performance year.

We provide several illustrative examples of how the proposed exception related to TIN changes would work in practice, including the effect of such exceptions on the application of payment adjustments under ASM. In our first example, ASM participant Dr. A (TIN A/NPI A) receives a final score and an ASM payment multiplier for their performance at TIN A in the 2027 ASM performance year. Dr. A receives an exception for the 2028 ASM performance year based on termination of billing rights to TIN A and reassignment of billing rights to TIN B. Under TIN B, Dr. A remains located in the same mandatory geographic area as they were located under TIN A. Dr. A is not required to meet the specified ASM requirements under TIN A or

TIN B for the 2028 ASM performance year. However, because Dr. A began reassigning billing rights to TIN B after the end of the 2027 ASM performance year but before the end of the 2029 ASM payment year, we would apply the ASM payment multiplier determined for the 2027 ASM performance year to payments for Medicare Part B covered professional service claims submitted by Dr. A under TIN B during the 2029 ASM payment year. We refer readers to section III.D.2.g. of this proposed rule and § 512.750(f) for additional information on payment adjustment provisions related to TIN changes that occur after an ASM performance year but before the end of the corresponding ASM payment year. We also note that Dr. A in this example could be selected as an ASM participant under TIN B for the 2030 ASM performance year if they meet ASM participant eligibility criteria under TIN B based on CY 2028 data. In this situation, Dr. A would be included in the list of ASM participants for the 2030 ASM performance year.

We also provide an example of how the proposed exception due to TIN changes would work for an NPI who is selected as an ASM participant under multiple TIN/NPI combinations. As discussed in the CY 2026 PFS final rule, we believe that it would be rare, but possible, for the same NPI to be selected as an ASM participant under multiple TINs for the same ASM performance year (90 FR 49602). An exception based on a TIN change for one TIN/NPI combination does not affect the ASM participant's obligation to meet specified ASM requirements under any other TIN/NPI combination for which we selected the NPI as an ASM participant. For example, Dr. B (NPI B) is selected as an ASM participant under TIN C and TIN D for the 2028 ASM performance year. If Dr. B stops reassigning billing rights to TIN C during the 2028 ASM performance year and receives an exception for the 2028 ASM performance year, then Dr. B is excepted from the specified ASM requirements under TIN C but must continue to meet ASM’s requirements under TIN D for the 2028 ASM performance year.

We propose at § 512.710(c)(3)(ii) that an exception related to specialty type redesignation would be effective on the CMS-determined date and would apply for the

applicable ASM performance year and remain effective for all ASM performance years in the remainder of the ASM test period. We believe that excepting ASM participants for specified specialty type redesignations for the remainder of the ASM test period would be appropriate since these ASM participants do not represent the target specialty type of an ASM cohort, and would, therefore, improve the specificity and consistency of the ASM cohort for the purposes of performance comparison.

We considered effectuating the exception related to specialty type redesignation type on the CMS-determined date and only having it apply for the applicable ASM performance year. However, we believe that effectuating the exception for the remainder of the ASM test period would be preferrable since we believe an ASM participant would be unlikely to revert to their previous primary specialty type redesignation during the remainder of the ASM test period.

We provide several illustrative examples of how the proposed exception related to specialty type redesignations would work in practice, including the effect of such exception on the application of payment adjustments under ASM. For example, consider ASM heart failure participant Dr. C (TIN E/NPI C) who receives a final score and an ASM payment multiplier for their performance under TIN E for the 2027 ASM performance year. Dr. C receives an exception during the 2028 ASM performance year because they redesignated their primary specialty type to cardiac electrophysiology as part of their Medicare enrollment and met the notification requirements. Dr. C would be excepted from the specified ASM requirements for the 2028 ASM performance year and the remainder of the ASM test period under TIN E. However, they would continue to receive payment adjustments on their Medicare Part B covered professional service claims submitted under TIN E during the 2029 ASM payment year based on the ASM payment multiplier determined for their performance during the 2027 ASM performance year. As we emphasized in the CY 2026 PFS final rule (90 FR 49696 through 49699), our goal is to maintain accountability for an ASM participant's performance for a given ASM performance year through performance-based payment adjustments during the corresponding ASM payment year.

We also note that a specialty type redesignation exception would apply to all TIN/NPI combinations for which we selected the NPI as an ASM participant, provided the notification requirements are met and we approve an exception for each TIN/NPI combination. For example, Dr. D (NPI D) is considered an ASM heart failure participant under TIN F and TIN G for the 2028 ASM performance year. Dr. D redesignates their primary specialty type to interventional cardiology as part of their Medicare enrollment during the 2028 ASM performance year and meets the notification requirements for both TIN F and TIN G. If we approve the exception, Dr. D would be excepted from specified ASM requirements for the 2028 ASM performance year and the remainder of the ASM test period under both TIN F and TIN G.

We seek comment on the proposed effect of an exception from specified ASM requirements at § 512.710(c)(2). We also seek comment on the proposed duration of an exception related to TIN changes as proposed at § 512.710(c)(3)(i), as well as the alternative we considered of setting the duration of a TIN change-related exception as the remainder of the ASM test period. We seek comment on the proposal at § 512.710(c)(3)(ii) that an exception related to specialty type redesignation would apply for the ASM performance year for which we approve the exception and for the remainder of the ASM test period. Finally, we seek comment on the alternative we considered to effectuate an exception related to specialty type redesignation for the applicable ASM performance year only.

(5) ASM Participant Terminations

In the 2026 PFS final rule, we finalized application of the Standard Provisions for Mandatory Innovation Center Models (42 CFR part 512, subpart A) to ASM (90 FR 49720). These provisions describe actions that we may take to remediate actions associated with risks to program integrity. We discussed how the standard provisions are not intended to encompass all the terms and conditions that would apply to each Innovation Center model, because each model has unique design features and implementation plans that may require additional, more tailored provisions.

In addition to the remedial actions enumerated in the standard provisions at § 512.160(b), we now propose to include an additional remedial action for purposes of ASM whereby we could terminate an ASM participant from participation in the model upon determining that one or more grounds for remedial action described in § 512.160(a) has taken place. Grounds for remedial action include, for example, when a model participant has: failed to comply with terms of the Innovation Center Model or applicable Medicare program requirements; taken action to threaten the health or safety of a patient; submitted false data or made false representations in connection with the Innovation Center model; or undergone a change in control that presents a program integrity risk.

We also propose that we could terminate an ASM participant if we determine that their continued participation would be inconsistent with the purposes of ASM or applicable law.

Under this proposal, any termination of an ASM participant's participation would occur only upon a determination by CMS. For the avoidance of doubt, our proposal would not establish a right for an ASM participant to terminate their participation.

We believe that reserving authority to terminate an ASM participant's participation, where appropriate, such as in circumstances involving egregious conduct, would provide additional protections for the program and for beneficiaries. We propose to codify this provision at § 512.710(h) and to include a corresponding reference to termination in proposed revised § 512.710(a)(1), which addresses the duration of participation under ASM.

We seek comment on this proposal at § 512.710(h).

c. Data Submission

(1) Background

We finalized in the CY 2026 PFS final rule that an ASM participant must meet established data submission requirements across the quality, improvement activities, and Promoting Interoperability ASM performance categories, consistent with §§ 512.725, 512.735, and 512.740, respectively (90 FR 49596 through 49605). We did not establish data submission

requirements for the cost ASM performance category or for administrative claims-based quality measures as we will calculate performance on these measures using administrative claims data.

For the quality ASM performance category, we require the submission of numerator and denominator data for at least one required quality measure that satisfies the data completeness criteria (that is, data is submitted on at least 75 percent of the ASM participant's patients that meet a quality measure's denominator criteria). ASM participants in small practices (that is, a TIN with 15 or fewer clinicians) may submit quality data at the group level (that is, TIN level) while ASM participants in non-small practices must submit quality measure data at the individual clinician level (that is, TIN/NPI level). Data submission for the improvement activities ASM performance category requires an ASM participant to attest at the group level (that is, TIN level) that the required activities are completed by all ASM participants within the TIN. Finally, for the Promoting Interoperability ASM performance category, ASM participants must submit all required measure data (or claim any applicable exclusions), attestations, CMS Electronic Health Record (EHR) Certification ID, and performance period dates at the group level (that is, TIN level). Data submission for the Promoting Interoperability ASM performance category may reflect data from clinicians who are not ASM participants. Regardless of the data submission level for each ASM performance category, each ASM participant receives an individual-level final score and corresponding ASM payment adjustment factor and ASM payment multiplier, which is used to adjust payments for each ASM participant’s Medicare Part B covered professional service claims.

(2) Quality ASM Performance Category Data Submission for ASM Participants in Small Practices

We finalized policies at § 512.720(a) addressing data submission for the quality ASM performance category, including the requirement that quality measure data be submitted at the individual level (that is, TIN/NPI level). However, as finalized at § 512.720(f), an ASM

participant that is in a small practice may report quality ASM performance category data at the group level (that is, TIN level).

After reviewing our provisions finalized in the CY 2026 PFS final rule, we believe it would improve readability and overall clarity of the regulatory text if we addressed the quality data submission policy for ASM participants in small practices together with the generally applicable policies for each ASM performance category, which appear at § 512.720(a).

Accordingly, we propose to remove existing § 512.720(f) and instead address our quality ASM performance category data submission policy for ASM participants in small practices at § 512.720(a)(1)(i)(C). In relocating this regulatory text, we also propose to make technical clarifying edits to better reflect our policy intent that an ASM participant in a small practice has the option to submit ASM quality measure data at either the group level (that is, TIN level) or the individual level (that is, TIN/NPI level). Our intent is to provide ASM participants in small practices an additional flexibility in reporting ASM quality measure data.

We propose conforming adjustments at § 512.720(a)(1)(i)(A) to correct a minor typographical error and at § 512.720(a)(1)(i)(B) to cross-reference to proposed new § 512.720(a)(1)(i)(C). Our proposed reorganization of these provisions would not substantively change the policy under existing provisions, but we believe the proposed changes would bring greater clarity to the structure of the regulation and regulatory text.

We invite public comment on these proposed adjustments to § 512.720(a)(1)(i).

(3) Improvement Activities ASM Performance Category Data Submission

In the CY 2026 PFS final rule, we finalized that ASM participants submit improvement activity ASM performance category data by attesting to the completion of required improvement activities at the group level (that is, TIN level) (90 FR 49599 through 49602). We believed that group-level data submission would be appropriately reflective of the team-based care and coordination envisioned by the improvement activities (90 FR 49601). We also believed that group-level data submission for the improvement activities ASM performance category would

reduce administrative burden (90 FR 49601). In subsequent sub-regulatory guidance, we clarified that a group-level attestation for completing a required improvement activity means that all ASM participants within a TIN successfully completed the requirements of that improvement activity for the applicable ASM performance year. We also clarified that a clinician who is not an ASM participant, but who has reassigned billing rights to a TIN that includes one or more ASM participants, would not be subject to any ASM participation obligations solely on that basis, including the requirements of the improvement activities ASM performance category.

Since the publication of the CY 2026 PFS final rule, we have received feedback from interested parties that group-level data submission for the improvement activities ASM performance category may have unintentional consequences on scoring for ASM participants in certain circumstances. For example, if only 8 ASM participants in a TIN with 10 ASM participants complete a required improvement activity, then the group could not submit an attestation that all ASM participants within the group completed the improvement activity. In this example, each of the 8 ASM participants who completed the improvement activity would receive a 10-point deduction on their final score. While the group-level data submission for the improvement activities ASM performance category may reduce administrative burden related to data reporting, we believe it would be appropriate to adjust these data submission provisions to reduce the likelihood of final score penalties on an ASM participant who fully or partially completes the requirements of the improvement activities ASM performance category and associated data submission requirements.

Accordingly, we propose at § 512.720(a)(1)(ii)(B) to allow an ASM participant to submit data for the improvement activities ASM performance category at either the group level (that is, TIN level) or the individual level (that is, TIN/NPI level). We believe this proposal would offer greater flexibility in how an ASM participant or their affiliated group submits data for the improvement activities ASM performance category depending on their specific circumstances and data submission preferences. While we believe that many of ASM's improvement activities

would be jointly implemented by ASM participants within a group to improve team-based care and coordination, we believe that this added data submission flexibility would mitigate the chance of an unintended negative adjustment to the final score of an ASM participant who fully or partially meets the improvement activities ASM performance category requirements. We note that this proposal would not affect how an ASM participant or its affiliated TIN may choose to structure a CCA required under IA-2.

We seek comment on our proposal at § 512.720(a)(1)(ii)(B) to allow ASM participants to attest to completing ASM's improvement activities at either the group level (that is, TIN level) or the individual level (that is, TIN/NPI level).

(4) Treatment of Multiple Data Submissions for the Quality, Improvement Activities, and Promoting Interoperability ASM Performance Categories

In the CY 2026 PFS final rule, we finalized policies addressing the treatment of multiple data submissions for the quality, improvement activities, and Promoting Interoperability ASM performance categories at § 512.720(e) (90 FR 49604 through 49606). For the quality and improvement activities ASM performance categories, when we receive multiple data submissions for an individual ASM participant from multiple organizations (for example, a qualified registry, practice administrator, or an electronic health record (EHR) vendor), we calculate and score each submission and assign the highest score to the ASM participant. When we receive multiple data submissions for an individual ASM participant from the same organization, we score the most recent submission. For the Promoting Interoperability ASM performance category, we calculate each submission and assign the highest score.

We believe our policies for multiple data submissions would be clearer if we addressed each ASM performance category separately, rather than discussing the quality ASM performance category and the improvement activities ASM performance category together. Accordingly, we propose to make technical modifications to regulatory text describing multiple data submissions, such that § 512.720(e)(1) would address the quality ASM performance category, § 512.720(e)(2)

would address the improvement activities ASM performance category, and § 512.720(e)(3) would address the Promoting Interoperability ASM performance category. Except for the proposed new policy for small practices at proposed § 512.720(e)(1)(iii), discussed later in this section of this proposed rule, the remaining proposed revisions to § 512.720(e)(1) would not constitute substantive changes from the policies finalized in the CY 2026 PFS final rule. Rather, those proposed revisions would reorganize the existing provisions and make clarifying modifications to the regulatory text.

Specifically, we propose to:

- Address the multiple data submissions policy for the ASM quality performance category at § 512.720(e)(1), the improvement activities ASM performance category at § 512.720(e)(2), and the Promoting Interoperability ASM performance category at § 512.720(e)(3). To accomplish this, we would:

++ Add the informative heading "Quality ASM performance category" to § 512.720(e)(1).

++ Revise §§ 512.720(e)(1)(i) and 512.720(e)(1)(ii) to reflect our policy for scoring multiple data submissions for the quality ASM performance category and make technical revisions to the text.

++ Redesignate existing § 512.720(e)(2) describing our multiple data submission policy for the Promoting Interoperability ASM performance category as new paragraph § 512.720(e)(3)(i).

++ Redesignate the portions of §§ 512.720(e)(1)(i) and 512.720(e)(1)(ii) that address our multiple data submission policy for the improvement activities ASM performance category to §§ 512.720(e)(2)(i) and 512.720(e)(2)(ii).

++ Add the informative heading "Improvement activities ASM performance category" at § 512.720(e)(2).

++ Revise newly redesignated §§ 512.720(e)(2)(i) and 512.720(e)(2)(ii) to make technical clarifications for the treatment of multiple data submissions for the improvement activities ASM performance category.

++ Add the informative heading "Promoting Interoperability ASM performance category" to new paragraph § 512.720(e)(3).

We invite public comment on this proposed reorganization of § 512.720(e).

(a) Multiple Data Submissions for the Quality ASM Performance Category for ASM Participants in Small Practices

In the CY 2026 PFS final rule, we finalized that ASM participants in small practices may report quality measures in the quality ASM performance category at the group level (that is, TIN level) (90 FR 49602). We finalized this policy because we recognize that reporting quality measures at the individual clinician level (that is, TIN/NPI level) may be particularly burdensome for ASM participants in small practices who may have limited capacity for data aggregation and reporting. We believe that EHR customization for individual-level reporting, and the costs associated with updating reporting mechanisms, may pose a larger burden on ASM participants in small practices compared to ASM participants in larger practices because small practices may not have the requisite support, such as infrastructure or staffing, to facilitate individual-level reporting. Importantly, this reporting flexibility does not change ASM's intention to measure individual ASM participant performance; rather, this flexibility is limited to the reporting and scoring of ASM non-administrative claims-based quality measures. All other reporting and scoring requirements for the cost and quality ASM performance categories remain at the individual ASM participant level regardless of practice size. ASM participants in small practices would retain the option to report quality measure data at the individual level if they choose.

After internal review of the provisions finalized in the CY 2026 PFS final rule, we believe that permitting multiple submissions at different reporting levels within a small practice

could create unintended incentives and scoring effects. If multiple reporting levels are permitted within the same small practice, an ASM participant's quality ASM performance category score could depend in part on the reporting level used, rather than on a consistent approach to reporting and evaluating quality performance. For example, a small practice could submit individual-level data for higher-performing ASM participants and group-level data for lower performing ASM participants. This variability could reduce comparability across ASM participants and create inconsistent scoring outcomes among ASM participants in similar practice arrangements. We believe ASM participants in small practice should report quality data at the reporting level that best meets their needs and capabilities.

To ensure fair and consistent scoring of the quality ASM performance category, we are proposing at § 512.720(e)(1)(iii) that if we receive any quality ASM performance category data at the group level (that is, TIN level) from an ASM participant in a small practice, we would score the group-level submission and assign that score to all individual ASM participants in the small practice. This proposal would mean that any individual-level (that is, TIN/NPI-level) submission received for any ASM participants in that small practice would not be scored if any group-level quality data submission is received.

We believe this proposal would maintain the desired reporting flexibility to lower the administrative burden for ASM participants in small practices while preserving the integrity of the ASM scoring framework. Specifically, ASM participants in small practices would continue to have the option to report non-administrative claims-based ASM quality measures at either the group or individual level. Our proposed policy would mitigate the opportunity for ASM participants in small practices to submit data at multiples levels most opportune to achieve a higher score and establish a consistent scoring framework so that ASM participants in small practices are encouraged to submit required data based on needs and capabilities, rather than strategic performance considerations. Table B-D1 in this section of this proposed rule

summarizes existing finalized policies and new proposals relating to our treatment of multiple data submissions for the quality ASM performance category.

TABLE B-D1: PROPOSED TREATMENT OF MULTIPLE DATA SUBMISSIONS FOR THE QUALITY ASM PERFORMANCE CATEGORY

ASM Participant in a Small Practice	Multiple Quality Data Submissions Received	Source of Multiple Quality Data Submissions	Group-level Quality Data Submission Received	Quality Data Submission Scored
No	No	N/A	Not Permitted	Individual-level (TIN/NPI)
	Yes	Multiple Organizations	Not Permitted	Highest Individual-level (TIN/NPI)
		Single Organization	Not Permitted	Most Recent Individual-level (TIN/NPI)
Yes	No	N/A	Yes	Group-level (TIN)
			No	Individual-level (TIN/NPI)
	Yes	Multiple Organizations	Yes	Highest Group-level (TIN)
			No	Highest Individual-level (TIN/NPI)
		Single Organization	Yes	Most Recent Group-level (TIN)
			No	Most Recent Individual-level (TIN/NPI)

We seek comment on our proposal at § 512.720(e)(1)(iii) to score any group-level quality data submission received from small practices and assign that score to all ASM participants in the small practice regardless of any individual-level quality data submission received for individual ASM participants in that same small practice.

d. Quality ASM Performance Category

(1) Background

As discussed in the CY 2026 PFS final rule, the quality ASM performance category supports the broader goals of the model by incentivizing improvements in the quality of care and reductions in unnecessary or low-value services for patients with heart failure and low back pain. To accomplish these objectives, we finalized in the CY 2026 PFS final rule the use of ASM cohort-specific quality measure sets at § 512.725(b) (heart failure) and § 512.725(c) (low back pain) (90 FR 49606). ASM participants must report all measures applicable to their ASM cohort,

with administrative claims-based measures calculated by us. This structure is similar to other CMS programs, such as MIPS Value Pathways (MVPs), that entail reporting on a clinically relevant subset of measures tailored to an eligible clinician's specialty and patient population. It also minimizes reporting burden, promotes consistency in measurement over the duration of the ASM test period, and supports rigorous evaluation by maintaining a stable set of quality indicators.

In finalizing these policies, we sought to ensure that each ASM cohort-specific quality measure set reflects agency goals to advance value-based care by linking payment to meaningful improvements in clinical outcomes and beneficiary experience. The measures selected for ASM represent a mix of utilization-focused measures, evidence-based care measures, and patient-reported outcome or experience measures. This structure supports nationwide measurement efforts focused on outcomes, safety, and patient experience.

We intend for the quality measure sets applicable to each ASM cohort to remain stable throughout the ASM test period; however, we may propose additions or removals through notice-and-comment rulemaking if refinements to the measure sets are warranted. Such updates may be considered in response to interested parties' feedback, changes in clinical guidelines, updates to measures used in ASM or other CMS programs, or the development of new quality measures. This framework keeps the quality ASM performance category aligned with current clinical practice while providing predictability that may reduce administrative burden over time.

(2) Low Back Pain Quality Measure Set

(a) Low Back Pain Imaging Measure for the ASM Low Back Pain Cohort

In the CY 2026 PFS proposed rule, we proposed inclusion of the "Magnetic Resonance Imaging (MRI) Lumbar Spine for Low Back Pain, Respecified to Be Relevant to ASM Participants Treating Low Back Pain" measure in the ASM low back pain quality measure set (90 FR 32593 through 32597), but did not finalize its inclusion based on interested parties' feedback (90 FR 49616 through 49618). We indicated in the CY 2026 PFS final rule that we

intended to revisit the inclusion of this measure in future notice-and-comment rulemaking (90 FR 49617). We indicated revisiting because the ASM low back pain cohort had only four quality measures, and none were focused on excess utilization or efficiency. As our goal is to have a well-rounded measure set for each ASM cohort that includes this focus area, we sought to include a measure that would complete the ASM low back pain quality measure set.

We are proposing at § 512.725(c)(5) to include the "Magnetic Resonance Imaging (MRI) Lumbar Spine for Low Back Pain (modified for ASM)" measure in the ASM low back pain quality measure set. This proposal would meet the goals of the ASM low back pain cohort's quality measure set of having an excess utilization focused measure. This measure is modified from the "Magnetic Resonance Imaging (MRI) Lumbar Spine for Low Back Pain" measure that was specified for use in hospital outpatient departments at the facility level and previously included in the Hospital Outpatient Quality Reporting Program (HOQRP) as OP-8 (73 FR 68766).[166] While we removed the measure from the HOQRP in 2017 due to limited reliability from low average facility-level volumes, we have since re-evaluated the measure for use in ASM. In reassessing this measure, we considered interested parties' feedback, technical expert input, and measure reevaluation activities. Commenters and experts indicated that, while the clinical concept remains important for assessing low-value imaging, the prior specification presented challenges related to attribution at the facility level, small sample sizes, and limited applicability to certain care delivery contexts. Interested parties also recommended exploring refinements to improve measure reliability and alignment with clinician decision-making in ambulatory specialty settings.

In response, we have made targeted specification modifications to improve the measure's applicability and statistical reliability in the ASM context. We believe these modifications

[166] Hospital Outpatient Quality Reporting | Partnership for Quality Measurement. P4qm.org. Published 2025. Accessed April 23, 2025. *https://p4qm.org/taxonomy/term/216*.

address the previously identified limitations while preserving the measure's clinical intent of reducing unnecessary imaging for low back pain.

We believe the proposed administrative claims-based quality measure would effectively evaluate overuse and incentivize reductions in inappropriate MRI imaging for low back pain. Routine imaging (such as MRI) is not recommended for patients with non-specific low back pain in the absence of certain clinical indicators and concerning features.[167] However, analyses have shown that a significant proportion of patients with low back pain undergo imaging, often within the first few weeks of symptom onset, despite the lack of clear indication.[168] Overuse of imaging for low back pain can lead to unnecessary health care costs and potential patient harm from the cascade effect, where MRI findings, many incidental, may prompt further unnecessary testing or procedures.[169,170] By including this measure in the ASM low back pain quality measure set, ASM would aim to incentivize adherence to evidence-based guidelines and a reduction of unnecessary MRIs for patients with uncomplicated low back pain, where an MRI is not clinically indicated, particularly in the initial stages of evaluation and management. We believe this could also improve patient experience to the extent it reduces time spent at medical appointments and out-of-pocket health care costs. Furthermore, as an administrative claims-based quality measure, ASM low back pain participants would not assume new reporting requirements for this measure. We would provide detailed measure information for the MRI Lumbar Spine for Low Back Pain (modified for ASM) on the ASM website before the start of the 2027 ASM performance year, if finalized, to educate ASM participants on how they would be measured.

---

[167] North American Spine Society. Clinical Guidelines for Multidisciplinary Spine Care: Diagnosis and Treatment of Low Back Pain. North American Spine Society; 2020. *https://www.spine.org/Portals/0/assets/downloads/ResearchClinicalCare/Guidelines/LowBackPain.pdf*.

[168] Medicare Payment Advisory Commission. Health Care Spending and the Medicare Program: A Data Book. Medicare Payment Advisory Commission; July 2021. Accessed July 7, 2026. *https://www.medpac.gov/wp-content/uploads/2021/10/July2021_MedPAC_DataBook_Sec7_SEC.pdf*.

[169] Litkowski PE, Smetana GW, Zeidel ML, Blanchard MS. Curbing the Urge to Image. *The American Journal of Medicine*. 2016;129(10):1131-1135. doi: *https://doi.org/10.1016/j.amjmed.2016.06.020*.

[170] Chou R. Diagnostic Imaging for Low Back Pain: Advice for High-Value Health Care From the American College of Physicians. *Annals of Internal Medicine*. 2011;154(3):181. doi: *https://doi.org/10.7326/0003-4819-154-3-201102010-00008*.

Our modifications seek to improve clinical validity and reliability for the purposes of ASM. Two of our modifications were related to denominator exclusions and the measure's performance period. We also made modifications to provider attribution, minimum case count, and the lookback period for antecedent care, for which we offer alternative options that seek comment on. We believe the modifications we propose in this proposed rule as part of the "Magnetic Resonance Imaging (MRI) Lumbar Spine for Low Back Pain (modified for ASM)" measure to be appropriately tailored to measure performance of ASM participants ordering inappropriate MRIs for patients with low back pain.

We seek comment on the inclusion of MRI Lumbar Spine for Low Back Pain (modified for ASM) measure in the ASM low back pain quality measure set at § 512.725(c)(5).

We discuss modifications to the measure's specifications in the remainder of this section of this proposed rule, including seeking comment on potential alternatives to the proposed modifications related to provider attribution, minimum case count, and the lookback period for antecedent care.

(i) Denominator Exclusions

We conducted an evaluation of the measure's denominator exclusions to ensure that they reflect current clinical guidelines and appropriately identify cases where early lumbar spine imaging is clinically justified. This evaluation focused on exclusions that previously removed a large number of cases under the OP-8 specifications and involved reviewing each diagnosis code individually. Removing a large number of cases in OP-8 presented risks to the applicability and reliability of the measure.

We identified three clinical areas that had a large number of exclusions: cancer diagnoses, neurological impairment, and autoimmune or inflammatory conditions. Physicians assessed each code under these categories for appropriateness to include in the measure denominator. Most conditions, such as "red flag" signs and symptoms and for malignant neoplasms and autoimmune disorders where imaging would be warranted (regardless of

completion of conservative therapy), were maintained as denominator exclusions. Conditions, such as benign neoplasm of the colon and hemangioma of skin and subcutaneous tissue, were removed as denominator exclusions since their presence would not warrant an immediate MRI for a patient with low back pain; the condition alone would not preclude a patient with low back pain from attempting conservative therapy prior to receiving a lumbar MRI. To improve clinical validity and acceptability, conditions and diagnoses were not removed as denominator exclusions if they were present in the list of denominator exclusions in the Healthcare Effectiveness Data and Information Set (HEDIS) Use of Imaging Studies for Low Back Pain measure.[171] Under this approach, we ultimately aligned with the same exclusion logic used in the HEDIS Use of Imaging Studies for Low Back Pain measure and only diagnosis codes present in that measure and supported by clinical review remained as denominator exclusions in our ASM measure. As a result of these refinements, the ASM measure's exclusion criteria differ from the prior OP8 specification in these three clinical areas with the goal of more closely aligning to evidence-based practice guidelines.

In our analysis, these changes result in the inclusion of a significant number of imaging studies that would previously have been excluded, representing 52 percent of the cases that would have been removed under the earlier specification. Retaining these cases strengthens this measure by increasing denominator volume and improving our ability to identify potentially unnecessary imaging. We believe these refinements enhance the measure's clinical validity by ensuring that exclusions are limited to diagnoses that represent appropriate indications for more immediate imaging that do not warrant a prior trial of conservative therapy.

(ii) Performance Period

We evaluated the performance period for the measure to ensure that ASM participant-level scores are reliable and suitable for use in the model's quality assessment framework. The

---

[171] National Committee for Quality Assurance. *Use of Imaging Studies for Low Back Pain (LBP).* **NCQA**, *https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/use-of-imaging-studies-for-low-back-pain-lbp/*. Accessed 6 Apr. 2026.

original HOQRP version of the measure used a single-year performance period, which limited the number of eligible MRI studies available for scoring and contributed to concerns about measure reliability.[172] To address these issues, we tested an expanded performance period that included all eligible lumbar spine MRI studies occurring within a rolling 24-month window. Under this approach, each MRI meeting denominator criteria during the 2-year period was included in measure calculation, thereby significantly increasing the number of cases available for analysis. Testing showed that the expanded 2-year performance period resulted in approximately a 100 percent increase in denominator volume relative to a 1-year period. This increase in case volume improved the precision of ASM participant-level estimates and reduced small-sample volatility, particularly for clinicians with lower annual MRI volumes. We believe that a 2-year performance period enhances measure stability and supports more dependable performance assessment across all ASM low back pain participants and overcomes limitations and concerns that existed when the measure existed in the HOQRP. This is especially important for utilization measures, where annual case counts can vary substantially among specialties and practice types. Based on these findings, we believe that a rolling 24-month period provides the most robust and actionable representation of clinician imaging practices.

(iii) Provider Attribution

The management of low back pain often involves several specialists over an extended period, and diagnostic and treatment decisions typically develop through multiple clinical encounters rather than a single visit. In modifying the original HOQRP measure for use in ASM, we had to address how to transition the measure from its original hospital outpatient department attribution method, which assigned imaging only to the facility that billed the MRI claim, to an approach that reflects physician-level accountability. This work included evaluating a single-participant attribution method that assigns each MRI to the physician with the highest

[172] Hospital Outpatient Specifications Manuals, Hospital Outpatient Quality Reporting. CMS.gov. Accessed March 27, 2026. *https://qualitynet.cms.gov/outpatient/specifications-manuals*.

number of qualifying encounters during the lookback period and a multiple-participant attribution method that assigns the MRI to all physicians who provided qualifying services to the patient. Testing showed that the multiple-participant method increased the number of attributed MRI studies by roughly 26 percent after exclusions, which strengthened measure stability and improved representation of the various physicians involved in that beneficiary's care. Multiple attribution better reflects real-world care patterns, particularly in increasingly common cases where beneficiaries receive longitudinal care by different team members over time. This approach also supports ASM's goals by recognizing the shared nature of clinical responsibility for decisions that influence downstream utilization and patient outcomes. Also, including all clinicians who contributed meaningfully to the beneficiary's care ensures that performance assessment captures the full set of ASM low back pain participants who may influence imaging decisions. We believe this attribution method provides a more complete and accurate understanding of imaging practices within the ASM low back pain cohort. For these reasons, we are proposing multiple-participant attribution.

We also considered an alternative approach that would attribute each MRI to a single physician. Under this option, an MRI would be assigned to the ASM participant who furnished the highest number of qualifying encounters during the attribution window, which reflects a single point of clinical responsibility for many beneficiaries. This approach would provide a more streamlined assignment method and could reduce attribution complexity for the measure, but may not be reflective of real-world practice patterns and results in fewer attributed beneficiaries per ASM participant and thus slightly lower measure reliability

We seek comment on the proposed use of a multiple-participant attribution method for this quality measure. We also seek comment on the alternate proposal of an attribution method involving a single ASM participant.

(iv) Minimum Case Count

We evaluated the appropriate minimum case count threshold for the MRI Lumbar Spine for Low Back Pain (modified for ASM) measure to ensure that clinician-level performance scores are reliable for use in the model's quality assessment framework. Low case volumes may produce substantial variation in provider scores and a wider distribution of results, which could reduce the measure's ability to distinguish true performance differences. At lower thresholds, such as one or 10 cases, our analysis found that many ASM low back pain participants would have insufficient volume to support stable estimates, and reliability decreased accordingly. At a threshold of 20 cases, the measure showed stronger reliability and a narrower distribution of scores across ASM participants, indicating that estimates were more consistent and reflective of meaningful patterns of imaging use. The threshold of 20 cases aligns with the ASM participant eligibility criteria that, in part, requires an ASM low back pain participant to have historically been attributed at least 20 low back pain EBCM episodes. The threshold of 20 cases also aligns with the case minimums for the other quality measures in the ASM low back pain quality measure set. This alignment ensures that the case count threshold is both operationally feasible and representative of the expected care volume for ASM participants. In addition, maintaining a minimum of 20 cases reduces the influence of isolated or atypical events that may disproportionately affect results when volumes are low. The analysis further showed that a substantial proportion of ASM low back pain participants would continue to meet eligibility for scoring at this case threshold, preserving the ability to assess quality performance across a broad ASM participant population. We believe that maintaining a minimum of 20 cases appropriately balances inclusiveness and methodological rigor. For these reasons, we propose a threshold of 20 cases for the MRI Lumbar Spine for Low Back Pain (modified for ASM) measure.

We also considered an alternative minimum case count of 10 for the MRI Lumbar Spine for Low Back Pain (modified for ASM) measure. A threshold of 10 would allow a greater number of ASM low back pain participants to be scored on the measure, particularly those with smaller patient panels or lower annual imaging volume. Although reliability is lower at this

threshold relative to a minimum of 20 cases, a 10-case minimum would offer meaningful insight into specialist practice patterns while expanding the proportion of ASM low back pain participants scored on the measure.

We seek comment on the proposed minimum case count of 20. We also seek comment on the alternate proposal of a minimum case count of 10.

(v) Lookback Period

We evaluated the attribution lookback period to determine the timeframe during which clinician services should be considered for assigning each lumbar spine MRI to ASM low back pain participants. The measure needs a lookback period long enough to capture clinical encounters that inform decisions about imaging, while still maintaining a clear and comprehensive lookback approach. Chronic low back pain is managed over extended periods, and patients frequently receive evaluation and treatment, and require care coordination from multiple clinicians during this time. Based on these care patterns, we examined whether a longer window would more accurately identify the set of clinicians who meaningfully influence imaging decisions. Testing demonstrated that a 365-day lookback period compared to a shorter window like 90-days substantially increased the number of attributed MRI studies by approximately 27 percent. We believe a 365-day period better reflects the longitudinal nature of chronic low back pain management and ensures that attribution captures the full course of care that precedes a patient's imaging event. A full-year window also aligns with the model's annual performance period and improves consistency across the various quality measures included in the model. We believe that adopting a 365-day lookback window strengthens the completeness of performance assessment by ensuring that clinicians who contribute meaningfully to care are appropriately included. For these reasons, we are proposing to use a 365-day lookback period for attribution of MRI studies within the measure.

We also considered an alternative 120-day lookback period. This approach would limit attribution to ASM low back pain participants who furnished lower back pain-related services in

closer proximity to the imaging event and, therefore, would provide a more focused reflection of recent clinical decision-making. However, it would also result in fewer cases per ASM participant, which could create a narrower view of the ASM participant's trends related to MRI referral and low back pain.

We seek comment on the proposed 365-day lookback period and the alternative of a 120-day lookback period.

(b) Removing Functional Status Change for Patients with Low Back Impairments (MIPS Q220) and Adding Functional Outcome Assessment (MIPS Q182)

In the CY 2026 PFS final rule (90 FR 49620 through 49622), we finalized inclusion of Functional Status Change for Patients with Low Back Impairments (MIPS Q220) in the ASM low back pain quality measure set because it captures functional outcomes that are directly relevant to patients' experience of low back pain and their ability to perform daily activities. We noted that the measure aligns with the model's emphasis on patient-centered outcomes and longitudinal management and complements the broader set of prevention and utilization-focused measures included in the ASM low back pain quality measure set.

Since publication of the CY 2026 PFS final rule, the measure steward has indicated that they no longer intend to maintain Functional Status Change for Patients with Low Back Impairments (MIPS Q220), including key operational components such as the survey's online portal. Consistent with this change, we are removing this measure from the MIPS measure inventory.

Accordingly, we are proposing at § 512.725(c)(4) to remove the Functional Status Change for Patients with Low Back Impairments (MIPS Q220) from the ASM low back pain quality measure set and replace it with Functional Outcome Assessment (MIPS Q182). This proposal would address the absence of the MIPS 220 measure by replacing one measure of functional status with another.

We believe that Functional Outcome Assessment (MIPS Q182) represents an appropriate replacement as it meets similar goals as the inclusion of MIPS Q220 and may be familiar to many ASM low back pain participants. However, we note that we intend to pursue the future adoption of a more robust patient-reported outcome performance measure (PRO-PM) to further emphasize the importance of functional status improvement within ASM. Such a change to the ASM low back pain quality measure set would be proposed via future notice-and-comment rulemaking.

Functional Outcome Assessment (MIPS Q182) promotes the routine assessment of functional status and requires clinicians to document a care plan when functional outcome deficiencies are identified. As such, the measure supports a more patient-centered approach to care by encouraging ASM participants to incorporate patients' reported experiences and functional status assessments and limitations into clinical decision-making. The measure leverages patient-reported outcome tools and surveys to facilitate meaningful communication between clinicians and their patients regarding symptoms, daily functioning, and treatment goals; as a result, identified concerns can be addressed as part of the evaluation and management of the patient.

We believe that systematic measurement and improvement of functional status can increase patient self-efficacy, improve overall well-being, and potentially reduce downstream healthcare utilization and costs. Additionally, the use of validated and standardized assessment tools may enhance the reliability and sensitivity of detecting functional impairments and monitoring changes over time, particularly among older adults with low back pain.[173]

Although Functional Outcome Assessment (MIPS Q182) does not require the use of a specific instrument, examples of appropriate, validated tools relevant to the ASM low back pain cohort include the Modified Oswestry Disability Index and the Patient-Reported Outcomes

[173] Wong AY, Karppinen J, Samartzis D. Low back pain in older adults: risk factors, management options and future directions. *Scoliosis and Spinal Disorders*. 2017;12(1):1-23. doi: *https://doi.org/10.1186/s13013-017-0121-3*.

Measurement Information System (PROMIS). The use of such tools is supported by clinical guidelines and professional organizations. For example, the American Academy of Orthopaedic Surgeons recommends the Modified Oswestry Disability Index as a preferred instrument for assessing functional outcomes in spine care.[174,175] These functional status instruments may also capture information related to modifiable risk factors, such as physical activity levels and social isolation, which can inform clinical discussions and interventions aimed at preventing the progression of low back pain and associated comorbid conditions.

This proposal also responds to interested parties' feedback regarding operational concerns with Functional Status Change for Patients with Low Back Impairments (MIPS Q220). In addition, Functional Outcome Assessment (MIPS Q182) aligns with the Quality Payment Program's Rehabilitative Support for Musculoskeletal Care MIPS Value Pathway (MVP), further supporting its inclusion in the ASM. We also note that Functional Outcome Assessment (MIPS Q182) has a MIPS CQM collection type, the same collection type as the Functional Status Change for Patients with Low Back Impairments (MIPS Q220).

By embedding accountability for assessing and addressing functional status into the ASM quality measure set for ASM participants who treat low back pain, this measure supports a comprehensive, longitudinal approach to low back pain management, including appropriate evaluation, treatment planning, and ongoing monitoring of patient outcomes.

We seek comment on our proposal at § 512.725(c)(4) to remove the Functional Status Change for Patients with Low Back Impairments (MIPS Q220) from the ASM low back pain quality measure set and replace it with Functional Outcome Assessment (MIPS Q182).

(3) Data Completeness Requirement for the Quality ASM Performance Category

---

[174] North American Spine Society. Clinical Guidelines for Multidisciplinary Spine Care: Diagnosis and Treatment of Low Back Pain. North American Spine Society; 2020.

[175] Performance Measures by Orthopaedic Subspecialty. Aaos.org. Published 2025. Accessed April 23, 2025. *https://www.aaos.org/quality/research-resources/patient-reported-outcome-measures/performance-measures-by-orthopaedic-subspecialty*.

As discussed in the CY 2026 PFS final rule (90 FR 49631), we finalized policies to establish a data completeness requirement for applicable quality measures in the quality ASM performance category. Under this requirement, ASM participants reporting MIPS clinical quality measures (MIPS CQMs) or eCQMs would be required to submit data for at least 75 percent of patients who meet the denominator criteria for each measure, regardless of payer.

The regulatory text at § 512.725(f)(3) describing the data completeness requirement includes a non-substantive typographical error of a misplaced possessive "s" on "ASM".

We propose at § 512.725(f)(3) correct this typographical error so that it would read: "CMS excludes from an ASM participant's total measure achievement points and total available measure achievement points any measure required under paragraph (b) or (c) of this section that meets the respective measure's data completeness requirement but does not have a benchmark." We believe this correction clarifies the regulatory text without substantively changing the policy under existing provisions.

We seek comment on our proposal to modify § 512.725(f)(3) to correct this typographical error.

(4) Scoring and Benchmarks for Quality Measures

As discussed in the CY 2026 PFS final rule (90 FR 49634 through 49635), we finalized policies to benchmark and score ASM quality measures. We will use measure-specific benchmarks where separate benchmarks are calculated for each measure and collection type to reflect meaningful performance differences among ASM participants. Quality measure benchmarks will be derived from ASM participant data from the current or prior ASM performance years, or another CMS-determined period. We determined that separate benchmarks by collection type (for example, MIPS CQM and eCQM) are more appropriate than a single benchmark for each measure aggregated across collection types due to established scoring variation across collection types. Benchmarks will be decile-based percentile distributions, which enable consistent scoring and translate measure performance values uniformly. To score reported

data against the benchmarks, ASM participants' performance on each measure will be mapped to decile ranges, with one to 10 achievement points assigned according to the decile in which the measure's reported rate falls.

In the CY 2026 PFS final rule, we explained that administrative claims-based quality measures do not require data submission (90 FR 49616) and finalized corresponding administrative claims-based quality measure scoring policies (90 FR 49630). However, we did not specify whether we would score such measures at the group (that is, TIN) or individual (that is, TIN/NPI) level.

We are now proposing to specify the level at which we would calculate administrative claims-based quality measures. Specifically, we propose at § 512.725(e)(3)(i) to score all administrative claims-based quality measures at the individual (that is, TIN/NPI) level to ensure that performance assessment reflects the individual ASM participant performance regardless of eligibility to report quality measures at the group (that is, TIN) level. Administrative claims-based quality measures do not require ASM participants to submit data, thereby reducing reporting burden for all ASM participants, including those that may be from a small group practice or face resource constraints. Scoring these measures at the individual (that is, TIN/NPI) level preserves the model's intended focus on individual specialist accountability. .

We also propose modifications to §§ 512.725(h)(1) and 512.725(h)(2) to clarify quality ASM performance category scoring policies applicable to quality measures reported by an ASM participant, compared to administrative claims-based quality measures calculated by us. These proposals aim to align regulatory text with the nature of quality measure collection types, distinguishing quality measures for which ASM participants actively submit data from administrative claims-based quality measures that we calculate and therefore do not require data submission.

Accordingly, we propose to reorganize and revise regulatory text at § 512.725(h)(1)(i) to clarify the different requirements that administrative claims-based quality measures and non-

administrative claims-based quality measures must meet to be scored. Specifically, we propose to remove the phrase "on which data is submitted" from § 512.7250(h)(1)(i), which describes how ASM participants are awarded achievement points for quality measures that meet the specified criteria, to conform with the proposed reorganization of this section of regulatory text.

We also propose to describe all scoring requirements for non-administrative claims-based quality measures at § 512.725(h)(1)(i)(A). Specifically, we propose to redesignate former regulatory text § 512.725(h)(1)(i)(A) through (h)(1)(i)(C) as § 512.725(h)(1)(i)(A)(*1)* through (h)(1)(i)(A)(*3*), respectively. We then propose to revise § 512.725(h)(1)(i)(A) to describe that quality measures other than administrative claims-based quality measures must meet the requirements described at § 512.725(h)(1)(i)(A)(*1)* through (h)(1)(i)(A)(*3*) to be scored. We also propose to redesignate regulatory text formerly at § 512.725(h)(1)(i)(D) to § 512.725(h)(1)(i)(B) and to revise text to clarify the scoring requirements for administrative claims-based quality measures. We note that these proposed revisions do not make substantive changes to existing scoring requirements but would provide greater clarity to ASM participants on the specific requirements for quality measures to be scored.

We also propose to clarify our provisions related to the determination of quality measure benchmarks. Specifically, we propose to remove § 512.725(h)(2)(iii), which describes the periods we may use to calculate administrative claims-based quality measure benchmarks. We believe this paragraph is unnecessary in light of § 512.725(h)(2)(i), which sufficiently describes the periods we may use to calculate any quality benchmark, whether administrative claims-based or otherwise. To conform with this proposal, we also propose to remove cross-references to § 512.725(h)(2)(iii) from §§ 512.725(h)(1)(i)(D) and 512.725(h)(2)(i), as well as redesignate former § 512.725(h)(2)(iv) as new § 512.725(h)(2)(iii). These proposals would allow more flexibility in determining appropriate and fair benchmarks and ensure that benchmark time periods align with the performance periods of the administrative claims-based quality measures.

We also propose to clarify quality measure scoring when we are unable to determine a

benchmark. Specifically, we propose at § 512.725(h)(2)(iv) that we would exclude any required quality measure for which we cannot calculate a benchmark in the determination of an ASM participant's quality ASM performance category score. We would do so by removing the total measure achievement points (that is, the points calculated for the numerator of the quality ASM performance category score) and the total available measure achievement points (that is, the points calculated for the denominator of the quality ASM performance category score) from the quality ASM performance category score calculation for any quality measure that lacks a benchmark. While we state that a quality measure must have a benchmark to be scored under proposed § 512.725(h)(1)(i), we believe that this proposal clarifies the effect of a quality measure lacking a benchmark on the overall quality ASM performance category score.

We seek comment on our proposal at § 512.725(e)(3)(i) to score all administrative claims-based quality measures at the TIN/NPI level. We also seek comment on our proposed reorganization of regulatory text at § 512.725(h)(1)(i) to separately describe the scoring requirements for non-administrative claims-based quality measures and administrative claims-based quality measures. We seek comment on our proposals at § 512.725(h)(2) to clarify provisions related to the determination of quality measure benchmarks. Finally, we seek comment on our proposal at § 512.725(h)(2)(iv) describing how we would account for quality measures without benchmarks in the quality ASM performance category score calculation.

(5) Voluntary Data Submission for the Development of Patient-reported Outcome-based Performance Measures (PRO-PMs)

As discussed in the CY 2026 PFS final rule (90 FR 49612), we are considering future adoption of one or more patient-reported outcome-based performance measures (PRO-PMs) in ASM that would evaluate changes in patient-reported health status, physical function, symptoms, aggregate patient-reported health status, or other related outcomes over time. Unlike a functional status process measure that assesses whether a functional status assessment or other patient-reported assessment was completed, a PRO-PM would collect information directly from patients

to assess whether the care furnished by an ASM participant is associated with improvement in, or slowing of decline in, ASM beneficiary-reported outcomes. We believe such measures could better capture outcomes that matter to ASM beneficiaries and support more patient-centered specialty care. Standardized assessment of patient-reported health status using a validated questionnaire can be useful for providing incremental information related to patient functional status and prognosis. It is also an independent predictor of hospitalization and mortality.[176] PRO-PMs may also encourage ASM participants to incorporate the patient voice and lived experience into clinical decision-making, treatment planning, longitudinal monitoring, and shared decision-making. At this time, we are considering the development of PRO-PMs specific to each ASM targeted chronic condition.

We are interested in using the Patient-Reported Outcomes Measurement Information System (PROMIS) as the basis for a PRO-PM as it is a set of standardized, validated patient-reported outcome instruments that can be used to assess domains such as physical function, symptoms, pain interference, mental health, social health, and quality of life.[177] We believe PROMIS would allow for a standardized measurement framework across ASM participants, ASM targeted chronic conditions, and care settings. Unlike other patient-reported outcome (PRO) instruments that exclusively focus on a particular clinical population, PROMIS includes domains relevant across chronic conditions and can be administered through flexible formats, including short forms and computer adaptive tests. It also has condition-specific profiles, like PROMIS+HF, that is relevant to ASM.[178] Finally, other Innovation Center models either use or plan to use PROMIS, such as the Advancing Chronic Care with Effective, Scalable Solutions

[176] Heidenreich PA, Bozkurt B, Aguilar D, et al. 2022 AHA/ACC/HFSA Guideline for the Management of Heart failure: a Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. *Circulation*. 2022;145(18). doi:*https://doi.org/10.1161/cir.0000000000001063*.
[177] "Patient-Reported Outcomes Measurement Information System (PROMIS)." *NIH Common Fund*, National Institutes of Health, https://commonfund.nih.gov/promis.
[178] Ahmad, Fatima S., et al. "Validation of PROMIS+HF Profile Instruments in Heart Failure Patients." ESC Heart Failure, vol. 9, no. 5, 2022, pp. 3380–3392. PubMed Central, *https://pmc.ncbi.nlm.nih.gov/articles/PMC9715763/*.

(ACCESS) Model.[179] We also note that PROMIS is already a permitted standardized tool to satisfy the Functional Status Assessments for Heart Failure measure (MIPS Q377) in the ASM heart failure cohort quality measure set and the proposed Functional Outcome Assessment measure (MIPS Q182) in the ASM low back pain cohort quality measure set.

We recognize that some ASM participants may currently use different patient-reported assessment instruments. To the extent scientifically appropriate, existing crosswalks or linking methods may help inform transitions from other instruments to PROMIS. For example, PROsetta Stone provides methods for linking PROMIS scores with other patient-reported outcome measures (PROMs) that assess similar concepts, which may support comparability across instruments.[180] This could provide flexibility for ASM participants using other instruments while preserving the standardized measurement framework that would be important for PRO-PM development.

While we are prioritizing PROMIS data collection, we are also interested in collecting data from other PRO instruments where appropriate to support evaluation and validation of PROM-to-PROM crosswalks that may facilitate future PRO-PM implementation.

We believe providing an opportunity for voluntary data submission would be an important step toward developing meaningful, patient-centered outcome measures for ASM. Incentivizing early submission of PROMIS and, potentially, other PRO data would help us determine whether future PRO-PMs are feasible and appropriate to be proposed for inclusion in the model through notice-and-comment rulemaking. This voluntary data submission approach would also provide ASM participants an opportunity to build PRO data collection infrastructure before any future PRO-PM would be proposed as a quality measure used in evaluating performance under ASM.

---

[179] "ACCESS (Advancing Chronic Care with Effective, Scalable Solutions) Model." *Centers for Medicare & Medicaid Services*, U.S. Department of Health and Human Services, *https://www.cms.gov/priorities/innovation/innovation-models/access*.
[180] "PROsetta Stone." *PROsetta Stone*, *https://www.prosettastone.org*.

(a) Quality ASM Performance Category Scoring Incentive for Voluntary Patient-reported Outcome (PRO) Data

To support the development of PRO-PMs under ASM, we propose to establish a voluntary data submission opportunity and scoring incentive for ASM participants to report PRO data, including data collected using PROMIS instruments and, as applicable, other CMS-specified PRO instruments. The goal of this data submission would be to support the development, testing, and potential future inclusion of PRO-PMs in ASM's quality measure sets. Since ASM currently does not require ASM participants to submit PROMIS or other PRO data for measure development purposes, we recognize that there may be insufficient incentives for ASM participants to voluntarily collect and submit such data. We believe establishing an appropriate incentive for voluntary data submission by ASM participants would support efforts to collect the data needed to inform PRO-PM development and whether any developed PRO-PM would be feasible for inclusion in an ASM cohort's quality measure set during the ASM test period. We believe this proposal is consistent with the Innovation Center's authority under section 1115A of the Act to test innovative payment and service delivery models that improve the quality and coordination of care, including approaches that support development and assessment of patient-centered quality measurement and beneficiary-reported outcomes.

Specifically, we propose at § 512.725(i) to create a quality ASM performance category scoring incentive by adding 5 points to an ASM participant's quality ASM performance category score for an applicable ASM performance year if the ASM participant submits beneficiary-level PRO data that meets criteria established by CMS, provided such additional points would not cause the ASM participant's score to exceed the maximum quality ASM performance category score otherwise available under the model. We refer readers to the proposed PRO data submission criteria discussed later in this section of this proposed rule. We also refer readers to section III.D.2.f.(4) of this proposed rule where we propose to notify an ASM participant if they

meet the data submission requirements to receive the quality ASM performance category scoring incentive through their annual ASM performance report.

We believe that this scoring incentive approach would recognize the additional effort required to collect and submit PRO data and would avoid disadvantaging ASM participants not yet prepared to voluntarily collect and submit PRO data. The proposed 5-point scoring incentive added to the quality ASM performance category score represents half of the maximum quality measure achievement points for a single quality measure. We believe this amount appropriately incentivizes voluntary data submission by offering an increase to the quality ASM performance category score without equaling the maximum achievement points that can be earned through performance on quality measures. We believe such an approach would preserve the integrity and importance of the existing quality measure set required of each ASM participant. We further believe that structuring the scoring incentive so that an ASM participant's total quality ASM performance category score cannot exceed the category's maximum score would preserve the integrity and fairness of performance comparisons while encouraging voluntary data submission.

Eligibility for the scoring incentive for voluntary data submission would be limited to the ASM cohorts for the ASM performance years in which we are actively developing a PRO-PM. For example, if we establish a voluntary heart failure PRO data submission opportunity in the 2027 ASM performance year, only ASM heart failure participants would be eligible to receive the 5-point scoring incentive for the 2027 ASM performance year and ASM low back pain participants would not be eligible for the scoring incentive for that year.

We clarify that we are not proposing at this time to (1) adopt a new PRO-PM in the quality measure for either ASM cohort, (2) evaluate ASM participants on PROMIS performance, or (3) require ASM participants to collect or submit PROMIS or other PRO data. Rather, this proposal is intended to support voluntary data collection to support our evaluation of the feasibility, reliability, validity, and appropriateness of one or more future PROMIS-based or other PRO-based PRO-PMs before any such measure would be proposed for inclusion in an

ASM cohort's quality measure set, which we would propose through future notice-and-comment rulemaking.

We considered an alternative approach under which ASM participants could receive a higher number of additional points as this could provide greater incentive to voluntarily submit sufficient data for measure development purposes. We are not proposing a higher number of additional points because it could reduce the distinction between the measure achievement points available for existing performance-based quality measures and the voluntary submission of PRO data for measure development purposes. Conversely, we are not proposing a lower number of additional points to the quality ASM performance category score because we believe this may not provide a sufficient incentive to encourage meaningful participation in voluntary data submission.

We also considered an alternative approach to award 10 points, the maximum quality measure achievement score, for the existing PROM-related process measure for ASM participants who successfully: (1) submit a required PROM-related process measure included in the quality ASM performance category measure set and (2) voluntarily submit the CMS-specified PRO data for an applicable ASM performance year. For example, under this alternative, an ASM heart failure participant who successfully reports the Functional Status Assessments for Heart Failure measure (MIPS Q377) and voluntarily submits the CMS-specified PRO data would automatically receive 10 measure achievement points for the Functional Status Assessments for Heart Failure measure regardless of actual performance as assessed against the applicable benchmark. For the same reasons noted above regarding our intent to draw distinction between performance-based quality measurement and data submission, we are not proposing this alternative. Additionally, we believe this approach would not provide meaningful incremental incentives for some ASM participants because those ASM participants who successfully collect and voluntarily submit the required PRO data may already be likely to perform well on the associated PROM-related process measure.

We also considered establishing a tiered incentive structure under which the number of additional points awarded to the quality ASM performance category score would be scaled based on the quantity, completeness, representativeness, or other related characteristics of the voluntarily submitted PRO data. For example, ASM participants that submit data for a larger number of ASM beneficiaries, achieve higher response or follow-up completion rates, or submit additional data elements that could support measure development and testing would receive a larger scoring incentive than ASM participants that meet the minimum data submission requirements. We are not proposing this alternative because our goal is that all voluntarily submitted data intended for measure development should meet the minimum requirements necessary to support reliable and scientifically sound measure development and testing. We are concerned that a tiered approach could create an incentive that prioritizes submission volume over data quality or could imply that data meeting the minimum submission requirements is less valuable for measure development purposes. Therefore, we believe a single incentive tied to successful completion of all required data submission requirements is a more appropriate approach.

We also considered whether to encourage voluntary PRO data submission through non-scoring mechanisms, such as providing ASM participants with enhanced feedback reports, analytic tools, educational resources, or other related support. We recognize that such resources could be of operational value to ASM participants while supporting our development of PRO-based quality measures. However, we are not proposing a non-scoring-based incentive as we do not believe this would, by itself, provide sufficient incentive to encourage broad voluntary participation in PRO data collection and submission activities. While we may consider providing operational support or resources in the future, we believe a direct scoring incentive is more likely to generate the quantity and quality of data necessary to support timely PRO-PM development and testing.

We further considered another alternative whereby the maximum quality ASM performance category score would not be capped, allowing an ASM participant's quality ASM performance category score to exceed the maximum points otherwise available for the quality ASM performance category for the limited purpose of encouraging voluntary PRO data submission. For example, under this alternative, an ASM participant who earns a quality ASM performance category score of 46 points and voluntarily submits PRO data for the applicable performance year would receive 51 points out of 50 points available for the final quality ASM performance category. We are not proposing this alternative because it would be inconsistent with the existing quality ASM performance category scoring methodology. The quality and cost ASM performance categories were intentionally designed to have equal weight in the calculation of a final score. Allowing the quality ASM performance category score to exceed its current maximum could disrupt that balance and place disproportionate emphasis on quality scoring relative to cost performance. We believe maintaining the current maximum quality ASM performance category score preserves comparability across ASM participants and the integrity of the quality scoring framework.

Finally, we considered another alternative incentive whereby we would add additional points to the final score of an ASM participant who successfully reports the CMS-specified PRO data for the applicable ASM performance year. Under this approach, the additional points would be added to the final score after calculation of any applicable ASM performance category scores to directly increase the ASM participant's final score. We are not proposing this alternative because it would disconnect the incentive from the quality ASM performance category, where the benefits of collecting and reporting PRO data are most appropriately reflected. In addition, applying additional points directly to an ASM participant's final score could have broader effects on overall model performance and payment adjustment outcomes than intended and would be less consistent with the targeted objective of encouraging voluntary data submission to support future PRO-PM development.

We seek comment on our proposal at § 512.725(i) to provide 5 additional points to the quality ASM performance category score of an ASM participant who voluntarily submits CMS-specified PRO data and meets all data submission requirements for an applicable ASM performance year. We seek comment on all alternatives that we considered. We also invite comment on whether the proposal and alternatives would support voluntary data submission to achieve the goal of developing PRO-PMs applicable to ASM.

(b) Requirements for Successful Voluntary PRO Data Submission

Development of a valid, reliable, and feasible PRO-PM requires sufficient beneficiary-level PRO data prior to implementation and scoring of the measure. In particular, data is needed to: (1) analyze measure reliability and validity, (2) evaluate feasibility of data collection and submission, (3) measure response rates and missingness, (4) examine potential nonresponse bias, (5) identify appropriate risk adjustment variables, and (6) determine whether a measure can meaningfully and fairly distinguish performance across ASM participants within a given ASM cohort. For potential PRO-PMs, development may require that data be collected over an extended episode or longitudinal assessment period, including baseline and follow-up PRO assessments. Accordingly, early collection and submission of PRO data by ASM participants is important to support timely development and testing of PRO-PMs such that we could propose measures for future inclusion in ASM's respective quality measure sets through future notice-and-comment rulemaking.

To support PRO-PM development, we would specify the applicable PRO instrument(s), the required data that an ASM participant would need to voluntarily submit, and applicable data collection periods. Accordingly, we propose to define the data submission requirements that an ASM participant would need to meet to ensure we receive sufficient and reliable data to develop and test PRO-PMs applicable to ASM.

Specifically, at § 512.725(i)(1), we propose to define all data submission requirements an ASM participant would need to meet to receive the proposed scoring incentive in the quality ASM performance category for an applicable ASM performance year .

First, at § 512.725(i)(1)(i), we propose that an ASM participant would need to submit CMS-specified baseline assessment data for at least 20 ASM beneficiaries during the first data collection period specified by us. By baseline data, we mean the initial CMS-specified PRO assessment data collected for an ASM beneficiary during the applicable data collection period that occurs before the collection of any corresponding follow-up assessment data for the beneficiary. After baseline data is collected, an ASM participant would submit CMS-specified follow-up assessment data for at least 20 ASM beneficiaries for whom they previously submitted a baseline assessment during the preceding data collection period specified by us.

Our goal in establishing minimum baseline and follow-up assessment requirements is to ensure we receive sufficient longitudinal PRO data to support development and testing of future PRO-PMs. We believe that collecting baseline assessment data initially then collecting corresponding follow-up assessment data during a subsequent data collection period would allow us to evaluate changes in beneficiary-reported outcomes over time while reducing operational burden during the initial year of data collection. The specific amount of time between a baseline and follow-up assessment would depend on the selected PRO instrument(s) and ASM targeted chronic condition, however, we anticipate that a collection period of at least 6 months between a beneficiary's baseline and follow-up assessments may be necessary to allow sufficient time to observe meaningful changes in patient-reported outcomes. We would provide specifications regarding the timing of baseline and follow-up assessments and specific data collection periods through sub-regulatory technical guidance.

Second, at § 512.725(i)(1)(ii), we propose that an ASM participant would need to report all required data elements for the applicable PRO instrument as specified by us for the applicable data collection period. We anticipate that required data elements would include at least: (i) the

PRO instrument name and version, (ii) ASM participant identification information, (iii) ASM beneficiary identification information and linkage information, (iv) assessment date, (v) baseline or follow-up assessment indicator, (vi) mode of administration, (vii) item-level responses, (viii) nonresponse and missingness indicators, (ix) raw and standardized scores, (x) score calculation method, and (xi) other data elements needed to support measure testing and risk adjustment model testing. If testing would require use of a crosswalk, such as PROsetta, we anticipate that we would also require reporting of data elements specific to the crosswalk. The required data elements and format in which an ASM participant would need to submit the data would be specific to the selected PRO instrument(s) and would be specified by us in sub-regulatory technical guidance.

Third, at § 512.725(i)(1)(iii), we propose that an ASM participant would need to submit data on a minimum set of risk variables for each ASM beneficiary from whom they collect PRO data. Risk adjustment is necessary to ensure that performance results under a PRO-PM reflect quality of care rather than patient complexity to avoid penalizing clinicians who may serve higher-risk beneficiary populations. Reporting a minimum set of risk variables for each ASM beneficiary receiving a PRO assessment would allow us to develop a scientifically acceptable, robust, and reliable risk model for any developed PRO-PM. The reported risk variable data would be used to conduct assessments of association between risk variables and the measured PRO to inform risk variable selection and ensure the risk model captures the most clinically and statistically relevant risk variables. Example risk variables could include but are not limited to age, race, ethnicity, socioeconomic status, clinical comorbidities, baseline clinical severity, physiological measures (for example, body mass index or blood pressure), pain history, surgical history, disease classification, medication usage, behavioral factors, functional and disability status, and other condition-specific characteristics. We believe that the risk variables would be different for each ASM targeted chronic condition for which we would develop a PRO-PM. We intend to provide the minimum risk variables applicable for the selected PRO instrument(s),

including each risk variable's technical specifications, through sub-regulatory technical guidance.

Fourth, at § 512.725(i)(1)(iv), we propose that an ASM participant must submit the PRO data for any applicable data collection period by the generally applicable data submission deadline for the applicable ASM performance year, which is March 31st, or later in the calendar year, as specified by as, following the close of the applicable ASM performance year. We recognize that—depending on the applicable PRO instrument, measure concept, and assessment interval—baseline and follow-up assessments for an ASM beneficiary may need to occur across ASM performance years to allow a sufficient interval between the initial and follow-up PRO assessments. In such cases, we would specify through technical guidance how ASM participants would submit baseline and follow-up data for data collection periods that span ASM performance years and how this would impact the availability of the scoring incentive for a given ASM performance year. We believe that aligning the voluntary PRO data submission deadline with the generally applicable data submission deadline for ASM performance category data would streamline and simplify the data submission and would provide us adequate time to confirm if the submitted PRO data meets the requirements to receive the proposed scoring incentive for the quality ASM performance category. We anticipate that the PRO data submission would occur through one or more mechanisms, such as a CMS-specified file format, registry submission, qualified clinical data registry or other intermediary, Health Level Seven Fast Healthcare Interoperability Resources (HL7 FHIR)-based submission, or another electronic submission mechanism specified by CMS. We would provide additional operational details through technical guidance, including applicable submission deadlines, data formats, validation processes, and any minimum data completeness or case minimum requirements. We also seek to preserve flexibility to align submission requirements with existing ASM participant workflows and health information technology capabilities to the extent feasible.

We recognize that in some instances ASM participants may need to correct their voluntary data submission. Accordingly, we propose at § 512.725(i)(2) that ASM participants could correct and resubmit any PRO data corresponding with voluntary data submission by the proposed data submission deadline of March 31st in accordance with the generally applicable data submission deadline for the applicable performance year, or a later date specified by CMS. Because the proposed scoring incentive would affect the quality ASM performance category score, we propose to only accept timely submissions, corrections, or resubmissions and reject those received after the data submission deadline. We believe this approach is necessary to preserve the integrity and finality of the scoring process and payment adjustment methodology and to align voluntary PRO data submission with other ASM performance category data submission requirements. We would consider providing submission error reports or other technical feedback identifying errors, missing data elements, beneficiary linkage issues, data completeness concerns, or other issues before the applicable data submission deadline to support ASM participants.

Relatedly, we propose at § 512.725(i)(3) that an ASM participant may seek review under ASM's timely error notice process for technical errors related to CMS' determination of whether the ASM participant met the voluntary PRO data submission requirements or correctly received the quality ASM performance category scoring incentive for the applicable ASM performance year as provided in the ASM participant's annual ASM performance report. To align with ASM's timely error notice requirements and process described at § 512.755, the ASM participant may submit a written timely error notice if they believe an error occurred in calculations due to data quality, misapplication of methodology, or other related issues that would relate to whether the ASM participant qualified for the proposed quality ASM performance category scoring incentive for the applicable ASM performance year. Examples of such errors include beneficiary linkage errors, failure to account for data timely submitted by the ASM participant, or other

technical errors in our evaluation of the voluntary PRO data submission against data requirements.

We considered requiring that an ASM participant submit PRO data on more than 20 ASM beneficiaries or fewer than 20 ASM beneficiaries during each CMS-specified data collection period specified. We also considered requiring that an ASM participant submit PRO data on a minimum percentage of their ASM beneficiaries (for example, 25 to 100 percent) during the applicable data collection period. However, we believe an adequate number of ASM participants collecting and reporting PRO data on a minimum of 20 ASM beneficiaries each would provide an adequate sample size for PRO-PM development and align with the 20-case minimum for quality measures under ASM.

We also considered requiring an ASM participant to submit PRO data more frequently during an ASM performance year (for example, quarterly or biannually). Multiple data submission time points, such as quarterly or on a rolling basis rather than a single annual submission, may offer several advantages. It would enable the selected submission mechanism (for example, data submission portal) to provide ASM participants who voluntarily submit data with timely, actionable feedback on the quality of the data submitted, flagging inaccuracies and offering opportunities for correction and resubmission before the applicable data collection period and ASM performance year ends. Iterative data collection and feedback could support a continuous improvement process, helping ASM participants identify and resolve data quality issues early. This would be particularly helpful for avoiding the scenario where a provider submits data once annually, only for that data to be found unusable at the point of determining eligibility for the quality ASM performance category scoring incentive. More frequent data submissions would likely improve the quality of data for measure development and testing. While more frequent data submission would offer several advantages, we believe that aligning the voluntary data submission deadline with the overall data submission deadline for ASM performance category data would be administratively simpler for ASM participants.

We also considered requiring ASM participants to submit both baseline and follow-up assessment data for the same ASM beneficiaries during a single ASM performance year. Under this alternative, an ASM participant would be required to collect and submit both the initial and follow-up PRO assessments within the same ASM performance year to receive the voluntary PRO data submission scoring incentive. We recognize that this approach could accelerate collection of matched assessment data and potentially expedite certain measure development and testing activities. However, we are not proposing this alternative because the appropriate interval between baseline and follow-up assessments may vary depending on the selected PRO instrument, the targeted chronic condition, and the future PRO-PM concept under development. We are also concerned that requiring both assessments within a single ASM performance year could limit flexibility, increase operational burden on ASM participants, and reduce the amount of time available to observe meaningful changes in ASM beneficiary-reported outcomes.

For any data collection period following a baseline data collection period, we considered that an ASM participant would need to submit baseline assessment data for additional ASM beneficiaries that were either newly eligible for a selected instrument or had not previously been assessed using a selected instrument. This new baseline data would be in addition to the follow-up assessment data that we propose to require. We believe that this structure could increase the amount of data available to develop a PRO-PM over time. However, we would require additional information to determine the minimum number of new baseline assessments that would be appropriate to require the ASM participant to collect during a subsequent data collection period.

We also considered whether to require additional criteria for successful voluntary PRO data submission, including submission of a denominator file of eligible ASM beneficiaries; use of a CMS-specified sampling methodology, such as consecutive, all-eligible, all-payer, or random sampling; minimum response or completion rates; minimum baseline and follow-up completion thresholds; and documentation of exclusions, where applicable, for identified ASM beneficiaries. We are not proposing these additional requirements at this time because the

appropriate denominator, sampling approach, response-rate threshold, completion threshold, and exclusion documentation requirements may vary based on the selected PRO instrument, ASM targeted chronic condition, data submission mechanism, and measure concept under consideration for development.

We seek comment on the proposed requirements for voluntary PRO data submission at § 512.725(i)(1) that an ASM participant would need to meet to receive the proposed quality ASM performance category scoring incentive. We also seek comment on all alternatives considered and other data submission requirements we should consider to support PRO-PM development under ASM. Additionally, we seek comment on the appropriate timing of data submission and the scope of data elements that should be required for successful voluntary data submission, particularly data elements necessary to evaluate a PRO-PM's feasibility, reliability, and validity. We also invite comment on the specific risk variables applicable for each ASM targeted chronic condition that we should require ASM participants to report. We are particularly interested in comments on the earliest feasible timeframe for ASM participants to begin collecting and submitting PROMIS or other CMS-specified PRO data, the operational challenges ASM participants may face, and the types of technical assistance or guidance that would facilitate voluntary data submission. Finally, we seek comment on data submission mechanisms that would simplify the voluntary reporting of PRO data to support PRO-PM development under ASM.

e. Promoting Interoperability ASM Performance Category

(1) Background

As discussed in the CY 2026 PFS final rule (90 FR 49658 through 49661), we believe the Promoting Interoperability ASM performance category measures finalized under § 512.740 support the overall goals of ASM to enhance the quality of care, reduce costs by encouraging upstream chronic condition management, empower patients to engage in their care, and promote collaboration between specialists and primary care. ASM's Promoting Interoperability objectives

and measures align with the Promoting Interoperability goals, objectives, and measures used in other programs, including MIPS.

We finalized at § 512.740(b)(2) that an ASM participant must report on MIPS Promoting Interoperability objectives and measures, as specified in technical documents. Specifically, under §§ 512.740(b)(2)(i) through (iv), we finalized inclusion of the following objectives under the Promoting Interoperability ASM performance category:

- Electronic Prescribing;
- Health Information Exchange (HIE);
- Provider to Patient Exchange; and
- Public Health and Clinical Data Exchange (90 FR 49658).

We aim to align ASM and MIPS Promoting Interoperability requirements where possible to promote consistency across programs and reduce burden and operational complexity for ASM participants who may already be familiar with MIPS Promoting Interoperability measures and attestations.

In support of alignment with MIPS, we propose certain updates in ASM, to include proposals that align with those being issued through this proposed rule for the MIPS Promoting Interoperability performance category, as well as proposals that align with policies previously finalized for inclusion in MIPS that we did not yet adopt for ASM. We refer readers to section IV.A.4.f.(4) of this proposed rule for further discussion on MIPS Promoting Interoperability proposals.

Specifically, we propose to:

- Revise the HIE objective at § 512.740(b)(2)(ii) to reorganize its structure and add an optional measure, Electronic Prior Authorization (Measure ID # PI_HIE_7), for the 2027 ASM performance year at proposed new § 512.740(b)(2)(ii)(B);
- Starting in the 2028 ASM performance year, require the Electronic Prior Authorization measure and require the new Electronic Prior Authorization for Prescription Drugs measure

(Measure ID # PI_HIE_8) at proposed new § 512.740(b)(2)(ii)(C);

- Adopt a measure exclusion policy for ASM for measures within the Public Health and Clinical Data Exchange objective at proposed § 512.740(b)(2)(iv), consistent with a longstanding MIPS policy;

- Make technical modifications to the language describing measure-level exclusions for measures that include an option to claim an exclusion at § 512.740(b)(3)(i)(C);

- Remove the requirement to report through attestation the security risk analysis measure by striking § 512.740(b)(3)(ii);

- Remove Office of the National Coordinator for Health Information Technology (ONC) direct review required attestations by striking § 512.740(b)(4)(i);

- Retain the requirement to avoid knowingly and willfully taking actions to limit or restrict interoperability of CEHRT but redesignate it from current § 512.740(b)(4)(ii) to § 512.740(b)(4)(i);

- Redesignate current § 512.740(c)(2) describing the Promoting Interoperability ASM performance category scoring policy as § 512.740(c)(3) without changing the regulatory text; and

- Adopt a measure suppression policy at new § 512.740(c)(2) that aligns with the policy we adopted in the CY 2026 PFS final rule for MIPS.

Table B-D2 summarizes existing finalized requirements and new proposals in this proposed rule for the objectives and measures in the Promoting Interoperability ASM performance category for the 2027 ASM performance year. We discuss new proposals in the remainder of this section of this proposed rule.

TABLE B-D2: PROPOSED ASM PROMOTING INTEROPERABILITY OBJECTIVES AND MEASURES FOR THE 2027 ASM PERFORMANCE YEAR

Objectives	Measures	Available Points (based on performance)	Redistribution if exclusion is claimed
e-Prescribing	e-Prescribing	1 to 10 points	10 points to HIE objective
	Query of PDMP	10 points	10 points to the e-Prescribing measure
	Select one of the following three reporting options:	30 points for the objective	Measure specific

Health Information Exchange (HIE)	Option 1	Support Electronic Referral Loops by Sending Health Information	1 to 15 points	15 points to Provide Patients Electronic Access to Their Health Information measure
		Support Electronic Referral Loops by Receiving and Reconciling Health Information	1 to 15 points	15 points to the Support Electronic Referral Loops by Sending Health Information measure
	Option 2	HIE Bi-Directional Exchange	30 points	No exclusion
	Option 3	Enabling Exchange under TEFCA	30 points	No exclusion
	Option to report the Electronic Prior Authorization measure		No bonus points	Not applicable
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information		1 to 25 points	No exclusion
Public Health and Clinical Data Exchange	Report to the following public health or clinical data registries: 1. Immunization Registry Reporting 2. Electronic Case Reporting		25 points for the objective	25 points to the Provide Patients Electronic Access to their Health Information measure if an exclusion is claimed for both measures.
	Option to report one of the following public health agency or clinical data registry measures: • Public Health Registry Reporting, • Clinical Data Registry Reporting, or • Syndromic Surveillance Reporting		No bonus points	Not applicable

(2) Proposed Update to CEHRT Definition

We refer readers to section IV.A.4.f.(4) of this proposed rule for a discussion of proposed updates to the definition of CEHRT under MIPS. Under § 512.705, we define CEHRT for the purposes of ASM as technology that meets the requirements set forth in MIPS regulations at § 414.1305. We are not proposing to depart from this approach. Therefore, any updates finalized to the definition of CEHRT under MIPS would be incorporated for purposes of ASM under the existing definition at § 512.705. We refer readers to Table C-G1 of this proposed rule for a summary of changes.

(3) Electronic Prior Authorization Measures in the Health Information Exchange Objective

(a) Overview

In the "Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, Merit-based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the

Medicare Promoting Interoperability Program" final rule (89 FR 8758) (hereinafter referred to as the "2024 CMS Interoperability and Prior Authorization final rule"), we finalized requirements for Medicare Advantage organizations, Medicaid managed care plans, State Medicaid agencies, CHIP agencies, CHIP managed care entities, and issuers of qualified health plans on the Federally-facilitated Exchanges (collectively, "impacted payers") to improve the electronic exchange of health care information and streamline prior authorization for medical items and services. Impacted payers must implement and maintain prior authorization application programming interface (API) technology to communicate information related to prior authorization requests (89 FR 8763). As we explained in the 2024 CMS Interoperability and Prior Authorization final rule, the efficiencies associated with payer implementation of these APIs will be more fully realized when requesting providers also use API-enabled processes to submit prior authorization requests.

Accordingly, we finalized the addition of an Electronic Prior Authorization measure as a required measure for MIPS eligible clinicians under the MIPS Promoting Interoperability performance category HIE objective (89 FR 8910 through 8927).

(b) 2027 ASM Performance Year: Electronic Prior Authorization Measure

We believe adopting the Electronic Prior Authorization measure within ASM would support broader Departmental efforts to advance interoperability, modernize prior authorization processes by encouraging ASM participants to develop capabilities that advance the interoperable exchange of data related to prior authorization requests, and support alignment with MIPS. This measure describes requesting a prior authorization electronically using CEHRT to send a request through a payer's Prior Authorization API for at least one medical item or service (excluding prescription drugs) ordered within the applicable performance year.

We now propose to include the Electronic Prior Authorization measure (Measure ID # PI_HIE_7) in the Promoting Interoperability ASM performance category under the HIE objective, consistent with MIPS, starting in the 2027 ASM performance year. For the 2027 ASM

performance year, we propose that the Electronic Prior Authorization measure would be available as an optional, unscored ASM Promoting Interoperability measure, without any scoring penalty for non-reporting. We propose to codify this measure for ASM at § 512.740(b)(2)(ii)(B).

We propose to rely on the measure specifications used in MIPS for the Electronic Prior Authorization measure and refer readers to section IV.A.4.f.(4) of this proposed rule for a discussion of the technical specifications for the Electronic Prior Authorization measure under MIPS, including proposed modifications to the measure specifications, which we propose to adopt in ASM.

To report the Electronic Prior Authorization measure, an ASM participant would submit a “yes” response attesting they satisfactorily met the requirements of the measure. We do not propose to adopt any exclusions for this measure for the 2027 ASM performance year, since the measure would be optional and attesting "no" or not attesting at all would not result in a scoring penalty.

Under our proposal for ASM, the Electronic Prior Authorization measure would be included under the HIE objective, consistent with MIPS. Under the current ASM HIE objective, an ASM participant satisfies the objective by reporting one of three available reporting options:

- Support Electronic Referral Loops by Sending Health Information (Measure ID # PI_HIE_1) and Support Electronic Referral Loops by Receiving and Reconciling Health Information (Measure ID # PI_HIE_4).
- Health Information Exchange (HIE) Bi-Directional Exchange (Measure ID # PI_HIE_5).
- Enabling Exchange Under the Trusted Exchange Framework and Common Agreement (TEFCA) (Measure ID # PI_HIE_6).

We are not proposing to change that an ASM participant must satisfy one of these three reporting options to fulfill the requirements for the HIE objective. Rather, our proposal makes the Electronic Prior Authorization measure available as an optional, voluntary measure that

could be reported in addition to one of the required HIE reporting options for the 2027 ASM performance year. While no points would be awarded to ASM participants that report this measure through submission of a "yes" attestation, we believe including the Electronic Prior Authorization as an optional measure could encourage ASM participants to develop workflows and infrastructure to support reporting the measure once it is required beginning with the 2028 ASM performance year.

We emphasize that, under our proposal, ASM participants who elect not to report for the Electronic Prior Authorization measure in the 2027 ASM performance year would not be penalized.

We considered, but do not propose, offering 5 bonus points to an ASM participant's Promoting Interoperability ASM performance category score for the 2027 ASM performance year if an ASM participant voluntarily attests "yes" to the Electronic Prior Authorization measure as an alternative policy to our proposal to treat this optional measure as unscored for the 2027 ASM performance year. We considered this approach because temporary bonus points during an optional performance year could encourage ASM participants to begin establishing and operationalizing the capabilities needed to use a Prior Authorization API with CEHRT before the measure would be required beginning with the 2028 ASM performance year. We further recognize that MIPS proposes to offer bonus points for this measure. However, we do not propose to offer bonus points for the Electronic Prior Authorization measure within the Promoting Interoperability ASM performance category because we intend to maintain a more simplified and streamlined scoring framework that does not incorporate the full complexity of MIPS bonus point structures. MIPS offers bonus points for certain optional measures under the Public Health and Clinical Data Exchange objective, however ASM does not offer bonus points for these measures. Our proposal to not offer bonus points for the Electronic Prior Authorization measure is consistent with our approach for optional measures within the Public Health and Clinical Data Exchange objective. We believe that including bonus points in the Promoting

Interoperability ASM performance category would add administrative and scoring complexities we do not intend to introduce.

We seek comment on the proposal at § 512.740(b)(2)(ii)(B) to include the Electronic Prior Authorization measure as an optional, unscored measure in the Promoting Interoperability ASM performance category for the 2027 ASM performance year. We also seek comment on the alternative we considered where we would offer bonus points to ASM participants who attest "yes" to the Electronic Prior Authorization measure for the 2027 ASM performance year. Specifically, we seek comment on whether offering bonus points would encourage early adoption among ASM participants.

(c) 2028 ASM Performance Year: Electronic Prior Authorization Measure

Beginning with the 2028 ASM performance year, we propose that an ASM participant would be required to report the Electronic Prior Authorization measure through submission of a "yes" attestation or, alternatively, claim an applicable exclusion, to satisfy the measure requirements. In such cases, the Electronic Prior Authorization measure would not affect the total score for the Promoting Interoperability ASM performance category. However, if an ASM participant submits a "no" response, fails to submit any attestation, or does not claim an applicable exclusion for the Electronic Prior Authorization measure, the ASM participant would receive a score of zero for the Promoting Interoperability ASM performance category. This scoring approach is consistent with the approach taken for MIPS eligible clinicians under proposed and existing policies.

Also starting in the 2028 ASM performance year, we propose to recognize exclusions to this measure and would adopt the same exclusion criteria as MIPS adopted in 2024 CMS Interoperability and Prior Authorization final rule (89 FR 8909 through 8927), which are discussed in this proposed rule without proposed modifications.

We believe requiring this measure beginning with the 2028 ASM performance year rather than in the 2027 ASM performance year would provide ASM participants time and flexibility to

prepare to successfully report the measure.

We propose to include this requirement at § 512.740(b)(2)(ii)(C)(1). We seek public comment on our proposal to require the Electronic Prior Authorization measure beginning with the 2028 ASM performance year.

(d) 2028 ASM Performance Year: Electronic Prior Authorization for Prescription Drugs Measure

The proposed rule “Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability Standards and Prior Authorization for Drugs for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children’s Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, and Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges” (hereinafter referred to as the "2026 CMS Interoperability Standards and Prior Authorization for Drugs proposed rule") introduced proposals that would require impacted payers to support various exchange standards in support of prior authorization for prescription drugs (91 FR 19890). Specifically, beginning on October 1, 2027, impacted payers would be required to support electronic prior authorization for all prescription drugs that require prior authorization.

As more payers support standardized electronic prior authorization capabilities, we believe measuring the use of prior authorization for prescription medications would be a valuable addition to our assessment of meaningful use of CEHRT under the Promoting Interoperability ASM performance category. Standards-based electronic prior authorization may improve timeliness and transparency of medication access by facilitating documents-gathering and tracking of prior authorization status within clinician EHR workflows to support care coordination and close the prescriber-to-dispenser loop.

Accordingly, beginning with the 2028 ASM performance year, we propose at § 512.740(b)(2)(ii)(C)(2) to adopt the Electronic Prior Authorization for Prescription Drugs measure (Measure ID # PI_HIE_8) as a required measure under the Promoting Interoperability

ASM performance category. This measure would focus on prescription drugs covered under a pharmacy benefit and dispensed at pharmacies. We propose to include this measure under the HIE objective, consistent with our proposal to include the Electronic Prior Authorization measure under this objective. We propose to include the availability of exclusions for the Electronic Prior Authorization for Prescription Drugs measure, consistent with those recognized under MIPS, starting in the 2028 ASM performance period. We propose to adopt the same measure specification and exclusion criteria for the Electronic Prior Authorization for Prescription Drugs measure that are being proposed under MIPS for the MIPS Promoting Interoperability performance category. We refer readers to section IV.A.4.f.(4) of this proposed rule for discussion on measure specifications and exclusions.

To successfully report this measure, an ASM participant would be required to submit a "yes" response attesting that they have requested electronic prior authorization using CEHRT for at least one prescription drug during the performance period, or alternatively, claim an applicable exclusion. Under our proposal, this measure would not contribute to an ASM participant's Promoting Interoperability ASM performance category score; however, if an ASM participant submits a "no" response, fails to submit any attestation, or does not claim an applicable exclusion for the Electronic Prior Authorization for Prescription Drugs measure, the ASM participant would receive a score of zero for the Promoting Interoperability ASM performance category starting in the 2028 ASM performance year.

We emphasize that, under our proposal to include the prior authorization measures under the HIE objective for ASM, an ASM participant would continue to be required to report one of the three existing HIE reporting options at current § 512.740(b)(2)(ii).

We also underscore that we are not proposing to require the Prior Authorization measure or the Prior Authorization for Prescription Drugs measure until the 2028 ASM performance year.

As stated, we aim to align proposals for ASM, as appropriate, with the direction of MIPS policy for the Promoting Interoperability performance category. This includes alignment for the

Electronic Prior Authorization measures with MIPS and with broader Departmental goals of improving interoperability and modernizing prior authorization processes. In the 2024 CMS Interoperability and Prior Authorization final rule, we explained that electronic prior authorization policies are intended to encourage provider adoption of electronic prior authorization processes and improve the exchange of information needed to support more efficient prior authorization workflows (89 FR 8910 through 8927). Although that final rule finalized the Electronic Prior Authorization measure only for medical items and services, excluding drugs, we believe those same policy goals support adoption of an Electronic Prior Authorization for Prescription Drugs measure under ASM beginning with the 2028 ASM performance year. We believe requiring both electronic prior authorization measures beginning in the 2028 ASM performance year would promote more consistent electronic prior authorization capabilities and workflows across ASM participants' operations and would support broader movement toward more efficient exchange of prior authorization information.

We seek comment on all aspects of these proposals.

(4) Exclusions to the Public Health and Clinical Data Exchange Objective in the Promoting Interoperability ASM Performance Category

In the CY 2026 PFS final rule, we finalized that an ASM participant must submit a "yes" attestation for the two required measures in the Public Health and Clinical Data Exchange objective (the Immunization Registry Reporting and Electronic Case Reporting measures) to earn 25 points for the objective (90 FR 49658 through 49662). We noted the potential availability of exclusions for the Immunization Registry Reporting and Electronic Case Reporting measures in tables published in the preamble to the proposed rule (Table 61; 90 FR 32745) and in the preamble to the final rule (Table B-D6; 90 FR 49659). However, we did not explicitly propose an exclusion policy in the narrative preamble text or memorialize that policy in the regulatory text itself. As a result, the current regulation at § 512.740(b)(2)(iv) reads as though an ASM participant must report both measures to satisfy the objective, without the

availability of exclusions for either measure.

We propose to clarify that exclusions are available to ASM participants for the Immunization Reporting Registry and Electronic Case Reporting measures by amending our regulation at § 512.740(b)(2)(iv). Under our proposal, an ASM participant would receive full credit for the Public Health and Clinical Data Exchange objective by reporting both Public Health and Clinical Data Exchange measures (Immunization Registry Reporting and Electronic Case Reporting), reporting one measure and claiming one exclusion, or claiming two exclusions. We believe this proposal would simplify ASM participant reporting requirements by aligning exclusions available in MIPS and redistributing points for excluded measures in accordance with MIPS redistribution policies.

MIPS specifies certain exclusion criteria that apply to each of the Immunization Registry Reporting and Electronic Case Reporting measures. We propose to adopt the same exclusion criteria as specified in MIPS sub-regulatory guidance for ASM, consistent with our aim to drive alignment where possible.

We seek comment on this proposal at § 512.740(b)(2)(iv), including the proposal to use the same exclusion criteria that MIPS uses for the Immunization Registry Reporting and Electronic Case Reporting measures.

(5) Security Risk Analysis Measure

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), as implemented through the HIPAA Security Rule (45 CFR part 160 and subparts A and C of part 164), includes administrative safeguards required of covered entities and business associates, including a risk analysis component and a risk management component. The Security Risk Analysis measure was adopted to require that MIPS eligible clinicians attest to having conducted a security risk analysis and security risk management activities as required by the HIPAA Security Rule. In the CY 2026 PFS final rule (90 FR 49656 through 49568), we incorporated this measure into the Promoting Interoperability ASM performance category by requiring that ASM

participants complete the actions included in the MIPS Promoting Interoperability Security Risk Analysis measure. At the time, we believed it would help drive more secure, efficient, and meaningful use of CEHRT under ASM.

To reduce reporting burden, beginning with the 2027 ASM performance year, we now propose to remove the requirement at § 512.740(b)(3)(ii) that an ASM participant submit an affirmative attestation as to completing a security risk analysis within the calendar year . We consider the use of CEHRT to demonstrate security risk analysis and security risk management activities sufficient as it complies with requirements pertaining to the security of data created and maintained by CEHRT in accordance with the HIPAA Security Rule.

Given that ASM participants are covered entities under the HIPAA Security Rule and the requirements of the Security Risk Analysis measure are derived from the HIPAA Security Rule requirements, we do not believe that removing the Security Risk Analysis measure from the Promoting Interoperability ASM performance category will weaken any cybersecurity requirements for ASM participants. Furthermore, our proposal aligns with the proposal in MIPS to remove the Security Risk Analysis from MIPS Promoting Interoperability; we refer readers to section IV.A.4.f.(4) of this proposed rule for further discussion.

To conform with removal of the Security Risk Analysis measure, we propose to redesignate current § 512.740(b)(3)(iii) as § 512.740(b)(3)(ii).

We seek comment on the proposal to remove the Security Risk Analysis measure and attestation requirement from the Promoting Interoperability ASM performance category.

(6) Supporting Providers with the Performance of CEHRT

In the CY 2026 PFS final rule (90 FR 49661), we finalized that an ASM participant must support the performance of CEHRT by submitting certain affirmative attestations to receive a Promoting Interoperability ASM performance category score greater than zero. Specifically, as finalized at §§ 512.740(b)(4)(i)(A)(1) and (2), an ASM participant must support the performance of CEHRT by:

- Providing acknowledgement of the requirement to cooperate in good faith with the Office of the National Coordinator for Health Information Technology (ONC) direct review of the ASM participant's health information technology certified under the ONC Health IT Certification Program if a request to assist in ONC direct review is received; and

- If requested, cooperate in good faith with ONC direct review of the ASM participant's health information technology certified under the ONC Health IT Certification Program as authorized by 45 CFR part 170, subpart E, to the extent that such technology meets (or can be used to meet) the definition of CEHRT, including by permitting timely access to such technology and demonstrating its capabilities as implemented and used by the ASM participant in the field.

An ASM participant may optionally attest to the following:

- The ASM participant acknowledges the option to cooperate in good faith with ONC-ACB surveillance of his or her health information technology certified under the ONC Health IT Certification Program if a request to assist in ONC-ACB surveillance is received.

- If requested, that the ASM participant cooperates in good faith with ONC-ACB surveillance of the ASM participant's health information technology certified under the ONC Health IT Certification Program as authorized by 45 CFR part 170, subpart E, to the extent that such technology meets (or can be used to meet) the definition of CEHRT, including by permitting timely access to such technology and demonstrating its capabilities as implemented and used by the ASM participant in the field.

Consistent with the proposal to remove these attestations from the MIPS Promoting Interoperability performance category, we propose to remove the ONC Direct Review attestation and ONC-ACB Surveillance attestation from the Promoting Interoperability ASM performance category starting in the 2027 ASM performance year.

This proposal aligns with our goals of reducing administrative burden while focusing on high-value, outcome-oriented measures. Removing attestations from the Promoting Interoperability ASM performance category reduces the number of discrete manual steps and

reporting fields required for successful adherence to reporting requirements without diminishing central goals of the Promoting Interoperability ASM performance category.

We refer readers to section IV.A.4.f.(4) of this proposed rule for further discussion on the proposal to remove these attestations in MIPS.

We seek comment on the proposal to remove the ONC Direct Review attestation and ONC-ACB Surveillance attestation.

(7) Adopting a Measure Suppression Policy for the Promoting Interoperability ASM Performance Category

We finalized a measure suppression policy under the MIPS Promoting Interoperability performance category beginning with the CY 2026 MIPS performance year (90 FR 49881 through 49887). Under this policy, when circumstances arise that impede effective measurement of a MIPS Promoting Interoperability measure, we may suppress the measure by excluding it from MIPS Promoting Interoperability performance category scoring or from the determination of whether a MIPS clinician is a meaningful EHR user for the applicable MIPS performance year (§ 414.1380(b)(4)(iii)).

A decision to suppress a measure does not eliminate the requirement that MIPS eligible clinicians report the measure. However, regardless of the data, attestation, or other information related to the suppressed measure that is submitted by the MIPS eligible clinician, the suppressed measure would not affect the objective's score or the determination of meaningful EHR user status (90 FR 49883).

We also finalized suppression of the Electronic Case Reporting measure for the CY 2025 MIPS performance year because the Centers for Disease Control and Prevention (CDC) temporarily paused onboarding new health care organizations for production of electronic case reporting data and new local public health agencies for receipt of electronic case reporting data (90 FR 49886 through 49893).

We did not adopt a measure suppression policy for the Promoting Interoperability ASM

performance category because ASM performance had not yet begun. We stated we would monitor developments as the first ASM performance year approaches, with the goal of maintaining alignment with the MIPS Promoting Interoperability performance category where possible and indicated we may propose changes in future rulemaking.

After further consideration, we propose at § 512.740(c)(2) to adopt a Promoting Interoperability measure suppression policy within ASM starting in the 2027 ASM performance year. Specifically, we are proposing that if certain circumstances occur that impact our assessment of ASM participant performance on a measure specified for the Promoting Interoperability ASM performance category under § 512.740(b), we may suppress the affected measure by: (1) excluding it from our calculation of the Promoting Interoperability ASM performance category objective score under § 512.740(c); or (2) excluding it from the determination of meaningful EHR user status, if the affected measure is not scored. We propose to redesignate current § 512.740(c)(2) describing the Promoting Interoperability ASM performance category scoring policy as § 512.740(c)(3), without making changes to that existing regulatory text, to describe the measure suppression policy at § 512.740(c)(2).

For an applicable ASM performance year, we propose to determine whether circumstances warrant suppression of an ASM Promoting Interoperability measure based on consideration of the same factors we identified for MIPS (90 FR 49883):

- The nature, breadth, and duration of the circumstance's effect on ASM participants' ability to fulfill the measure requirement;
- The availability of certified health IT modules to fulfill the measure;
- Whether the circumstance affects the measure such that calculating the measure score would lead to misleading or inaccurate results, including with respect to performance or compliance;
- Out-of-date or conflicting technical standards;
- Technical or operational capacity of required partners; or

- Other factors as determined by CMS.

We are further proposing that, if we determine that a measure must be suppressed, we would notify ASM participants through existing communication channels. To the extent technically feasible, we intend to notify ASM participants prior to the beginning of the applicable data submission period. We note that, like in MIPS, the duration of suppression for a measure in ASM would be for an entire ASM performance year. If prolonged issues persist regarding a given circumstance, we would assess the circumstance to determine if a measure would warrant suppression for a subsequent ASM performance year.

We believe this policy would ensure the integrity of the ASM scoring methodology while protecting ASM participants from being penalized for circumstances beyond their control.

We invite public comment on our proposal at § 512.740(c)(2) to adopt the proposed measure suppression policy.

f. Final Score

(1) Background

In the CY 2026 PFS final rule (90 FR 49664 through 49679), we adopted a scoring methodology to evaluate the annual performance of each ASM participant through a final score. The final score represents an ASM participant's aggregate performance on a scale of zero to 100 points based on applicable performance standards for measures and activities in each ASM performance category. This scoring framework promotes accountability for performance across ASM participants within each ASM cohort. We use the final score to determine the ASM payment adjustment factor applied to an ASM participant's Medicare Part B claims for covered professional services during the corresponding ASM payment year.

We calculate the final score based on performance in the quality, cost, improvement activities, and Promoting Interoperability ASM performance categories (90 FR 49677). We also established policies to award additional points to ASM participants who furnish care to complex patient populations and to ASM participants who are part of small practices or who are solo

practitioners (90 FR 49670 through 49676).

(2) Requirements to Receive a Final Score

In the CY 2026 PFS final rule (90 FR 49668 through 49669), we finalized that an ASM participant must meet minimum data submission requirement to receive a final score for an ASM performance year. An ASM participant who does not meet these data submission requirements receives a final score of zero points for the applicable ASM performance year, which results in the maximum negative payment adjustment applicable for the corresponding ASM payment year. Conversely, an ASM participant who meets the minimum data submission requirements but cannot be evaluated on quality and cost performance does not receive a final score and instead receives a neutral payment adjustment for the applicable ASM payment year. We refer readers to Table B-D8 in the CY 2026 PFS final rule for a summary of ASM's final score policies and their impact on payment adjustments (90 FR 49670).

After internal review of ASM's final scoring provisions, we believe we could clarify regulatory text describing when we will not assign an ASM participant a final score. Specifically, we propose to revise § 512.745(a)(2)(iii)(B) by striking the "Do not receive" language that starts §§ 512.745(a)(2)(iii)(B)(*1*) and 512.745(a)(2)(iii)(B)(*2*). We then propose to revise § 512.745(a)(2)(iii)(B) to read "Do not receive either:", referring to the conditions described at §§ 512.745(a)(2)(iii)(B)(*1*) and 512.745(a)(2)(iii)(B)(*2*). These specific changes do not introduce substantive changes to current requirements.

We seek comment on the proposed changes to clarify the regulatory text at § 512.745(a)(2)(iii)(B).

(3) Rural Scoring Adjustment

In the CY 2026 PFS proposed rule, we considered, but did not propose, including a rural scoring adjustment in the calculation of an ASM participant's final score (90 FR 32604), as our analysis of historic data did not reveal a systematic difference in expected performance between likely ASM participants in rural and non-rural areas. In response to our discussion considering

the rural scoring adjustment in the CY 2026 PFS proposed rule, we received interested parties' feedback recommending that we award a rural scoring adjustment to ASM participants in rural areas because ASM participants in rural areas face unique demands (90 FR 49676). However, we finalized ASM's final score policy without including a rural scoring adjustment.

The CY 2026 PFS final rule did establish policies to award additional points on the final score to ASM participants who furnish care to complex patient populations (up to 10 points) and to ASM participants who are part of small practices (10 points for ASM participants in small practices, 15 points for solo practitioner ASM participants) (90 FR 49670 through 49676). In the CY 2026 PFS final rule, we noted that small practice and solo practitioner scoring adjustments better support ASM participants in small practices by compensating for increased administrative burden and additional reporting requirements (90 FR 49676). We noted in the CY 2026 PFS final rule that we expected a high degree of overlap between ASM participants in rural areas and those in small practices based on historical MIPS performance data that we analyzed (90 FR 49677), indicating that ASM participants in rural areas would be eligible for the small practice scoring adjustment and be supported accordingly. We also noted that a rural scoring adjustment could weaken incentives for ASM participants in large rural systems to improve (90 FR 49676).

However, as supported by interested parties' comments on the CY 2026 PFS proposed rule, together with additional research and analysis, the unique circumstances facing ASM participants in rural areas may warrant adjustments to their final scores. We recognize that ASM participants in rural areas may face structural challenges that affect their ability to perform under ASM, including limited resources for technology modernization, workforce shortages that constrain reporting capacity, and barriers to system interoperability. A 2025 analysis of physician participants in the Quality Payment Program found significantly higher physician adoption of EHRs in urban areas (74 percent) compared to rural areas (64 percent).[181] Another recent study

[181] Anzalone AJ, Geary CR, Dai R, Watanabe-Galloway S, McClay JC, Campbell JR. Lower electronic health record adoption and interoperability in rural versus urban physician participants: a cross-sectional analysis from the

suggests that physicians in rural areas were less likely to report ideal interoperability experiences for medication notes.[182] A report from the HHS Assistant Secretary for Technology Policy (ASTP) notes that urban hospitals were more likely to engage in routine interoperable exchange (47 percent were routinely interoperable) than their rural counterparts (36 percent were routinely interoperable).[183] These findings align with interested parties' feedback highlighting additional interoperability barriers faced by rural clinicians. Accordingly, we believe ASM's existing scoring methodology may not adequately address the complex factors that may affect rural ASM participant's performance particularly because ASM has a unique focus on incentivizing interoperability improvements to strengthen care coordination.

Additionally, our analysis of preliminary ASM participants for the 2027 ASM performance year provides an updated understanding of the practice size of ASM participants in rural areas. In previous notice-and-comment rulemaking, we noted that we expected ASM participants in rural areas were primarily practicing in small practices and, therefore, would qualify for ASM's small practice or solo practitioner scoring adjustments (90 FR 49677). An additional rural scoring adjustment, on top of small practice or solo practitioner adjustments, for these ASM participants could have been duplicative and result in a disproportionate scoring benefit . However, upon review of updated data on preliminary ASM participants for the 2027 ASM performance year, we found that ASM participants in rural areas are typically part of larger practices and would be less likely to receive the small practice scoring adjustment.

To address continued interested parties' feedback about ASM participants in rural areas and additional analysis of preliminary ASM participants for the 2027 ASM performance year, we are proposing the inclusion of a rural scoring adjustment in the calculation of an ASM participant's final score. We believe adding a rural scoring adjustment would adequately increase

---

CMS quality payment program. BMC Health Serv Res. 2025 Jan 23;25(1):128. doi: 10.1186/s12913-024-12168-5. PMID: 39849475; PMCID: PMC11755824.

[182] Everson J, Adler-Milstein J, Phillips RL, Bazemore AW, Patel V. EHR Interoperability Experiences Reported by Family Physicians. JAMA Netw Open. 2025;8(11):e2542460. doi:10.1001/jamanetworkopen.2025.42460.

[183] *https://healthit.gov/data/data-briefs/interoperable-exchange-patient-health-information-among-us-hospitals-2023/.*

final scores to account for the unique challenges faced by this group of ASM participants.

To determine if an ASM participant is in a rural area, we propose at § 512.705 to adopt the same definition and determinations of a "rural area" as defined, interpreted, and updated at § 414.1305 under MIPS. We believe that aligning our rural area definition with MIPS will reduce confusion for ASM participants in rural areas who have previously participated in MIPS and received associated flexibilities with rural special status under MIPS.

To incorporate the rural scoring adjustment proposal into ASM's regulatory text, we first propose to redesignate current § 512.745(a)(5) as new § 512.745(a)(6). We then propose at new § 512.745(a)(5) to add 5 points to the final score of an ASM participant who (1) is in a rural area as proposed to be defined at § 512.705, and (2) meets the requirements to receive a final score greater than zero as described at § 512.745(a)(2)(i) for an applicable ASM performance year. We emphasize that ASM participants in rural areas remain eligible to receive ASM's small practice or solo practitioner scoring adjustment and the complex patient scoring adjustment if they meet such scoring adjustment's eligibility criteria described at § 512.745(a)(4) and § 512.745(a)(3), respectively.

We considered but are not proposing an alternative rural scoring adjustment policy to add 5 points to the final score of each ASM participant who (1) is in a rural area as proposed to be defined at § 512.705, (2) meets the requirements to receive a final score greater than zero as described at § 512.745(a)(2)(i) for an applicable ASM performance year, and (3) does not receive a small practice scoring adjustment as described in § 512.705(a)(4). However, rural practices regardless of size often face thinner operating margins that limit their potential investment in the quality and technology infrastructure necessary to succeed in ASM.[184] Uneven access to affordable broadband may further burden ASM participants in rural areas by financially

[184] HRSA National Advisory Committee on Rural Health and Human Services. *Interoperability and Broadband: Challenges to Rural Information Exchange* (January 2016). *https://www.hrsa.gov/advisory-committees/rural-health/correspondence/20160101*.

challenging their ability to leverage health information exchanges and data sharing.[185] We believe that a rural scoring adjustment for ASM participants in small and non-small rural practices alike most accurately accounts for the potential burdens faced by ASM participants in rural areas.

We also considered but are not proposing an alternative policy waiving Improvement Activity 2 (IA-2), Establishing Communication and Collaboration Expectations with Primary Care using CCAs, for ASM participants in rural areas. Although ASM participants in rural areas may face challenges forming partnerships with primary care practices due to limited primary care availability,[186] we believe that a rural scoring adjustment more broadly accounts for challenges that could affect ASM participant performance across the four ASM performance categories compared to only waiving IA-2.

To account for the proposed addition of the rural scoring adjustment, we propose corresponding adjustments to the final score formula at § 512.745(a)(6) We also propose to revise § 512.745(a) to cross-reference the final score formula now described at § 512.745(a)(6).

We seek public comment on our proposed definition of rural area at § 512.705 and our proposal at § 512.745(a)(5) to add 5 points to the final score of an ASM participant who is in a rural area and meets the requirements to receive a final score greater than zero. We also seek comment on the alternative we considered to only add the rural scoring adjustment to the final scores of ASM participants in rural areas who are not eligible to receive a small practice scoring adjustment, as well as the alternative to waive IA-2 for ASM participants in rural areas. We seek comment on our corresponding proposal at § 512.745(a)(6) to incorporate the rural scoring adjustment into the final score formula.

---

[185] Pritzker, Penny, and Tom Vilsack. "Broadband Opportunity Council Report and Recommendations." *USDA, US Department of Commerce*, 20 Aug. 2015, *obamawhitehouse.archives.gov/sites/default/files/broadband_opportunity_council_report_final.pdf*.

[186] *https://www.ers.usda.gov/data-products/charts-of-note/chart-detail?chartId=106208*.

(4) ASM Performance Report

In the CY 2026 PFS final rule (90 FR 49678), we finalized that we will provide performance information to each ASM participant for each ASM performance year through an annual ASM performance report. The ASM performance report will include information on each ASM performance category score, scoring adjustments as applicable, the final score, the ASM payment adjustment factor, and the ASM payment multiplier.

To incorporate additional information on scoring incentives and scoring adjustments proposed in this proposed rule, we propose to revise the structure of the regulatory text on the ASM performance report in § 512.745(b). These proposed structural revisions to the regulatory text's structure are intended to improve readability on the logical flow of components of the annual ASM performance report, starting with each ASM performance category score, scoring incentives, scoring adjustments, final score, and ending with the resulting payment adjustment information. These specific changes do not introduce substantive changes to current requirements.

We also propose at revised § 512.745(b)(2) to provide ASM participants with information on whether they receive the quality ASM performance category scoring incentive for successful voluntary reporting of PRO data through the annual ASM performance report, as applicable. We refer readers to section III.D.2.d.(5) of this proposed rule for additional information on the proposed voluntary PRO data submission and associated quality ASM performance category scoring incentive.

We also propose at revised § 512.745(b)(5) to provide ASM participants with information on their rural scoring adjustment, if applicable, in the annual ASM performance report.

We believe these proposals would help an ASM participant understand their performance and whether they qualified for new scoring incentives and scoring adjustments proposed in this proposed rule.

We seek comment on our proposed clarifying revisions to § 512.745(b). We also seek comment on our proposal at § 512.745(b)(2) to provide information on the quality ASM performance category incentive for voluntary reporting of patient-reported outcome data, as applicable, and our proposal at § 512.745(b)(5) to provide information on the rural scoring adjustment, as applicable, in the annual ASM performance report.

g. Payment Approach

(1) Background

In the CY 2026 PFS final rule, we finalized the overall payment approach for ASM (90 FR 49679 through 49699). We will apply performance-based payment adjustments to all payments for Medicare Part B covered professional service claims from ASM participants during an ASM payment year based on their performance during the corresponding prior ASM performance year. We explained that this approach will create meaningful financial incentives tied to performance in the model, while maintaining administrative feasibility and transparency (90 FR 49679 through 49680). To determine these payment adjustments, we finalized a methodology to compare ASM participant performance within each ASM cohort using final scores, which reflect ASM participants' performance across the four ASM performance categories (90 FR 49681 through 49683). We also finalized a methodology to calculate ASM payment adjustment factors and ASM payment multipliers used to apply the payment adjustments from the distribution of final scores (90 FR 49685 through 49696). We also finalized the level of two-sided risk (that is, the maximum and minimum payment adjustment), including the gradual increase in the two-sided ASM risk level from 9 percent in the 2027 and 2028 ASM performance years to 12 percent in the 2031 ASM performance year. We explained that this methodology supports strong incentives for performance improvement while maintaining ASM risk levels similar to MIPS during early model years. We will apply the ASM payment multiplier to all payments for Medicare Part B for covered professional services, not only those services related to each ASM cohort's ASM targeted chronic condition, during an ASM payment year

(90 FR 49696 through 49699).

(2) Application of ASM Payment Adjustments with Changes in TIN Affiliations

In the CY 2026 PFS final rule, we finalized that Medicare Part B professional service claims submitted by an NPI who is an ASM participant for an ASM performance year but under a TIN (1) that we did not select the NPI as an ASM participant for the applicable ASM performance year and (2) to which the NPI began assigning billing rights after the ASM performance year but before the end of the corresponding ASM payment year would be adjusted using the ASM payment multiplier calculated for the ASM participant. In the limited instances where a single NPI is selected as an ASM participant under multiple TINs for an ASM performance year, we finalized that we would apply the highest of any ASM payment multipliers to all Medicare Part B covered professional service claims submitted under a new TIN during the applicable ASM payment year (90 FR 49696). We refer readers to Table B-D10 in the CY 2026 PFS final rule for additional information on how ASM payment adjustments will be applied under multiple scenarios (90 FR 49697). The goal of these policies is to maintain accountability for the ASM participant's performance through the application of their performance-based payment adjustments. By doing so, we track accountability to the ASM participant regardless of their specific TIN affiliation at the time we make payment adjustments.

While we are not proposing substantive changes to these policies in this proposed rule, we note that there are inconsistencies in the regulatory text describing how we will adjust payment in situations where the ASM participant begins reassigning billing rights to a new TIN during an ASM payment year.

Accordingly, to maintain consistency with the regulatory text governing the application of ASM's payment adjustments as described at § 512.750(a), at §§ 512.750(f)(1) and (f)(2), we propose to revise the regulatory text at § 512.750(f) to replace the phrases "adjusts payments" and "adjust claims" with "multiplies the amount otherwise paid under Medicare Part B for covered professional services". We are also proposing clarifying revisions to § 512.750(f)(1).

We propose to remove unnecessary text at § 512.750(f)(1)(i) because we only calculate ASM payment multipliers for ASM participants with final scores as described at § 512.750(c)(1). To improve readability of the provision with the proposed removal of § 512.750(f)(1)(i), we propose to revise § 512.750(f)(1) to incorporate the text previously described at § 512.750(f)(ii).

We are also proposing revisions to clarify how we would adjust payments for NPIs selected as ASM participants under multiple TINs and who reassign billing rights to a new TIN after an ASM performance year. Accordingly, we propose to remove unnecessary language in § 512.750(f)(2) and § 512.750(f)(2)(i) to more clearly describe how we would adjust payments using the highest ASM payment multiplier calculated for an NPI who we select as an ASM participant under multiple TINs. We also propose at § 512.750(f)(2)(ii) to replace the phrase "assigning billing rights" with "reassigning billing rights" to improve the accuracy of the regulatory text. These proposals do not create substantive changes to the proposed policies but would ensure clarity and consistency in language used to describe the application of payment adjustments under ASM under § 512.750.

We seek comment on our proposals to revise the regulatory text at § 512.750(f)(1) and § 512.750(f)(2).

h. Applicability of CMS-Sponsored Model Safe Harbor at 42 CFR 1001.952(ii)

In the CY 2026 PFS final rule, we determined that the CMS- model arrangements and patient incentives safe harbor at § 1001.952(ii) would be available to ASM participants that comply with applicable requirements (90 FR 49709) and codified the availability of the safe harbor for ASM at § 512.765 in regard to remuneration associated with beneficiary incentives and remuneration exchanged under CCAs.

Once a clinician is selected as an ASM participant for any ASM performance year during the ASM test period, that clinician remains an ASM participant for the duration of the ASM test period. However, in limited circumstances, an ASM participant may not be required to meet specified model requirements for a given ASM performance year. Specifically, if we determine

that an ASM participant does not satisfy the ASM participant eligibility criteria as specified under § 512.710(a)(2) or is determined to meet an exception under § 512.710(c) for a given ASM performance year, the ASM participant is not: (1) subject to ASM performance assessment under § 512.715, (2) required to submit data under § 512.720, (3) subject to final scoring under § 512.745, and (4) eligible for the waivers available under the model described at § 512.775 (90 FR 49572, 90 FR 49583).

We finalized the application of these policies in the CY 2026 PFS final rule, however, we did not address the availability of the CMS-sponsored model arrangements and patient incentives safe harbor under § 1001.952(ii), as made available for ASM at § 512.765, in instances where an ASM participant is not subject to specified ASM requirements due to not meeting ASM participant eligibility criteria as described in § 512.710(a)(2) or a determination that an exception applies under § 512.710(c).

We now propose that the CMS-sponsored model arrangements and patient incentives safe harbor would be available only for remuneration attributable to periods during which an ASM participant is performing under the model. Conversely, the CMS-sponsored model arrangements and patient incentives safe harbor would not be available for remuneration attributable to a period during which an ASM participant is not performing under the model due to not meeting ASM participant eligibility criteria as described at § 512.710(a)(2) or a determination that an exception applies under § 512.710(c).

We believe this proposal appropriately ties the availability of the model-specific safe harbor to underlying model activities performed during a period of model performance. For example, we recognize that remuneration associated with a CCA may not be exchanged contemporaneously with the ASM performance year to which it relates. In such instance, remuneration exchanged pursuant to a CCA may be calculated based on an ASM participant's performance during an ASM performance year in which the ASM participant was eligible for and not excepted from ASM performance but may not be exchanged until a subsequent year

because the applicable ASM payment adjustment factor, and net payment adjustment, would not calculated until after the close of the ASM performance year. An ASM participant who reassigns billing rights to a new TIN or redesignates their primary specialty type mid-ASM performance year may be excepted from ASM participation for that performance year under § 512.710(c). In such instance, the ASM participant may rely on the availability of the safe harbor during the portion of the year in which they were performing under the model. Our proposal is not intended to retrospectively render the safe harbor unavailable with respect to remuneration attributable to the period in which the ASM participant was actively performing under the model and all applicable safe harbor requirements were satisfied. The limitation on safe harbor availability described at proposed § 512.765(c) would apply prospectively from the date we determine the exception applies under § 512.710(c).

Accordingly, we propose that the availability of the CMS-sponsored model safe harbor would depend on the period of ASM performance to which the remuneration is attributable.

Specifically, we propose to add § 512.765(c) to state that the CMS-sponsored model arrangements and patient incentives safe harbor is available only with respect to remuneration attributable to a period in which the ASM participant was performing under the model, and is not available with respect to remuneration attributable to any period of the ASM test period for which the ASM participant does not meet ASM participant eligibility criteria under § 512.710(a)(2) or is excepted from specified ASM requirements under § 512.710(c).

Limiting the availability of the safe harbor to remuneration attributable to model performance helps support program integrity and beneficiary protections while preserving flexibility for ASM participants to use incentives that support patient and primary care engagement in performance activities aligned with the model's purpose.

We seek comment on this proposal.

i. Collaborative Care Arrangements (CCAs)

(1) Background

The improvement activities ASM performance category is intended to advance core goals of ASM to drive better outcomes through improved care coordination, increased collaboration between specialists and primary care practices, and interventions that address upstream drivers of health.

We finalized two improvement activities for ASM in the CY 2026 PFS final rule at § 512.735 that we believe best support these aims:

- Improvement Activity 1 (IA-1): Connecting to Primary Care and Ensuring Completion of Health-Related Social Needs Screening; and
- Improvement Activity 2 (IA-2): Establishing Communication and Collaboration Expectations with Primary Care using CCAs (90 FR 49648 through 49655).

To receive the maximum score available for the improvement activities ASM performance category, an ASM participant must attest "yes" to both improvement activities.

IA-2 specifications require an ASM participant to enter into at least one collaborative care arrangement (CCA) with a primary care practice with which the ASM participant shares a patient who is an ASM beneficiary. IA-2 also requires that a CCA address at least three of the five elements specified at § 512.735(c)(2)(ii): data sharing, co-management, transitions in care planning, closed-loop connection, and care coordination integration.

In addition to IA-2 specifications at § 512.735(c)(2)(ii), we outline requirements for CCAs at § 512.771. The function of the CCA is to memorialize the coordination activities central to ASM and described in IA-2.

We now propose certain updates to the CCA provisions at § 512.771 to improve implementation by ASM participants and primary care practices and to more closely align CCA conditions with IA-2 by revising § 512.771(a) and adding new paragraph § 512.771(d). In summary, and as discussed in detail in respective sections of this proposed rule, our proposed changes to § 512.771 include:

- Permitting one or more ASM participant to enter into a CCA with the same primary

care practice, provided each ASM participant reassigns billing rights through the same entity's TIN and are named as parties to the CCA;

- Clarifying the requirement that an ASM participant and a primary care practice share a patient who is an ASM beneficiary and how this requirement applies in the context of the limitation on considering the volume or value of referrals;

- Streamlining the provision containing an illustrative list of authorities with which parties to a CCA must comply to simplify it, improve clarity, and reduce ambiguity;

- Updating the provisions that currently reference any elective exchange of payments between CCA parties to instead refer to the elective exchange of remuneration, to reflect a broader scope of value that may be exchanged under a CCA;

- Reorganizing regulatory requirements under § 512.771(a) that are associated only with the exchange of any elective remuneration under a CCA such that they appear together under a new paragraph at § 512.771(d) to bring greater clarity and to distinguish between those requirements that apply to all CCAs and those that apply only to CCAs that electively include the exchange remuneration;

- Revising the payment limitation that caps the exchange of remuneration based on an ASM participant's performance adjustment such that it can be more readily calculated in a timely manner and requiring that parties that elect to exchange remuneration before the limitation can be calculated reconcile any amounts that exceed the limitation following reconciliation;

- Clarifying that current requirements relating to traceability will continue to apply to monetary remuneration;

- Updating the contemporaneous documentation requirements to reflect any remuneration exchanged and add requirements to bring transparency into the methodologies used to determine the value of such remuneration; and

- Relocating the conditions associated with remuneration at current §§ 512.771(a)(7) and 512.771(a)(8) to new paragraphs §§ 512.771(d)(2) and 512.771(d)(3), respectively, in

accordance with our proposal to address requirements associated with CCAs that include an exchange of remuneration together under one paragraph. To conform with this relocation, we would redesignate existing sections §§ 512.771(a)(9) through 512.771(a)(13) to §§ 512.771(a)(7) through 512.771(a)(11). We would revise newly redesignated § 512.771(a)(7) (former § 512.771(a)(9)) to reference "[a]ll parties" rather than "[b]oth parties" and revise newly redesignated § 512.771(a)(9) (former § 512.771(a)(11)) to update documentation requirements as described, but otherwise would not revise text at newly redesignated § 512.771(a)(8) (former § 512.771(a)(10)), § 512.771(a)(10) (former § 512.771(a)(12)), or § 512.771(a)(11) (former § 512.771(a)(13)).

(2) Parties to a CCA

In the CY 2026 PFS final rule, we finalized at § 512.771(a)(1) a requirement that a CCA be in writing, signed by both parties, and contain the effective date of the arrangement. We also finalized at § 512.771(a)(2) a requirement that a CCA be exclusively between an ASM participant and a primary care practice with which the ASM participant shares at least one established patient who is an ASM beneficiary. At that time, we considered, but declined to permit, multiple ASM participants reassigning billing rights through the same TIN to be parties to a single CCA with a primary care practice party, citing concerns around the ability of ASM participants to accurately track any remuneration exchanged under a multi-ASM participant arrangement (90 FR 49712).

Following publication of the CY 2026 PFS final rule, we received interested party feedback anticipating significant burden associated with establishing separate CCAs for each individual ASM participant when more than one ASM participant is in the same group practice and such ASM participants wish to collaborate with the same primary care practice. As an example, 20 ASM participants operate within a single health system and reassign their billing rights to that system's TIN. Even if such ASM participants coordinate care regularly with the same primary care practice and wish to establish a CCA with the same primary care practice, the

current regulation would require negotiation, execution, documentation, and tracking of 20 separate CCAs.

We believe that requiring a separate CCA for each ASM participant could impose administrative burden without a corresponding programmatic benefit. We now believe that concerns related to tracking remuneration under CCAs involving multiple ASM participants could be addressed through more targeted safeguards that apply to CCAs that elect to include remuneration, rather than a broader restriction applicable to all CCAs, including those that do not involve any exchange of remuneration.

Accordingly, we propose to amend §§ 512.771(a)(1) and 512.771(a)(2) to permit one or more ASM participants to be parties to the same CCA, subject to defined conditions. First, each ASM participant would be required to be explicitly named as a party to the CCA. Second, we propose that for multiple ASM participants to participate in the same CCA, all such ASM participants would be required to reassign billing rights to the same TIN. We would maintain the existing requirements at § 512.771(a)(1) that the CCA be in writing and specify an effective date; we would also maintain the requirement that a CCA be signed by the parties but propose to amend regulatory text to stipulate CCA execution would be required for "all" parties rather than "both" parties.

We believe restricting a multi-ASM participant CCA to ASM participants within the same TIN is appropriate as clinicians who practice under the same group practice are more likely to be supported by shared operations, such as shared EHR systems, clinical support staff, and standardized administrative workflows. Accordingly, we believe terms of a CCA could be standardized across ASM participants within the same organization (that is, TIN) without compromising the level of detail needed to support meaningful care coordination. In contrast, ASM participants from separate, unaffiliated TINs may have distinct infrastructure, care coordination needs, support structures, and operational workflows. It is therefore unclear how a single arrangement could establish cohesive terms regarding shared responsibilities with a

primary care partner in a manner consistent with the intent of CCAs. We are concerned that attempting to encompass these different capabilities and variable workflows within a single agreement could result in vague, overly broad, or highly fragmented contractual terms, which could undermine the intent of the CCA.

Our proposal to permit one or more ASM participants billing under the same TIN to join the same CCA with a primary care partner does not alter ASM's fundamental accountability framework. As noted, we propose to clarify that any ASM participant seeking to join and rely on one CCA be expressly named as a party to the arrangement. We believe such requirement maintains individual ASM participant accountability, while reducing administrative burden. We are not proposing to permit a group practice or TIN to serve as a sole contracting party on behalf of unnamed ASM participants, as this could obfuscate individual ASM participant accountability and introduce operational complexity, particularly when an ASM participant departs a group practice during an ASM performance year. Requiring each ASM participant to be named as a party would mitigate such concerns while still reducing contracting burden.

We wish to emphasize that our proposals do not preclude an ASM participant's group practice from supporting the ASM participant or ASM participants with administrative functions associated with a CCA, such as recordkeeping or maintaining documentation on ASM participants' behalf, provided such support is consistent with other applicable authorities. Such administrative support does not substitute for the requirement that each ASM participant be named as a party and remain accountable for the core responsibilities described by the model and CCAs. Rather, we intend for our proposals to better account for the operational realities of group practices and the nature of the activities envisioned by a CCA, which inherently entails practice-level support. We do not intend for our proposals to disrupt such support arrangements.

We also note that we do not intend, and do not propose, to impose prescriptive requirements around the meaning of a "primary care practice" that must be a party to a CCA. Our intent is that a CCA reflects coordination between the ASM participant and their ASM

beneficiary's source of primary care services. We refer readers to discussion in response to interested party questions in the CY 2026 PFS final rule for further information (90 FR 49653).

Our proposal is also intended to reduce burden for ASM participants who practice within the same group and coordinate care with the same primary care practice. It is not intended to discourage individual CCAs. ASM participants who belong to the same group may continue to enter into separate CCAs and should consider a separate arrangement when doing so better reflects individual clinical relationships, sources of primary care for their individual ASM beneficiary panel, and care coordination needs. We also continue to encourage ASM participants to consider entering into multiple CCAs to the extent it would support meaningful coordination for a broader population of ASM beneficiaries but note that only one CCA is required to meet IA-2 specifications.

We seek comment on these proposals, including whether it would reduce administrative burden to permit more than one ASM participant to enter the same CCA while preserving individual accountability, program integrity, and appropriate oversight. We also seek feedback on whether this proposal could be read as disadvantaging ASM participants who are solo practitioners or part of a group practice where they are the only selected ASM participant. We do not believe this proposal would have any negative effect on these ASM participants, but we invite interested party perspectives on this.

(3) Requirement that CCA Parties Share a Patient Who Is an ASM Beneficiary

Sections 512.735(c)(2)(i) and 512.771(a)(2) both require that parties to a CCA share a patient who is an ASM beneficiary. Under our proposal to permit more than one ASM participant to join the same CCA, we would maintain the requirement at proposed revised § 512.771(a)(2) that an ASM participant party or ASM participant parties and the primary care practice party share at least one patient who is an ASM beneficiary. That is, the requirement that an ASM participant party or ASM participant parties and the primary care practice share a patient who is an ASM beneficiary would be satisfied so long as at least one shared patient who

is ASM beneficiary exists between any one ASM participant party to the CCA and the primary care practice party, regardless of the total number of ASM participants who are parties to that CCA.

We emphasize that the purpose of the requirement to share "one or more" patients who are ASM beneficiaries is to ensure a clear nexus exists between the CCA and coordination activities on behalf of ASM beneficiaries for whom both the primary care practice party and ASM participants have a care relationship. In the absence of shared ASM beneficiaries, there would be no care relationship to coordinate and, therefore, no basis for a CCA. We require only one shared ASM beneficiary as a minimum threshold condition because we believe that parties who commit to meaningfully coordinate care in a manner consistent with the purpose of a CCA will, organically, identify and collaborate on behalf of a much broader shared patient population as the arrangement is implemented. Thus, we continue to underscore, as we did in the CY 2026 PFS final rule (90 FR 49712 through 49713), that we encourage ASM participants to select primary care partners with whom they share multiple ASM beneficiaries as this would more meaningfully fulfill the goals of the CCA.

Lastly, current § 512.771(a)(2) requires that, for the purposes of the shared ASM beneficiary requirement, the ASM beneficiary must be an "established" patient. IA-2 specifications at § 512.735(c)(2)(i) does not include the "established" qualifier. Upon further review, we do not believe it is necessary to include the term "established" in CCA regulations and therefore propose to strike the term "established" at § 512.771(a)(2) to conform with IA-2 specifications.

We seek comment on our proposal to require at least one shared patient who is an ASM beneficiary under a CCA regardless of how many ASM participants are parties to such CCA. We invite feedback on whether requiring one shared patient who is an ASM beneficiary is sufficient to encourage the coordination goals envisioned by CCAs. We also seek comment on our proposal to remove the term "established" from CCA regulations at § 512.771(a)(2).

(4) Requirement to Comply with Applicable Laws

We finalized in the CY 2026 PFS final rule at § 512.771(a)(5) that both parties to a CCA must comply with all applicable statutes, regulations, and guidance, including without limitation: Federal criminal laws; the False Claims Act (31 U.S.C. 3729 *et seq.*); the anti-kickback statute (42 U.S.C 1320a-7b(b)); the civil monetary penalties law (42 U.S.C. 1320a-7a); and the physician self-referral law (42 U.S.C. 1395nn).

We now believe the illustrative list at § 512.771(a)(5) is unnecessary and that a simplified version of regulatory text may reduce potential confusion. Accordingly, we are proposing to remove the illustrative list of legal authorities and instead retain only the requirement that both parties to a CCA comply with all applicable statutes, regulations, and guidance. To conform with other proposals to § 512.771, we also propose to amend regulatory text to strike reference to "[b]oth" parties and instead require that "[a]ll" parties comply with this provision.

We invite comment on the proposed changes.

(5) Restriction on Conditioning Remuneration on Referrals

In the CY 2026 PFS final rule, we established that neither the opportunity to enter a CCA nor the amount of any payment under a CCA may be conditioned, directly or indirectly, on the volume or value of past or anticipated referrals or business generated by, between, or among the parties to the arrangement or any other person (90 FR 49711). Separately, § 512.771(a)(2) requires that an ASM participant and a primary care practice party to a CCA share at least one patient who is an ASM beneficiary.

Upon further consideration, we are concerned that the current language at § 512.771(a)(6) on conditioning entry into a CCA, in the context of the requirement for shared ASM beneficiaries at § 512.771(a)(2), may be read to unnecessarily constrain the formation of the type of arrangements the model is designed to promote. Because shared ASM beneficiaries among parties to a CCA may result from existing care relationships between ASM participants and primary care practices, the current language of § 512.771(a)(6) could be read to prohibit potential

collaborators from considering the beneficiary-sharing relationship required by § 512.771(a)(2). We did not intend the prohibition on conditioning entry into a CCA on referrals or business generated to prevent parties from considering whether they satisfy the shared-beneficiary requirement that is itself a requirement to CCAs.

Accordingly, we propose to revise § 512.771(a)(6) that an ASM participant may consider, as one criterion for entering into a CCA, whether they share at least one ASM beneficiary with a primary care practice. We propose that this would not violate the volume or value standard in § 512.771(a)(6) if the purpose of such criteria is to further the purpose of the CCA. This clarification is intended to remove an unintended barrier to CCA formation while preserving the prohibition on entering into arrangements based on referral patterns or that reward or induce referrals or other business generated.

This targeted revision would permit parties to consider whether they share one or more ASM beneficiaries only for purposes of satisfying the shared-beneficiary requirement at § 512.771(a)(2) and furthering the purpose of the CCA.

We seek comment on this proposal. We also invite comment on whether the proposed approach is sufficiently clear and appropriately accommodates the operational realities of how practices contemplate establishing CCAs.

(6) CCAs that Include the Exchange of Remuneration

In the CY 2026 PFS final rule, we stated our intent to allow ASM participants and their primary care partners to negotiate arrangements that are best suited to their practices (90 FR 49712). We also recognized that parties to a CCA may wish to include model-related incentives under a CCA to support shared accountability for the outcomes of ASM beneficiaries and to support coordination activities that benefit shared patients (90 FR 49713). Accordingly, we made the CMS-sponsored model arrangements safe harbor at § 1001.952(ii)(1) available under ASM at § 512.765 to protect remuneration exchanged under a CCA, provided that all requirements of the safe harbor at § 1001.952(ii)(1) and CCA regulations at § 512.771 are met

(90 FR 49713).

Upon further review, we believe that provisions of § 512.771 that refer to payments exchanged under a CCA should be revised to apply more broadly to remuneration exchanged under a CCA to the extent applicable. Applying these provisions to remuneration would better align § 512.771 with § 512.765 and the CMS-sponsored model arrangements safe harbor at § 1001.952(ii)(1), both of which address remuneration. It would also more accurately reflect the full range of value that parties may exchange under a CCA, including monetary payments and in-kind items or services that support care coordination and other model-related activities.

Accordingly, we propose to revise § 512.771 such that applicable provisions referencing payment instead reflect and apply more broadly to remuneration exchanged under a CCA. We believe this proposed modification would clarify that safe harbor protections and requirements in § 512.771 apply to both monetary and in-kind remuneration exchanged under a CCA. We emphasize that remuneration is not a required element of a CCA. Rather, parties to a CCAs may elect to include monetary or in-kind incentives that promote improvement activities or the goals of the model, provided that all applicable requirements are met (90 FR 49654). In-kind remuneration, such as shared data analytics platforms, care managers, or technology infrastructure could support the type of care coordination envisioned by ASM.

We also propose to add new paragraph § 512.771(d) to introduce the requirements that apply when parties to a CCA elect to exchange remuneration and to relocate the proposed, revised conditions applicable to remuneration under a CCA such that they appear together under new paragraph § 512.771(d). We believe this construction would more clearly distinguish the regulatory requirements that apply to all CCAs from the additional conditions that apply when remuneration is exchanged under a CCA.

We seek comment on our proposals to address remuneration, as applicable, throughout § 512.771 rather than just payment, and to reorganize § 512.771 such that conditions associated with remuneration at current §§ 512.771(a)(7) and (a)(8) are located under new paragraph

§ 512.771(d) at §§ 512.771(d)(2) and (d)(3), respectively. We are interested in whether the proposed reorganization would bring greater clarity to our regulations.

We also welcome comment on the types of services and remuneration that specialists and primary care partners exchange or contemplate exchanging to support and encourage coordination and collaboration goals, as we described in the CY 2026 PFS final rule (90 FR 49712). We remain interested in learning about the types of remuneration used to support collaborative care, such as shared personnel, infrastructure, data analytics, care management resources, technology, or other in-kind items or services, so that we may more clearly understand how such incentives are used to promote activities designed to aid coordination and can consider such feedback in future rulemaking.

(a) Requirement for Remuneration to Reasonably Relate to CCA Purpose

In the CY 2026 PFS final rule, we finalized at § 512.771(a)(3) that a CCA must be entered into for the purpose of either furthering the ASM participant's performance in the improvement activities ASM performance category or furthering the clinical goals of the model as described by § 512.771(b) (90 FR 49712 through 49714).

We did not include a corresponding requirement that any remuneration exchanged under a CCA connect to those purposes. Upon further review, we are concerned that, absent such a requirement, remuneration could be structured in a manner that is not sufficiently connected to the objectives the CCA intends to support.

We propose that any remuneration exchanged by the ASM participant party or parties and the primary care practice party to a CCA would be required to have a reasonable relationship to activities undertaken to further the ASM participant’s performance in the improvement activities ASM performance category or to advance the model’s clinical goals, which are: (1) promoting preventive care through improved management of ASM targeted chronic conditions; (2) empowering patients to actively participate and be accountable for quality and whole health outcomes; and (3) facilitating meaningful and efficient coordination between specialists and

primary care providers to increase independent physician participation in value-based payment programs.

Specifically, we propose to require at new § 512.771(d)(1) that any remuneration exchanged by the parties to a CCA be reasonably related to the purpose of the CCA, as defined in § 512.771(a)(3). We believe that aligning the purpose of any exchange of remuneration with the purpose of the CCA would support bona fide care coordination incentives while protecting program integrity. We do not anticipate that this requirement will result in any meaningful increase in compliance burden, particularly since including remuneration under a CCA is voluntary and because we already require that a CCA be entered into for the purposes specified at § 512.771(a)(3).

We seek comment on our proposal at § 512.771(d)(1) to require that any remuneration exchanged under a CCA be reasonably related to the purpose of the arrangement, consistent with § 512.771(a)(3).

(b) Limitation on Remuneration

In the CY 2026 PFS final rule (90 FR 49712 through 49714), we finalized a limitation to the amount of any payments exchanged under a CCA at § 512.771(a)(7). Specifically, we finalized a requirement that any payment exchanged under a CCA must not exceed the sum total of the payment adjustments made to an ASM participant's claims for a given ASM payment year, which would be calculated based on the of application of the ASM payment adjustment factor to the ASM participant's payments for Medicare Part B covered professional services during the corresponding ASM payment year.

Our intent was to ensure that any financial or in-kind exchanges between CCA parties remain appropriately tied to patient outcomes and ASM's clinical goals (90 FR 49712).

Upon further consideration, we believe the current methodology may be difficult for parties to operationalize and warrants revision. ASM payment adjustments are applied 2 CYs after the applicable ASM performance year. As a result, the information needed to determine the

maximum amount permitted to be exchanged may not be available until well after the close of the applicable ASM performance year. This could create operational difficulty for parties that wish to exchange remuneration during or near the ASM performance year when care coordination activities are occurring.

Accordingly, we propose updates to modify the temporal period used to calculate this limitation and provide for a reconciliation and repayment process to support compliance with the limitation. Consistent with our organizational update to § 512.771, we propose to include the revised limitation on remuneration in new § 512.771(d)(2).

We propose to maintain a limitation on the amount of remuneration exchanged under a CCA and to tie that limitation to performance-based payment adjustments made to an ASM participant's payments for Medicare Part B covered professional services. However, we propose that this limitation would be calculated using the ASM participant's ASM payment adjustment factor for the applicable ASM performance year, multiplied by the amount otherwise paid to the ASM participant by CMS under Medicare Part B for covered professional services during that ASM performance year. Stated another way, the proposed revision would change the temporal period used to calculate the limitation amount from the ASM payment year to the ASM performance year. Under both the current and proposed methodologies, the operative component is the ASM payment adjustment factor based on performance for the ASM performance year; the proposed revision changes only the temporal period used to calculate the limitation amount.

In accordance with our proposal permitting more than one ASM participant to join the same CCA, we propose to clarify that the remuneration limitation under proposed § 512.771(d)(2) would be calculated separately for each ASM participant that is a party to a CCA. This means that, where more than one ASM participant is included in the same CCA, the limitation on the amount of remuneration that may be exchanged under the arrangement would be calculated per each ASM participant. Accordingly, the remuneration limitation would be calculated separately for each ASM participant based on that ASM participant's ASM payment

adjustment factor and the amount otherwise paid to that ASM participant by CMS under Medicare Part B for covered professional services during the applicable ASM performance year. We believe this clarification is necessary to preserve individual ASM participant accountability while allowing multiple ASM participants to participate in a single CCA where appropriate.

We are also proposing additional safeguards to support consistent implementation of this limitation. Specifically, under proposed § 512.771(d)(2)(i), the CCA would be required to specify a methodology for identifying and calculating the total value of remuneration exchanged under the arrangement for the ASM performance year and determine whether the total value exceeds the applicable limitation. To the extent that remuneration is in-kind, we propose at § 512.771(d)(2)(ii) that the valuation of such remuneration would be based on the offeror's costs using any reasonable accounting methodology, or the fair market value of the in-kind item or service. We believe this would support ASM participants that elect to exchange in-kind remuneration in ensuring such exchange complies with our regulations. Under proposed § 512.771(d)(2)(iii), the arrangement would be required to provide for reconciliation, if applicable, after the limitation is determined. Under proposed § 512.771(d)(2)(iv), if the total value of remuneration exchanged under the arrangement for the ASM performance year exceeds the limitation, the party that received the excess amount would be required to repay that excess amount to the other party within a reasonable time. We believe these provisions would promote consistent administration, clarify compliance requirements, and facilitate CMS oversight. We anticipate that these revisions to the remuneration limitation would establish a more viable pathway for parties to exchange remuneration during or close to the applicable ASM performance year by offering greater regulatory certainty that, should those exchanges exceed the final limitation, there would be a defined mechanism to reconcile the difference later.

We recognize the inherent complexity with a limitation based on a mathematical formula as described in proposed § 512.771(d)(2) in the context of in-kind remuneration. Valuing in-kind remuneration to ensure it does not exceed the calculated threshold, and 'repaying' excess in-kind

value during the reconciliation process, may present operational difficulties that could impede good faith exchanges of in-kind items or services intended to support the purpose of the CCA. We considered but are not proposing an alternative where the limitation in proposed § 512.771(d)(2) would apply only to monetary payments (or cash equivalents) exchanged under a CCA. Under such alternative, we would establish a separate limitation for in-kind remuneration, such as requiring that any in-kind items or services exchanged meet a fair market value and commercial reasonableness standard rather than a limitation based on a dollar amount. While a separate safeguard tailored to in-kind remuneration could ease operational burden for ASM participants and their primary care partners, we believe that having one mathematical formula for valuing any remuneration exchanged under a CCA would be simpler for parties to CCAs to implement and therefore did not propose this approach.

We seek comment on these proposals, including the proposed update for calculating the limitation using the ASM performance year rather than the corresponding ASM payment year, the methodology and reconciliation requirements at proposed § 512.771(d)(2) and whether the proposed updates bring greater clarity to requirements that apply to CCAs that elect to include remuneration. We also seek comment on the alternative considered for in-kind remuneration limitations.

(c) Other Requirements for Remuneration Exchanged Under a CCA

We finalized in the CY 2026 PFS final rule that any payment exchanged under a CCA must be solely between the parties and be made by check, electronic funds transfer, or another traceable cash transaction (§ 512.771(a)(8)) (90 FR 49712 through 49714). Consistent with our organizational update to § 512.771, we propose to include this requirement, with revisions to address remuneration more broadly, in new § 512.771(d)(3).

Specifically, we would require that any remuneration exchanged under a CCA be solely between the parties and that, to the extent the exchange is a monetary payment, payment must be made by check, electronic funds transfer, or other traceable transaction at § 512.771(d)(3).

We seek comment on these proposals.

(d) Documentation Requirements

We finalized a requirement that ASM participants maintain contemporaneous documentation regarding all CCAs, including the relevant agreement and date and amount of payment at § 512.771(a)(11).

We propose to update documentation requirements to better support ASM participants and their primary care partners in their compliance with applicable regulations and to update references to conform with other changes proposed under § 512.771, including that we propose to redesignate existing § 512.711(a)(11) to § 512.711(a)(9).

Specifically, we propose to revise the documentation requirement at proposed revised § 512.771(a)(9) such that an ASM participant would be required to maintain contemporaneous documentation, in accordance with § 512.135, regarding all CCAs entered into, records of all remuneration exchanged for each ASM participant under a CCA, a description of the remuneration, the value of the remuneration, the methodology for determining the value of any in-kind remuneration, and the date on which the remuneration was exchanged.

We also propose to require documentation of the identity of each ASM participant that would be a party to the CCA. We propose this change to conform with our proposal that a CCA may include more than one ASM participant to promote appropriate recordkeeping regarding the identity of each ASM participant covered by a CCA.

Together, we believe these proposed changes would clarify the minimum documentation that must be maintained by an ASM participant, better support compliance, and reduce ambiguity regarding documentation when a CCA includes multiple ASM participants as parties. These proposed changes would be reflected in proposed revised § 512.771(a)(9), if finalized.

We considered requiring that ASM participants maintain documentation supporting that all ASM participants who join the same CCA reassign their billing rights through the same TIN as a safeguard supporting compliance with our proposal that, if more than one ASM participant

joins as a party to a CCA, such ASM participants must all reassign billing rights to the same TIN. We did not propose this approach as we believe we would be able to verify this information based on data already available to us.

We seek comment on these proposed changes. We also seek comment on the alternative documentation approach we considered and whether this approach would better support compliance and monitoring.

j. Medicare Program Waivers

In the CY 2026 PFS final rule, we adopted a policy at § 512.775 whereby we waive MIPS reporting obligations for an ASM participant in each ASM performance year in which the ASM participant meets ASM eligibility criteria at § 512.710(b), except as specified in § 512.710(a)(2). Section 512.710(a)(2) describes an ASM participant who does not meet eligibility requirements for mandatory participation in ASM for a given ASM performance year.

We also discussed in the CY 2026 PFS final rule how the waiver pertaining to MIPS reporting obligations would not apply in instances where an ASM participant is not subject to specified ASM performance requirements due to a change in TIN (90 FR 49582). However, the regulatory text at § 512.771(a) does explicitly reflect this policy.

Accordingly, we propose to update § 512.775(a) to replace the reference to "§ 512.710(a)(2)" with "§512.710(a)(2) or § 512.710(c)" such that the regulatory text accurately reflects our policy.

We seek comment on this proposal.

E. Limiting Medicare Coverage of Certain Individuals

1. Background

On July 4, 2025, Pub. L. 119-21, which we refer to as the "Working Families Tax Cut" (WFTC) legislation, was enacted. Section 71201 of the WFTC legislation amended title XVIII of the Social Security Act (the Act) to add a new section 1899C, which provides that, subject to section 1899C(b) of the Act, an individual may be entitled to, or enrolled for, Medicare benefits only if the individual is in one of the following four groups: (1) a citizen or national of the United States; (2) an alien who is lawfully admitted for permanent residence under the Immigration and Nationality Act (INA) (lawful permanent resident or LPR)[187]; (3) an alien who has been granted the status of Cuban and Haitian entrant (CHE); or (4) an individual who lawfully resides in the United States[188] in accordance with a Compact of Free Association (COFA migrant).

Prior to enactment of the WFTC legislation, benefits payable under the Medicare program for noncitizens generally depended on whether the individual was "lawfully present." Section 401 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) (Pub. L. 104-193, August 22, 1996), codified at 8 U.S.C. 1611, generally provides that, subject to certain exceptions, only "qualified aliens" are eligible for Federal public benefits. However, section 401(b)(3) of PRWORA provides that Medicare benefits under title XVIII of the Act are not limited solely to "qualified aliens," but instead may be available to individuals who are lawfully present in the United States. Section 401(b)(2) of PRWORA similarly provides that noncitizens who are lawfully present in the United States may be eligible for benefits payable under title II, such as Social Security retirement or disability insurance benefits. Historically, before paying Medicare or title II benefits, the Social Security Administration (SSA) used a common process to verify an individual's lawful presence status by determining

---

[187] As defined in section 501(e) of the Refugee Education Assistance Act of 1980 (Pub. L. 96–422).

[188] See section 402(b)(2)(G) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA).

whether the applicant was a U.S. citizen or was otherwise lawfully present in the United States and whether the individual resided in the United States. SSA maintains a large set of policy and operational guidance, called Program Operations Manual System (POMS), that CMS and SSA update as needed. The SSA's procedures for verifying lawful presence before payment of title II and Medicare benefits are delineated in POMS. Prior to the statutory changes to Medicare eligibility made by the WFTC legislation, a noncitizen could qualify for payment of Medicare benefits if they met all other eligibility criteria and the individual was in an immigration status or category considered lawfully present under 8 CFR 1.3(a), which encompasses a broad range of immigration classifications. These "lawfully present" categories included:

- An alien who is an LPR.[189]
- An alien who is granted asylum.[190]
- A refugee who is admitted to the United States.[191]
- An alien who is paroled into the United States for a period of at least 1 year.[192]
- An alien who is a Cuban and Haitian entrant.[193]
- An individual who lawfully resides in the United States under a Compact of Free Association (COFA).[194]

The WFTC legislation did not modify the requirements for payment of title II benefits under sections 202(y) and 223 of the Act. As such, noncitizens who are lawfully present in the United States, as defined by 8 CFR 1.3(a), may remain eligible for payment of title II benefits. As a result, eligibility for payment of title II benefits is no longer coextensive with eligibility for payment of Medicare benefits under title XVIII of the Act for certain noncitizens. Because continued reliance on the lawful presence verification framework used to determine noncitizen eligibility for payment of title II benefits would conflict with section 1899C of the Act when

---

[189] Under the Immigration and Nationality Act (INA) [8 U.S.C. 1101 et seq.].
[190] Under section 208 of INA [8 U.S.C. 1158].
[191] Under section 207 of INA [8 U.S.C. 1157].
[192] Under section 212(d)(5) of INA [8 U.S.C. 1182(d)(5)].
[193] As defined in section 501(e) of the Refugee Education Assistance Act of 1980 (Pub. L. 96–422).
[194] Pub. L. 99–239; Pub. L. 99–658; see also 8 U.S.C. 1612(b)(2)(G).

applied to Medicare, we propose to establish Medicare-specific definitions and related enrollment and termination criteria concerning citizenship, nationality, and immigration status.

2. Limiting Coverage Under Medicare Part A and Part B to Certain Individuals

a. Amending the Eligibility Criteria for Part A and Part B

Sections 226 and 226A of the Act establish the conditions under which individuals are entitled to Medicare Part A benefits based on attainment of age 65, disability, or end-stage renal disease (ESRD). Individuals entitled to Medicare Part A under these provisions are not required to pay premiums for such coverage (known herein as premium-free Medicare Part A) and may elect to enroll in Medicare Part B. In general, individuals entitled to title II retirement benefits prior to attaining age 65 or entitled to title II disability benefits, upon attainment of age 65 or after satisfying any applicable waiting period, respectively, are automatically enrolled in premium-free Medicare Part A and will be enrolled automatically in Medicare Part B unless they decline Medicare Part B enrollment.[195] There are no statutory requirements for citizenship, nationality, immigration status, or residency in sections 226 and 226A of the Act. Eligibility determinations, including citizenship and lawful presence verification, for premium-free Medicare Part A have historically been made through the title II lawful presence verification framework administered by the SSA.

Section 1818 of the Act establishes the conditions under which certain individuals who are not entitled to premium-free Medicare Part A may enroll in the hospital insurance program by paying a monthly premium (herein referred to as premium Medicare Part A). Under section 1818 of the Act, an individual who has attained age 65, enrolled in Medicare Part B, and is not otherwise entitled to premium-free Medicare Part A may enroll if the individual is a resident of the United States and is either a citizen of the United States or an alien lawfully admitted for permanent residence who has resided continuously in the United States for the 5 years immediately preceding the month in which the individual applies for enrollment.

---

[195] Section 1837 of the Act and the enrollment process outlined in 42 CFR 407.17.

Section 1836 of the Act establishes eligibility requirements for Medicare Part B (also known as supplementary medical insurance). Under section 1836 of the Act, an individual may enroll in Medicare Part B if the individual is entitled to Medicare Part A or, alternatively, has attained age 65, is a resident of the United States and is either a citizen of the United States or an alien lawfully admitted for permanent residence who has resided continuously in the United States for the 5 years immediately preceding the month in which the individual applies for enrollment. The WFTC legislation did not eliminate the 5-year continuous residency requirement for LPRs in sections 1818(a)(3) and 1836(a)(2) of the Act and, as a result, we are not proposing to alter this requirement. In other words, LPRs who meet the 5-year continuous residency requirement and other applicable Medicare requirements would maintain their Medicare benefit.

Similar to premium-free Medicare Part A, enrollment in Medicare Part B under section 1836(a)(1) of the Act has historically been administered in coordination with the SSA's lawful presence verification framework for confirming citizenship, nationality, lawful presence, and residency status for payment of title II benefits. However, section 1899C of the Act establishes specific statutory categories of individuals who may be entitled to, or enrolled in, Medicare under title XVIII of the Act. As a result, title II's lawful presence requirements no longer fully align with the Medicare Part B eligibility framework established by section 1899C of the Act.

To align Medicare eligibility regulations with section 1899C of the Act, we are proposing to add a new definition of "eligible noncitizen" at 42 CFR 400.200 that includes the categories of noncitizens eligible for Medicare under sections 1899C(a)(2) through (4) of the Act. Specifically, the proposed definition would state that an "eligible noncitizen" is an individual who is (1) an alien lawfully admitted for permanent residence under the INA; (2) an alien who has been granted the status of CHE, as defined in section 501(e) of the Refugee Education Assistance Act of 1980 (Pub. L. 96–422); or (3) an individual who lawfully resides in the United States in accordance with a COFA referred to in 8 U.S.C. 1612(b)(2)(G).

The proposed definition of "eligible noncitizen" is not intended to apply to noncitizen U.S. nationals who are expressly eligible for Medicare under section 1899C(a)(1) of the Act. The proposed definition of "eligible noncitizen" applicable to Medicare eligibility would be distinguishable from the immigration status or category criteria in 8 CFR 1.3 applicable to noncitizen eligibility for title II benefits, which continues to be based on the "lawfully present" framework in section 401(b)(2) of PRWORA.

We further propose to amend regulations at 42 CFR part 406 (Medicare Part A) and 42 CFR part 407 (Medicare Part B) to incorporate the proposed definition of "eligible noncitizen." We propose to add that, effective July 4, 2025, an individual must be a citizen or national of the United States or an eligible noncitizen as a basis for entitlement. These proposed changes would be added or included into the following sections:

- Premium-Free Medicare Part A:

++ New paragraph (a)(2) would be added to § 406.5 (Basis of eligibility and entitlement). This proposed new paragraph would add the requirement that, in addition to satisfying the applicable age, disability, or ESRD-based entitlement criteria, an individual must also be a citizen or national of the United States or an eligible noncitizen. This revision would align the eligibility and entitlement criteria for premium-free Medicare Part A with section 1899C(a) of the Act.

++ New paragraph (a)(2) would be added to § 406.10 (Individual age 65 or over who is entitled to Social Security or Railroad Retirement benefits, or who is eligible for Social Security benefits). This proposed new paragraph would clarify that individuals age 65 or over who otherwise qualify for premium-free Part A through Social Security or Railroad Retirement pathways must also satisfy the citizenship, nationality, or immigration status or category requirements established by section 1899C(a) of the Act. This would ensure that automatic or application-based entitlement under this section is limited to U.S. citizens, U.S. nationals, and eligible noncitizens.

++ Paragraph (b)(2) would be revised in § 406.11 (Individual age 65 or over who is not eligible as a Social Security or Railroad Retirement benefits beneficiary, or on the basis of government employment). This proposed revision would align the eligibility language in § 406.11 with section 1899C(a) of the Act and clarify that individuals qualifying under this pathway must also satisfy the citizenship, nationality, or immigration status or category standards in section 1899C(a) of the Act. This change would ensure that entitlement is not available under this section unless the individual is a U.S citizen, U.S. national, or eligible noncitizen.

++ New paragraph (a)(2) would be added to § 406.12 (Individual under age 65 who is entitled to Social Security or Railroad Retirement disability benefits). This proposed new paragraph would provide that individuals under age 65 who otherwise qualify for premium-free Part A on the basis of disability must also meet the citizenship, nationality, or immigration status or category requirements of section 1899C(a) of the Act. This would align the regulation implementing premium-free Part A entitlement based on disability with the requirements in section 1899C(a) of the Act.

++ New paragraph (c)(4) would be added to § 406.13 (Individual who has ESRD). This proposed new paragraph would clarify that individuals who otherwise qualify for premium-free Part A on the basis of ESRD must also be a citizen or national of the United States or an eligible noncitizen. This revision would align the regulation implementing premium-free Part A entitlement based on ESRD with the eligibility limitations in section 1899C(a) of the Act.

- Premium Medicare Part A:

++ In § 406.20 (Basic Requirements), paragraphs (b)(2)(i) and (b)(2)(ii) would be revised and new paragraphs (b)(2)(iii), (b)(2)(iv), and (c)(5) would be added. These proposed revisions would update the eligibility requirements for enrollment in premium Part A to incorporate the proposed definition of eligible noncitizen. These changes would align premium Part A eligibility with section 1899C(a) of the Act by clarifying that only U.S. citizens, U.S. nationals, and eligible noncitizens may enroll under this pathway.

- Medicare Part B:

++ New paragraphs (a)(2)(ii)(A) through (D) would be added in § 407.10 (Eligibility to Enroll). These proposed revisions would update the Part B enrollment regulation to incorporate the proposed definition of eligible noncitizen. These proposed changes would align the Part B eligibility regulation with section 1899C(a) of the Act and clarify that only U.S. citizens, U.S. nationals, and eligible noncitizens may enroll under this pathway.

We note that the WFTC legislation also has implications for the Medicare Part B Immunosuppressive Drug benefit (Part B-ID) under section 1836(b) of the Act. Part B-ID is a limited Part B benefit that provides coverage only for immunosuppressive drugs for certain individuals whose entitlement to Medicare based solely on end-stage renal disease (ESRD) ended 36 months after a successful kidney transplant and who do not have other disqualifying health coverage. Although eligibility for Part B-ID is governed by the specific criteria set forth in § 407.55, individuals seeking to enroll in, or remain enrolled in, Part B-ID must also satisfy the citizenship, nationality, or immigration status or category requirements in section 1899C(a) of the Act. Accordingly, we propose to revise § 407.55 (Eligibility to Enroll) to add new paragraphs (a)(1) and (2) to clarify that eligibility for Part B-ID is also subject to the limitations established by section 1899C(a) of the Act.

b. Termination of Entitlement for Individuals Who Were Entitled to, or Enrolled for, Medicare as of July 4, 2025, in accordance with Section 71201 of the WFTC Legislation ("Grace Period" Population)

Due to the statutory changes to Medicare eligibility made by section 71201 of the WFTC legislation, individuals who are not U.S. citizens or U.S. nationals and who have an immigration status or category other than LPR, CHE, or COFA migrant, and who were entitled to, or enrolled for, Medicare as of July 4, 2025, will no longer be eligible for Medicare on the date that is 18 months after July 4, 2025. As shorthand, we are referring to this 18-month time period as the "grace period" and the applicable individuals identified and notified during the grace period as

the “grace period population.” Section 1899C(b)(2)(A) of the Act directs the SSA to complete a review of all individuals entitled to, or enrolled for, Medicare as of July 4, 2025, and identify those beneficiaries entitled to, or enrolled for, Medicare as of July 4, 2025, who do not meet the requirements of section 1899C(a) of the Act. Section 1899C(b)(2)(A) provides 1 year for SSA to complete this task for the grace period population. Section 1899C(b)(2)(B) of the Act directs the SSA to provide notice to such beneficiaries as soon as practicable after identifying such beneficiaries that their entitlement to, or enrollment in, Medicare will be terminated as of the date that is 18 months after July 4, 2025.

The SSA shall identify all individuals who do not or potentially do not meet one of the eligibility criteria in section 1899C(a) per section 1899C(b)(2) of the Act. In accordance with section 1899C(b)(2)(B) of the Act, upon identifying individuals who do not or potentially do not meet one of the eligibility criteria in section 1899C(a), the SSA will then send, as soon as practicable, a notice to these identified individuals. The notice will inform them that SSA records indicate that they do not meet one of the eligibility criteria in section 1899C(a) of the Act, and their Medicare entitlement and enrollment will be terminated if they cannot provide evidence proving eligibility. Individuals would be instructed to contact the SSA if they believe the information is incorrect and to provide updated evidence of eligibility before their entitlement and enrollment is terminated. If applicable, the notice would state that a formal initial determination of ineligibility will be sent prior to their termination date if the individual takes no action to update their records or if the individual confirms that they do not meet the eligibility criteria in section 1899C(a) of the Act. As proposed, the SSA would provide a termination notice towards the end of December 2026 to all identified individuals determined to be ineligible based on data available to the SSA.. The termination notice would explain that the identified individuals do not satisfy the requirements in section 1899C(a) of the Act and therefore are not entitled to, and may not be enrolled for, Medicare. The notice would state that termination of enrollment will be effective February 1, 2027. The notice would inform individuals of their

appeal rights under existing appeals regulations for initial determinations delineated in 42 CFR, part 405, subpart I. Specifically, 42 CFR 405.900(b)(1) establishes that appeals of initial determinations for entitlement to benefits under Part A or Part B of Medicare are administered in accordance with the SSA's regulations governing reconsiderations of these initial determinations at 20 CFR, part 404, subpart J.

We note that entitlement to premium-free Part A and enrollment in premium Part A and Part B are referenced in the Act as "monthly insurance benefits" or "benefits for a month" (see section 226(c)(1) and (2) of the Act) and entitlement to or enrollment in Medicare always begins on the first day of the month and always ends on the last day of the month (see section 1838(a) and (b) of the Act). Consequently, the termination in proposed §§ 406.14(d)(2), 406.28(g)(3)(ii), and 407.27(e)(3)(ii) would be at the end of the calendar month.

Accordingly, we propose to amend the following regulations to implement termination procedures for individuals who were entitled to, or enrolled for, Medicare as of July 4, 2025, but do not meet or potentially do not meet the eligibility requirements of section 1899C(a) of the Act:

- Premium-Free Medicare Part A:

++ New § 406.14 (End of Entitlement Due to Change in Citizenship, Nationality, or Immigration Status or Category) would be added, in accordance with section 1899C(b)(1) of the Act, to establish the termination framework for individuals who were entitled to, premium-free Part A as of July 4, 2025, but who either do not meet or potentially do not meet the eligibility requirements of section 1899C(a) of the Act. Specifically, new paragraph (b) would provide that individuals entitled or enrolled as of July 4, 2025, who either do not meet or potentially do not meet the requirements of § 406.5(a)(2) will be identified and notified by the SSA per section 1899C(b)(2) of the Act. Individuals not meeting § 406.5(a)(2) requirements will have their entitlement or enrollment terminated in accordance with paragraph (d).

++ New paragraph (b)(3) would be added to § 406.10 (Individual age 65 or over who is entitled to Social Security or Railroad Retirement benefits, or who is eligible for Social Security benefits) to add a cross reference to the termination provision in the new § 406.14.

++ New paragraph (d)(2)(v) would be added to § 406.12 (Individual under age 65 who is entitled to Social Security or Railroad Retirement disability benefits) to add a cross reference to the termination provision in the new § 406.14.

++ New paragraph (f)(3) would be added to § 406.13 (Individual who has end-stage renal disease) to add cross reference to the termination provision in the new § 406.14(b).

- Premium Medicare Part A:

++ New paragraph (g)(1) would be added to § 406.28 (End of Entitlement Due to Change in Citizenship, Nationality, or Immigration Status or Category) in accordance with section 1899C(b)(1) of the Act, to establish the termination framework for individuals who were entitled to, or enrolled for, premium Part A as of July 4, 2025, but who either do not meet or potentially do not meet the eligibility requirements of section 1899C(a) of the Act. Specifically, the new paragraph (g)(1) would provide that individuals entitled to or enrolled as of July 4, 2025, who either do not meet or potentially do not meet the requirements of § 406.20(b)(2) will be identified and notified by the SSA per section 1899C(b)(2) of the Act. Individuals not meeting § 406.20(b)(2) requirements will have their entitlement or enrollment terminated in accordance with subparagraph (3).

- Medicare Part B:

++ New paragraph (e)(1) would be added to § 407.27 (Termination of entitlement: Individual), in accordance with section 1899C(b)(1) of the Act, to establish the termination framework for individuals who were enrolled in Part B as of July 4, 2025, but who either do not meet or potentially do not meet the eligibility requirements of section 1899C(a) of the Act. Specifically, the new paragraph (e)(1) would provide that individuals enrolled as of July 4, 2025, who either do not meet or potentially do not meet the requirements of § 407.10(a)(2) will be

identified and notified by the SSA per section 1899C(b)(2) of the Act. Individuals not meeting § 407.10(a)(2) requirements will have their enrollment terminated in accordance with paragraph (3).

c. Proposed Termination Process for Certain Noncitizens Entitled to, or Enrolled for, Medicare Who Were Not Identified and Notified by the SSA per Section 1899C(b)(2) of the Act (Outside of the "Grace Period" Population)

We turn now to the proposed termination processes that would be used for all other individuals whose eligibility for Medicare, including both initial eligibility and continued eligibility, is impacted by the statutory changes to Medicare eligibility made by section 71201 of the WFTC legislation and whose entitlement and enrollment was not terminated by the SSA under the processes implementing section 1899C(b) of the Act. The proposed termination processes for this population provides the framework to terminate enrollment in Medicare if they are not eligible to be entitled or enrolled per section 1899C of the Act while ensuring all impacted individuals are notified of termination and retain their appeal rights. Under this proposal, all terminations made under section 1899C of the Act would be prospective.

We propose that entitlement and enrollment for those not identified during the grace period and found not to meet the citizenship, nationality, or immigration status or category requirements in section 1899C(a) of the Act would end according to the termination processes in the following proposals: § 406.14(c) and (d) for those with premium-free Part A, § 406.28(g)(2) and (3) for those with premium Part A, and § 407.27(e)(2) and (3) for those with Part B benefits. The proposed termination processes in §§ 406.14(d), 406.28(g)(3) and 407.27(e)(3) include providing notice to such individuals that their entitlement and enrollment for Medicare will be terminated if they do not meet section 1899C(a) of the Act, and for terminating entitlement or enrollment where the SSA determines that the individual either does not or no longer meets the requirements of section 1899C(a) of the Act.

As stated, this proposed termination process would apply to anyone enrolled in Medicare whom the SSA determines does not meet eligibility requirements under section 1899C(a) of the Act and was not part of the grace period population per section 1899C(b)(2)(B) of the Act. There is a period of time between enactment of the WFTC legislation on July 4, 2025, and the SSA starting to screen individuals for new Medicare enrollment under the criteria in section 1899C(a) of the Act, which is expected in 2026. Individuals enrolled after enactment of the WFTC legislation but before screening procedures are implemented do not fall into the grace period population because they were not enrolled as of the date of enactment. Thus, individuals enrolled during the previously discussed time period who do not meet the eligibility requirements in section 1899C(a) of the Act would be terminated according to proposed §§ 406.14(d), 406.28(g)(3) or 407.27(e)(3), as appropriate.

Additionally, the proposed termination process would apply to anyone enrolled in Medicare whom the SSA determines does not meet the eligibility requirements in section 1899C(a) of the Act and was not notified as part of the grace period population per section 1899C(b)(2)(B) of the Act. This would include individuals whose status changed prior to the implementation of this proposed rule, if finalized as proposed, such as an individual who was enrolled in Medicare in October 2024 and met the eligibility requirements under section 1899C(a) of the Act based on their conditional LPR status when SSA identified and notified the grace period population. Therefore, they were not included in the grace period population per section 1899C(b)(2)(B) of the Act. However, if SSA's records indicate that their conditional LPR status expires December 2026, this proposed termination process would apply upon expiration of their conditional LPR status and would provide the framework for this individual's Medicare enrollment to be terminated as they would no longer satisfy the requirements of section 1899C(a) of the Act. We emphasize that the same process would also apply to individuals enrolled after this proposed rule is implemented, if finalized as proposed. As an example, consider the case of an individual enrolled in Medicare with conditional LPR status whose

enrollment began in April 2028. In February 2030, SSA records indicate that the individual's conditional LPR status expires in April 2030. Upon expiration of the individual's conditional LPR status in April 2030, the individual would no longer satisfy the requirements of section 1899C(a) of the Act, and the SSA would send notice to the individual that they no longer meet the requirements of section 1899C(a) of the Act. As a result, under the proposed process for termination of enrollment, the individual's Medicare enrollment would be terminated at the end of the month following the month in which the notice is dated.

There are several circumstances in which individuals are identified as no longer meeting the requirements of section 1899C(a) of the Act outside the grace period. We propose the same termination process for individuals in these circumstances in proposed §§ 406.14(d), 406.28(g)(3) or 407.27(e)(3), as appropriate.

For these individuals outside the grace period, we propose that a termination notice from the SSA would be sent to each individual identified as ineligible. We propose the notice would explain that, per data available to the SSA, , the individual does not satisfy the requirements of section 1899C(a) of the Act. Under the proposed termination process, an individual would not lose Medicare entitlement or enrollment during the month in which the SSA determines that the individual does not or no longer meets the requirements of section 1899C(a) of the Act. Rather, Medicare entitlement or enrollment would terminate at the end of the month following the month in which the notice is dated. For example, if the date of the termination notice is in March 2027, termination would be effective at the end of April 2027. This proposed termination timeline would be explained in the notice. The SSA will not terminate anyone's entitlement or enrollment prior to notification. Further, no termination of Medicare would occur for any individual entitled to, or enrolled for, Medicare for failure to meet the requirements of section 1899C(a) of the Act prior to the effective date of this rule, if finalized as proposed. We propose an effective date of January 1, 2027.

We propose that individuals whose Medicare entitlement and enrollment are terminated because they do not meet the requirements of section 1899C(a) of the Act would be provided appeal rights under the CMS' existing appeals regulations for initial determinations. Appeals of initial determinations for entitlement to benefits under Medicare Part A or Part B are administered in accordance with 20 CFR, part 404, subpart J. *See* 42 CFR 405.900(b)(1). We propose to include the information about appeal rights in the proposed termination notices.

Under this proposal, termination notices would be sent to affected individuals on an ongoing basis, as applicable, when the SSA receives information that an individual enrolled in Medicare does not meet the requirements of section 1899C(a) of the Act.

These proposals are necessary to ensure implementation of section 1899C of the Act is consistent with the efficient administration of the Medicare program under section 1102(a) of the Act. Therefore, to implement the proposed termination framework, we propose adding and revising the following sections:

- Premium-Free Medicare Part A:

++ New § 406.14 (End of entitlement due to change in citizenship, nationality, or immigration status or category) would be added. The proposed new § 406.14(c) would provide the termination framework for individuals entitled to premium-free Part A who were not identified and notified by the SSA per section 1899C(b)(2) of the Act and were subsequently determined by the SSA as not meeting the requirements of § 406.5(a)(2). Proposed § 406.14(d) describes the proposed termination notice and appeal rights in accordance with existing regulations governing Medicare entitlement determinations, states the effective date of premium-free Part A entitlement termination, and states that the individual should contact the SSA if their citizenship, nationality, or immigration status or category changes such that they may be entitled to, or enrolled for, premium-free Part A benefits.

++ New paragraph (b)(3) would be added to § 406.10 (Individual age 65 or over who is entitled to Social Security or Railroad Retirement benefits, or who is eligible for Social Security

benefits). This proposed new paragraph would add a cross-reference to § 406.14 so that individuals entitled to, or enrolled for, premium-free Part A through the age-65 pathway would be subject to the termination procedures in that section if they do not or no longer meet the citizenship, nationality, or immigration status or category requirements in section 1899C(a) of the Act.

++ New proposed paragraph (d)(2)(v) would be added to § 406.12 (Individual under age 65 who is entitled to Social Security or Railroad Retirement disability benefits). This proposed new paragraph would add cross-references to § 406.14(b) and (c) so that disability-based premium-free Part A entitlement would be subject to the proposed termination procedures for an individual who does not or no longer meets the citizenship, nationality, or immigration status or category requirements in section 1899C(a) of the Act.

++ New proposed paragraph (f)(3) would be added to § 406.13 (Individual who has ESRD). This proposed new paragraph would add a cross-reference to § 406.14 to specify that individuals entitled to, or enrolled for, premium-free Part A on the basis of ESRD would be subject to the proposed procedures for termination when an individual does not or no longer meets the citizenship, nationality, or immigration status or category requirements in section 1899C(a) of the Act.

- Premium Medicare Part A:

++ New proposed paragraph (g)(2) would be added to § 406.28 (End of entitlement) for individuals who were entitled to, or enrolled for, premium Part A, who were not identified and notified by the SSA per section 1899C(b)(2) of the Act and were subsequently determined by the SSA as not meeting the requirements of § 406.20(b)(2). Under proposed paragraph (g)(2), entitlement would end as provided under paragraph (g)(3) of this section.

++ New proposed paragraph (g)(3) would be added to § 406.28 (End of entitlement). It describes the proposed termination notice, which would specify the individual's appeal rights in accordance with existing regulations governing Medicare entitlement determinations, state the

effective date of premium Part A enrollment termination, and state that the individual should contact the SSA if their citizenship, nationality, or immigration status or category changes such that they may be entitled to, or enrolled for, premium Part A benefits.

++ Paragraphs (a) and (b) of § 406.50 would be revised to change the word "alien" to "eligible noncitizen."

- Medicare Part B:

++ New proposed paragraph (e)(2) would be added to § 407.27 (Termination of entitlement: Individual enrollment). This new paragraph would specify that individuals who are enrolled in Part B, who were not identified and notified by the SSA per section 1899C(b)(2) of the Act and were subsequently determined by the SSA as not meeting the requirements of § 407.10(a)(2), would have their enrollment terminated under the new proposed paragraph (e)(3) of the section.

++ New proposed paragraph (e)(3) would be added to § 407.27 (Termination of entitlement: Individual enrollment). This new paragraph would describe the termination notice, which would specify the individual's appeal rights in accordance with existing regulations governing Medicare entitlement determinations, state the effective date of Part B enrollment termination, and state that the individual should contact the SSA if their citizenship, nationality, immigration status or category changes such that they may be enrolled for, Part B benefits.

3. Enrollment Pathway for Individuals Who Gain or Regain Eligibility

Section 1899C of the Act limits eligibility for Medicare to specified categories of individuals based on citizenship, nationality, or immigration status or category. As a result, except as provided in section 1899C(b) of the Act, no individual may be entitled to, or enrolled for, Medicare if the individual does not meet the requirements of section 1899C(a) of the Act. Conversely, individuals may later become eligible if their citizenship, nationality, or immigration status or category changes, such that they satisfy section 1899C(a) of the Act, as well as applicable Medicare eligibility requirements.

To address circumstances in which individuals who initially did not meet the eligibility requirements of section 1899C(a) of the Act at the time they met all other Medicare eligibility requirements but, subsequently, do meet the section 1899C(a) of the Act requirements, we propose to establish a special enrollment period (SEP) under §§ 406.27(f) and 407.23(f). The SEP would also apply to those individuals whose Medicare entitlement or enrollment is terminated because they do not or no longer meet the requirements in section 1899C(a) of the Act, but who subsequently experience a change such that they meet the requirements of section 1899C(a) of the Act. Establishing an SEP for these scenarios is within the Secretary's authority under sections 1837(m) and 1838(g) of the Act, which provide for the establishment of SEPs for exceptional conditions. We consider the enactment of the WFTC legislation and addition of section 1899C of the Act to constitute an exceptional condition because it created a new and narrower class of noncitizens who may be eligible for Medicare than are eligible for title II benefits, despite the close associations between title II entitlement and Medicare entitlement, as discussed in section F.1. of this preamble, and despite the fact that lawful presence has been the standard for noncitizen eligibility for both title II and Medicare benefits for decades. In addition, the statutory changes made by the WFTC legislation fundamentally altered the consequences of changes in immigration status. Prior to enactment of the WFTC legislation, noncitizens enrolled in Medicare who had a loss of lawful presence status would have remained enrolled in Medicare, but payment for benefits would have been suspended. Now, in accordance with section 1899C of the Act, an individual who no longer meets the requirements of section 1899C(a) of the Act must have their entitlement and enrollment terminated. If such an individual later meets the requirements of section 1899C(a) of the Act, it may be at a time that does not clearly fall within an established enrollment period. In addition, individuals who otherwise meet the eligibility requirements for Medicare but for the eligibility requirements of section 1899C(a) of the Act may gain eligibility at a time that does not clearly fall within an established enrollment period. For this proposed SEP, we also propose that the general rule in §§ 406.27(a) and 407.23(a) that

an individual must have missed an enrollment period due to the exceptional condition would not apply. We believe this is necessary because, for example, as explained below, the 7-month initial enrollment period under sections 1818(c)(1) and 1837(d) of the Act does not align well with the unpredictable nature as to when an individual may experience a change in citizenship, nationality, or immigration status or category, such that they would meet the requirements of section 1899C(a) of the Act. As another example, an individual may lose and subsequently regain eligibility under section 1899C(a) of the Act during a period that does not overlap with an otherwise available enrollment period, such that no enrollment period is actually missed. Accordingly, this SEP would be available to individuals who later meet, or again meet, the requirements of section 1899C(a) of the Act, regardless of whether an enrollment period was missed.

We propose that the special enrollment period would begin in the month in which the individual, upon contacting the SSA, provides sufficient documentation to establish eligibility, and the proposed special enrollment period would end 6 months later. The duration of this proposed special enrollment period would be the same time frame afforded to individuals granted a special enrollment period for exceptional conditions under §§ 406.27 and 407.23. We propose that entitlement and enrollment would be prospective for premium Part A and Part B, beginning with the first day of the month following the month of enrollment. We believe a prospective effective date is appropriate and consistent with the Secretary's authority under section 1818(c)(8) of the Act for premium Part A and section 1838(g) of the Act for Part B to establish the date on which coverage begins for individuals enrolling during an SEP, in a manner consistent, to the extent practicable, with protecting continuity of health benefit coverage. Although an individual may in some cases be able to demonstrate an earlier date on which the requirements of section 1899C(a) of the Act were met, we are proposing a uniform prospective effective date for premium Part A and Part B because citizenship data in SSA records is gathered and verified at a point in time. o and does not provide a reliable or administrable basis

for consistently establishing earlier eligibility dates for enrollment purposes. In addition, a retroactive effective date for premium Part A and Part B could require the assessment of back-due premiums for months of coverage that the individual had not yet affirmatively elected, which would add operational complexity and could create unexpected financial obligations for beneficiaries. We believe a prospective-only approach is therefore the most practicable and administrable method for implementing this SEP for premium Part A and Part B.

We considered an alternative pathway which consisted of establishing an initial enrollment period for premium Part A and Part B for eligible noncitizens who would have been eligible for Medicare based on entitlement to benefits under title II of the Act and attainment of age 65 or completion of the 24-month waiting period for disability benefits, as applicable, but whose entitlement was never effectuated because they did not meet the citizenship, nationality, or immigration status or category requirements specified in section 1899C(a) of the Act. However, we note that the 7-month initial enrollment period articulated in sections 1818(c)(1) and 1837(d) of the Act is largely tied to the attainment of age 65 or completion of the 24-month waiting period for disability benefits and begins on the first day of the third month before the month in which an individual meets the eligibility requirements for premium Part A and Part B. Traditionally, this 3-month pre-eligibility period provides an opportunity for individuals to explore coverage options (for example, original Medicare or Medicare Advantage) and enroll in Part A and Part B. This 3-month period helps individuals avoid delays and gaps in coverage. As a practical matter, such an initial enrollment period could not be applied in an analogous manner to changes that would make an individual eligible for Medicare by virtue of meeting the requirements of section 1899C(a) of the Act because an individual may not be enrolled for Medicare benefits unless and until they meet the requirements of section 1899C(a) of the Act. As a result, establishing an initial enrollment period under sections 1818(c)(2) and 1837(d) of the Act or these individuals would effectively shorten the enrollment period by 3 months because such individuals could not be enrolled in Medicare until the section 1899C(a) of the Act

requirements are met, which would conflict with the requirements of the Act. Instead, we opted for a proposed approach of establishing a SEP for individuals enrolling in Medicare for the first time, as well as individuals who lost and regained Medicare, due to changes in citizenship, nationality, or immigration status or category because it comports with the requirements of the Act.

For premium-free Medicare Part A, we propose that entitlement may be retroactive for up to 6 months, but not earlier than the first month in which the individual met all the eligibility requirements in proposed § 406.5(a). Under this proposal, if acceptable evidence establishes the month in which the individual first satisfied the citizenship, nationality, or immigration status or category requirements in § 406.5(a)(2), the SSA would use that month, subject to the applicable retroactivity limit. If the earliest month of eligibility cannot be established based on acceptable documentary evidence, entitlement would instead begin on the first day of the month in which the SSA verifies that the individual satisfies § 406.5(a)(2).

Accordingly, to implement the enrollment processes described earlier for individuals who establish or reestablish eligibility under section 1899C(a) of the Act, we propose to amend the regulations at 42 CFR part 406 (Medicare Part A) and 42 CFR part 407 (Medicare Part B) to specify the availability, duration, and effective date rules for enrollment under these circumstances. We propose to add and revise the following sections:

- Premium-Free Medicare Part A:

++ Paragraph (b) would be revised in § 406.6 (Application or enrollment for hospital insurance) to include the citizenship, nationality, or immigration status or category requirements in section 1899C(a) of the Act for individuals who need not file an application for hospital insurance.

++ New paragraph (f) would be added to § 406.6 (Application or enrollment for hospital insurance) to establish rules for individuals who would otherwise qualify for premium-free Part A based on entitlement to title II benefits, but who were not entitled because they did not meet

the citizenship, nationality, or immigration status or category requirements in section 1899C(a) of the Act at the time they otherwise would have become eligible. It would also specify how such individuals may initiate entitlement upon later meeting those requirements and clarify the applicable entitlement effective date, including the circumstances under which premium-free Part A entitlement would begin consistent with current law. Subparagraph (1) applies to those who meet the conditions of paragraph (b) of this section and, as such, need not file an application for hospital insurance. These individuals must contact the SSA to initiate entitlement to hospital insurance. Subparagraph (2) applies to those who meet the conditions of paragraph (c) of this section and, as such, must file an application for hospital insurance. These individuals must contact the SSA to file such application.

- Premium Medicare Part A:

++ Paragraph (f) would be redesignated as paragraph (g) and new paragraph (f) would be added to § 406.27 (Special enrollment periods for exceptional conditions). This new paragraph would establish an SEP for individuals whose premium Part A enrollment was previously terminated because they lost the citizenship, nationality, or immigration status or category required under section 1899C(a) of the Act, but who later regain a qualifying status and again become eligible. The SEP would also apply to individuals who would otherwise meet the eligibility requirements for Medicare, except for those in section 1899C(a) of the Act, and later meet the eligibility requirements of section 1899C(a) of the Act. The new provision would specify the availability and duration of this SEP and clarify that enrollment under this pathway would be prospective, consistent with the Secretary's authority to establish SEPs for exceptional conditions. An individual does not need to miss an applicable enrollment period to be eligible for this SEP.

- Medicare Part B:

++ Paragraph (f) would be redesignated as paragraph (g) and new paragraph (f) would be added to § 407.23 (Special enrollment periods for exceptional conditions). This new paragraph

would establish a SEP for individuals whose Part B enrollment was terminated because they no longer met the citizenship, nationality, or immigration status or category requirements in section 1899C(a) of the Act, but who subsequently regain a qualifying status and again become eligible to enroll. The SEP would also apply to individuals who otherwise met the eligibility requirements for Medicare, except for those in section 1899C(a) of the Act, and later meet the eligibility requirements of section 1899C(a) of the Act. It would specify the duration of the SEP and the prospective effective date of Part B coverage for individuals enrolling under this pathway. An individual does not need to miss an applicable enrollment period to be eligible for this SEP.

4. Limiting Coverage under Medicare Part C, Medicare Part D, and Cost Plans to Certain Individuals

Under section 1851(a)(3) of the Act, Medicare Part C (Medicare Advantage (MA)) is available only to individuals who are entitled to Medicare Part A and are enrolled in Medicare Part B. Medicare Part D (the Medicare prescription drug benefit) is available to individuals who are entitled to Medicare Part A or are enrolled in Medicare Part B, as specified in section 1860D-1(a)(3) of the Act. Section 1876(a)(1)(A) of the Act outlines eligibility requirements to enroll in Medicare cost plans and provides that individuals may enroll in cost plans if they are entitled to Medicare Part A and are enrolled in Part B or are enrolled in Part B only. Eligibility for enrollment in an MA plan, Part D plan, or cost plan is therefore dependent on an individual's underlying entitlement to and/or enrollment in Medicare Part A and/or Part B, as applicable. Prior to the enactment of section 1899C of the Act, individuals who satisfied the statutory conditions for Medicare Part A entitlement and/or Medicare Part B enrollment, as applicable, were likewise eligible to enroll in MA plans, Part D plans, or cost plans, provided they met applicable enrollment requirements. The eligibility requirements in section 1899C of the Act apply to all parts of Medicare. Individuals who do not meet the eligibility requirements

of section 1899C of the Act are not eligible for Medicare Part A or Part B and may not enroll or remain enrolled in MA plans, Part D plans, or cost plans.

Individuals enrolled in MA plans, Part D plans, or cost plans who do not meet the eligibility requirements of section 1899C of the Act must be disenrolled from those plans. Under 42 CFR 417.460(b)(2)(iii), 422.74(b)(2)(ii), and 423.44(b)(2)(ii), individuals who lose eligibility for enrollment are involuntarily disenrolled from the plan. Such disenrollments will be prospective and effective the first day of the calendar month following the last month of entitlement to Part A or Part B as specified under 42 CFR 417.460(h), 422.74(d)(5), and 423.44(d)(3).

Plans do not process these disenrollments. CMS processes these automatically through the MARx system when the SSA provides updated eligibility and entitlement records and CMS will notify the plan of the disenrollment due to loss of entitlement, through MARx transaction reply codes. Plans have the option, but are not required, to provide a notice of disenrollment due to loss of entitlement. Since the SSA provides a loss of entitlement notice for Part A and Part B, there is no need to require plans to provide additional notification.

Accordingly, we propose to amend the regulations at 42 CFR part 417, part 422, and part 423 to incorporate the new eligibility limitations established by section 1899C of the Act. We propose to revise the following sections to reflect the applicability of section 1899C of the Act:

- Paragraph (b) of § 417.2 (Basis and scope): We propose to amend paragraph (b) of § 417.2 to add a reference to section 1899C of the Act, which establishes eligibility limitations applicable to cost plan enrollment.

- Paragraphs (a)(1)(xii) and (a)(2) of § 422.1 (Basis and scope): We propose to amend § 422.1 to add paragraph (a)(1)(xii) to reference section 1899C of the Act, which establishes eligibility limitations applicable to MA enrollment. We further propose to remove and reserve paragraph (a)(2) that references 8 U.S.C. § 1611.

- Paragraphs (a)(1) and (3) of § 423.1 (Basis and scope): We propose to amend paragraph (a)(1) of § 423.1 to add a reference to section 1899C of the Act, which establishes eligibility limitations applicable to Part D enrollment. We further propose to remove and reserve paragraph (a)(3) of § 423.1 that references 8 U.S.C. § 1611.

We are also proposing to add that effective July 4, 2025, an individual must be a citizen or national of the United States or an eligible noncitizen as a basis for entitlement. We propose to revise the following sections to add this language:

- Paragraph (h) of § 417.422 (Eligibility to enroll in an HMO or CMP).
- Paragraph (a)(7) of § 422.50 (Eligibility to elect an MA plan).
- Paragraph (a)(1)(iii) of § 423.30 (Eligibility and enrollment).

Additionally, we propose to update the regulations at 42 CFR part 417, part 422 and part 423 to clarify the circumstances under which individuals must be disenrolled from MA plans, Part D plans, or cost plans due to failure to meet the eligibility requirements of section 1899C of the Act. Though failure to meet the eligibility requirements of section 1899C of the Act results in a loss of Part A and Part B eligibility, we propose to create an involuntary disenrollment process for MA plans, Part D plans, and cost plans that is separate from the existing loss of entitlement to Part A or Part B disenrollment process. Administratively, separating failure to meet section 1899C of the Act eligibility requirements from all other reasons for loss of Part A or Part B entitlement allows CMS to better track the impact of this provision and create new technical processes with the SSA and internally. Specifically, we propose to revise the following sections to add this language:

- Paragraphs (b)(2)(iv) and (j) of § 417.460 (Disenrollment of beneficiaries by an HMO or CMP): We propose to amend paragraph (b)(2)(iv) of § 417.460 to state that a cost plan must disenroll an enrollee if they no longer meet the requirements of § 417.422(h). We propose to amend paragraph (j) of § 417.460 related to the disenrollment effective date to apply to an enrollee who is not a U.S. citizen, U.S. national, or eligible noncitizen.

- Paragraphs (b)(2)(v) and (d)(9) of § 422.74 (Disenrollment by the MA organization): We propose to amend paragraph (b)(2)(v) of § 422.74 to state that an MA plan must disenroll an enrollee if they no longer meet the requirements of § 422.50(a)(7). We propose to amend paragraph (d)(9) of § 422.74 related to the disenrollment effective date to apply to an enrollee who loses U.S. citizenship or nationality, or eligible noncitizen status.

- Paragraphs (b)(2)(vi) and (d)(8) of § 423.44 (Involuntary disenrollment from Part D coverage): We propose to amend paragraph (b)(2)(vi) of § 423.44 to state that a Part D plan must disenroll an enrollee if they no longer meet the requirements of § 423.30(a)(1)(iii). We propose to amend the heading for paragraph (d)(8) of § 423.44 related to the disenrollment effective date to apply to an enrollee who loses U.S. citizenship or nationality, or eligible noncitizen status.

We also propose to amend the regulations at 42 CFR part 422 and part 423 to replace the SEP that is currently applicable when an individual who is a non-U.S. citizen attains lawful presence status. Under this proposal, the SEP would apply when an individual becomes an eligible noncitizen by attaining the eligibility requirements of section 1899C(a) of the Act. The SEP would begin when the individual provides the SSA with sufficient information to demonstrate that the requirements of § 406.20(b)(2) and § 407.10(a)(2)(ii) have been met. Providing this information to the SSA and establishing eligibility would result in automatic entitlement for Part A, assuming that the individual was otherwise eligible for premium-free Part A. For Part B entitlement, the individual would also need to enroll in Part B under § 407.4(a)(2), after which the individual would become entitled to Part B.

We propose to revise this language in the following sections:

- Paragraph (b)(16) of § 422.62 (Election of coverage under an MA plan).

- Paragraphs (c)(21)(i) and (ii) of § 423.38 (Enrollment periods).

Because eligibility to elect an MA plan requires an individual to be both entitled to Medicare Part A and enrolled in Medicare Part B, the SEP at § 422.62(b)(16) would last for 2 months after the month in which the individual becomes entitled to Medicare Part A and enrolled

in Medicare Part B. Similar to the way the MA Initial Coverage Election Period (ICEP) works under § 422.62(a)(1), this SEP would be available as soon as the individual is entitled to Medicare Part A and enrolled in Medicare Part B. As a result, this SEP would be available to individuals who previously had and lost Part A and/or Part B because they were not eligible noncitizens. For such individuals, they would not have access to the ICEP because their new entitlement to Medicare Part A and enrollment in Medicare Part B would not be their "first" entitlement, as required by the ICEP. We propose this SEP as a way of ensuring that individuals gaining eligible noncitizen status have the opportunity to enroll in Medicare Advantage upon becoming entitled to Medicare Part A and enrolling in Medicare Part B. Consequently, this SEP will replace the existing SEP for gaining "lawful presence status," which is no longer a relevant eligibility criterion and needs to be removed. An enrollment using this SEP would be effective the first day of the calendar month following the month in which the election is made, as specified in § 422.68(d).

The Part D SEP at § 423.38(c)(21)(i) and (ii) would last for 2 months after either the individual's Part A or Part B entitlement date, since they can differ and individuals are eligible for Part D with either Part A or Part B. The SEP would end based on the earlier of the two entitlement dates. The Part D SEP needs a different timeline than its Part C equivalent since the eligibility criteria for the two programs differ. Importantly, we intend for this SEP to be used surrounding the period that an individual establishes their eligible noncitizen status with SSA, so we propose that the SEP eligibility window begins upon the entitlement to Part A or Part B, whichever is earlier. This timeline ensures that the SEP is based upon both the eligibility requirements for Part D and the intent to provide these individuals with an opportunity to enroll in Part D when initially eligible to make such an election after establishing eligible noncitizen status. This SEP would also replace the existing SEP for gaining "lawful presence status." An enrollment using this SEP would be effective the first day of the calendar month following the month in which the election is made, as specified in § 423.40(c).

F. Medicare Prescription Drug Inflation Rebate Program

1. Background

a. Overview of the Medicare Prescription Drug Inflation Rebate Program

Sections 11101 and 11102 of the Inflation Reduction Act of 2022 (IRA) (Pub. L. 117-169, enacted August 16, 2022) established requirements under which drug manufacturers must pay inflation rebates if they raise their prices for certain drugs payable under Part B and/or covered under Part D faster than the rate of inflation. Specifically, section 11101 of the IRA amended section 1847A of the Act by adding new subsection (i) which establishes a requirement for drug manufacturers to pay rebates into the Federal Supplementary Medical Insurance Trust Fund for Part B rebatable drugs if the specified amount, as determined under section 1847A(i)(3)(A)(ii) of the Act, exceeds the inflation-adjusted payment amount, which is calculated as set forth in section 1847A(i)(3)(C) of the Act. The IRA also provides for an adjustment to the beneficiary coinsurance amount in cases where the price of a Part B rebatable drug increases faster than the rate of inflation such that the beneficiary coinsurance is calculated based on the lower inflation-adjusted payment amount instead of the applicable payment amount. Section 1847A(i)(2) of the Act defines a "Part B rebatable drug," as a single source drug or biological product (as defined in section 1847A(c)(6)(D) of the Act), including a biosimilar biological product (as defined in section 1847A(c)(6)(H) of the Act), but excluding a qualifying biosimilar biological product (as defined in section 1847A(b)(8)(B)(iii) of the Act) for which payment is made under Part B, except such term also does not include a drug or biological described in clause (i) and (ii) of such section 1847A(i)(2)(A) of the Act.

Section 11102 of the IRA added section 1860D-14B of the Act, which requires drug manufacturers to pay rebates into the Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund for each 12-month applicable period, starting with the applicable period that began on October 1, 2022, for Part D rebatable drugs if the annual manufacturer price (AnMP) of such drug, which is calculated as set forth in section 1860D-

14B(b)(2) of the Act, exceeds the inflation-adjusted payment amount, which is calculated as set forth in section 1860D-14B(b)(3) of the Act. Section 1860D-14B(g)(1)(A) of the Act defines a "Part D rebatable drug," as a drug or biological described at section 1860D-14B(g)(1)(C) of the Act that is a "covered Part D drug" as that term is defined in section 1860D-2(e) of the Act, and excludes drugs and biologicals described in subparagraph (B) of such section 1860D-14B(g)(1) of the Act. The definition of a Part D rebatable drug includes drugs approved under a new drug application under section 505(c) of the Federal Food, Drug, and Cosmetic (FD&C) Act, drugs approved under an abbreviated new drug application under section 505(j) of the FD&C Act that meet certain sole source criteria described at sections 1860D-14B(g)(1)(C)(ii)(I) through (IV) of the Act, and biologicals licensed under section 351 of the Public Health Service (PHS) Act, including biosimilars.

The IRA sets forth different parameters for determining rebates under the Medicare Part B Drug Inflation Rebate Program and the Medicare Part D Drug Inflation Rebate Program. In regard to the rebates owed, for each calendar quarter beginning on or after January 1, 2023, the manufacturer of a Part B rebatable drug is required, for such drug, not later than 30 days after the date of receipt of the Rebate Report from us, to pay a rebate into the Federal Supplementary Medical Insurance Trust Fund if the amount specified in section 1847A(i)(3)(A)(ii)(I) of the Act exceeds the inflation-adjusted payment amount (calculated as set forth in section 1847A(i)(3)(C) of the Act) for an applicable calendar quarter. In contrast, for each 12-month applicable period beginning on or after October 1, 2022, the manufacturer of a Part D rebatable drug is required, for such drug, not later than 30 days after the date of receipt of the Rebate Report from us, to pay a rebate into the Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund if the amount of the AnMP (calculated as set forth in section 1860D-14B(b)(2) of the Act) exceeds the inflation-adjusted payment amount (calculated as set forth in section 1860D-14B(b)(3) of the Act). In regard to invoicing manufacturers for the rebate amount owed, under section 1847A(i)(1) of the Act, we must report rebate amounts to each manufacturer

of a Part B rebatable drug no later than 6 months after the end of each calendar quarter, except that for calendar quarters beginning in 2023 and 2024, section 1847A(i)(1)(C) of the Act provides that we had until September 30, 2025, to invoice manufacturers for rebates. In contrast, under section 1860D-14B(a) of the Act, we must report rebate amounts to each manufacturer of a Part D rebatable drug no later than 9 months after the end of each applicable period, except that for the first two applicable periods (that is, October 1, 2022, to September 30, 2023, and October 1, 2023, to September 30, 2024), section 1860D-14B(a)(3) of the Act provides that we had until December 31, 2025, to invoice manufacturers for Part D inflation rebates. Additionally, there are statutory differences in the inputs (that is, data sources) used to calculate the rebate amounts for Part B and Part D.

In the CY 2025 PFS final rule (89 FR 98228 through 98313), to implement sections 11101 and 11102 of the IRA, we codified these requirements and established other policies at parts 427 and 428 under title 42, chapter IV of the Code of Federal Regulations for Part B and Part D, respectively.

b. Summary of Proposed Policies for the Medicare Prescription Drug Inflation Rebate Program

We are proposing new policies for the Medicare Part B Drug Inflation Rebate Program as follows:

- Proposed § 427.20 would clarify the definition of "first marketed date" to clarify the data sources we would use to identify the first marketed date when relevant Average Sales Price (ASP) data is not available.

- Proposed § 427.101(b)(5) would modify the skin substitutes excluded product category for Part B rebatable drugs so that the exclusion applies only to certain skin substitutes products.

- Proposed §§ 427.302(e)(6) and (f)(1) would clarify what Consumer Price Index for All Urban Consumers (CPI-U) data would be used to determine the benchmark period CPI-U in place of the month for which CPI-U data are unavailable.

We also are proposing new policies for the Medicare Part D Drug Inflation Rebate Program as follows:

- Proposed § 428.20 would clarify the definition of "applicable period CPI-U" when the CPI-U data for the first month of the applicable period are not available.
- Proposed § 428.202(e)(6) would clarify what CPI-U data would be used to determine the benchmark period CPI-U in place of the month for which CPI-U data are unavailable.
- Proposed § 428.203(c) would require providers and suppliers that are covered entities as defined at § 10.3 to submit Part D 340B data to the 340B repository beginning with claims with a date of service on or after January 1, 2027.

2. Medicare Part B Drug Rebates for Single Source Drugs and Biological Products with Prices that Increase Faster than the Rate of Inflation

a. Definitions (§ 427.20)

In the CY 2025 PFS final rule (89 FR 98579), we codified at § 427.20 the definition of "first marketed date" to mean the earliest date of first sale of any NDC-11 within a billing and payment code among all products and package sizes under the same FDA application. In that definition, we specify that the first marketed date will be identified using ASP data reported by NDC-11 to CMS by a manufacturer as required under sections 1927(b)(3)(A)(iii)(I) and 1847A(f)(2) of the Act, if available. We note that we use "date of first sale" as reported in the ASP Data Collection System for the first marketed date as specified at § 427.20. There may be scenarios where a drug is being marketed but the first marketed date is not available in the ASP data such as when a manufacturer is not required to report ASP data under sections 1927(b)(3)(A)(iii)(I) or 1847A(f)(2) of the Act. In this example, ASP units sold also would be unavailable in the ASP Data Collection System. Currently we generally use the NDC Directory to identify the first marketed date when it is not available in the ASP Data Collection System. In this proposed rule, to improve transparency of operations to address instances when first marketed date is missing from ASP data, we are proposing to amend § 427.20 with respect to the

definition of the term “first marketed date” to clarify the data sources we would use to identify the first marketed date when ASP data are not available. Specifically, when the first marketed date is missing from ASP data for any NDC-11 associated with any FDA application number ever associated with the billing and payment code we propose to identify the first marketed date from an alternative public source, such as from the NDC Directory. For example, when the first marketed date is missing from ASP data for a given NDC, we would identify the first marketed date for the NDC-11 from the NDC Directory; and if the first marketed date also is missing from the NDC Directory for a given NDC, we would default to using the FDA approval date as listed in the Orange Book or Purple Book. We note that we believe data in the NDC Directory are accurate, reliable, and up to date. The Food and Drug Administration (FDA) updates the NDC Directory daily with information submitted to FDA by labelers. A labeler may be a manufacturer, including a repackager or relabeler, or the entity named on the product label that is required to list their products with FDA under 21 CFR part 207. The FDA also requires that labelers annually update their data or certify that there were no changes to their data listed in the NDC Directory.

b. Treatment of Skin Substitutes as a Part B Rebatable Drug Excluded Product Category (§ 427.101(b)(5))

In the CY 2025 PFS final rule (89 FR 98580), we codified skin substitutes (that is, products included within the suite of cellular- and tissue-based products that aid wound healing) as an excluded product category at § 427.101(b)(5) and therefore they are not considered Part B rebatable drugs. We finalized this policy because we aimed to create a consistent coding and payment approach for skin substitute products. Since that policy was finalized, in the CY 2026 PFS final rule (90 FR 49496, 50009), we modified how skin substitutes are paid under Part B. In particular, we finalized our proposal to limit application of the ASP payment methodology under section 1847A of the Act to skin substitutes that are approved as a drug or biological product under section 351 of the PHS Act. Additionally, we modified payment for the provision of

certain groups of skin substitutes as incident-to supplies.

To avoid an overly broad exclusion at § 427.101(b)(5), we are proposing to clarify that skin substitutes licensed as a drug or biological product under section 351 of the PHS Act would not be excluded from the definition of a Part B rebatable drug, and, as such, would be subject to Part B inflation rebates and subject to the beneficiary coinsurance adjustment under § 427.201. We note that currently there are no skin substitute products licensed as a drug or biological product under section 351 of the PHS Act; however, our proposal would make clear that any future skin substitute products that are licensed as a drug or biological product under section 351 of the PHS Act could be rebatable. We are proposing to amend § 427.101 by revising paragraph (b)(5), which describes skin substitutes as an excluded product category for Part B rebatable drugs, to state a skin substitute is "[a] product included within the suite of cellular- and tissue-based products that aid wound healing, other than skin substitute products that are licensed as a drug or biological product under section 351 of the Public Health Service Act". If finalized, this proposal would not impact Rebate Reports for the fourth quarter of 2026 or earlier.

c. Identification of the Benchmark Period CPI-U and Rebate Period CPI-U (§ 427.302)

Section 1847A(i)(3)(C) of the Act provides that, for each Part B rebatable drug by billing and payment code, CMS will calculate the inflation-adjusted payment amount for each quarter using the benchmark period CPI-U and the rebate period CPI-U, among other inputs, as described at § 427.302(g). For each Part B rebatable drug, we identify the applicable benchmark period CPI-U as described at §§ 427.302(e)(1) and (2), and subject to paragraphs (e)(3) through (5). Specifically, under section 1847A(i)(3)(E) of the Act and as described at § 427.302(e)(1), for a Part B rebatable drug first approved or licensed by the FDA on or before December 1, 2020, and with a first marketed date on or before December 1, 2020, the benchmark period CPI-U is the CPI-U for January 2021. Additionally, under section 1847A(i)(4)(A) of the Act and as described at § 427.302(e)(2), for a Part B rebatable drug that is a subsequently approved drug, the benchmark period CPI-U is the CPI-U for the first month of the first full calendar quarter

after a drug's first marketed date. For the rebate period CPI-U, we will identify and use the greater of the benchmark period CPI-U index level or the CPI-U index level for the first month of the calendar quarter that is 2 calendar quarters before the applicable calendar quarter in which the Part B rebatable drug is furnished, under section 1847A(i)(3)(F) of the Act and as described at § 427.302(f).

As stated in the CY 2025 PFS final rule (89 FR 98247), we will retrieve CPI-U index level information from the Bureau of Labor Statistics (BLS). The BLS did not release CPI-U survey data for October 2025 due to a lapse in appropriations.[196] As a result of the October 2025 CPI-U data being unavailable, multiple interested parties, including drug companies and a pharmaceutical industry trade association, requested that we clarify in a timely manner how we would calculate inflation rebates that would otherwise use the October 2025 CPI-U data. To respond to these inquiries and to promote transparency with regard to the most immediate calculations for the Inflation Rebate Program, including particular Part B beneficiary coinsurance calculations for the second quarter of 2026, we released an Health Plan Management System (HPMS) memo on March 6, 2026,[197] affirming our intent to use November 2025 CPI-U data in place of the missing October 2025 CPI-U data for such calculations. As we explained in that memo, we used the November 2025 CPI-U data issued by the BLS in place of the missing October 2025 CPI-U data because November 2025 was the first month with available CPI-U data in the calendar quarter identified by statute and regulation.

We released this memo in accordance with section 1847A(c)(5)(C) of the Act, which permits CMS to implement, by program instruction or otherwise, any of the provisions of section 1847A of the Act. We also noted that, to complete such calculations, it would have been impracticable to engage in notice-and-comment rulemaking to affirm the policy stated in that

---

[196] BLS, *https://www.bls.gov/cpi/additional-resources/2025-federal-government-shutdown-impact-cpi.htm#:%7E:text=Yes.,in%20appropriations%E2%80%9D%20will%20be%20included*.

[197] CMS, Medicare Prescription Drug Inflation Rebate Program: Impact of Missing October 2025 CPI-U Data on Medicare Part B Inflation Rebate Program in Second Quarter of 2026, *https://www.cms.gov/files/document/cpi-u-gap-filling-memo-final-508.pdf*.

memo because the timing of this final rule would be after our deadline to publish the April 2026 Medicare Part B Payment Limit files, including Part B rebatable drugs subject to a coinsurance adjustment. We further noted that the absence of October 2025 CPI-U data also would be relevant to calculating Part B and Part D inflation rebate amounts that will be reported to manufacturers in 2027 and later and stated our intent to address the broader need for a gap-filling methodology as part of future rulemaking through the Physician Fee Schedule.

Currently, our regulations do not address explicitly how the agency should identify the CPI-U, for the purposes discussed previously in this section of the preamble, when the otherwise relevant CPI-U index level information is unavailable from BLS, as occurred with respect to the October 2025 CPI-U. Therefore, we are proposing to amend § 427.302 by adding paragraph (e)(6) to ensure that in the event CPI-U data are unavailable, we would use the CPI-U data for the first month for which CPI-U data are available following the month for which CPI-U data are unavailable. This proposal also aligns with the policy and the rationale we provided in the HPMS memo released on March 6, 2026, to address the instance of unavailable CPI-U data for October 2025. Consistent with the reasons we set forth in such memo, this proposed approach most closely aligns with statute because it would result in use of CPI-U data from a month no earlier than the quarter specified by the statute. For the same reasons, we also are proposing to amend § 427.302 by adding paragraph (f)(1) to state that when CPI-U data are unavailable, we would use the first month for which CPI-U data are available following the month for which CPI-U data are unavailable.

As an alternative to the proposal at § 427.302(f), we considered using the Treasury Department's index number according to the index contingency provisions for Treasury Inflation-Protected Securities, which is based on the last available 12-month change in the CPI.[198] This alternative approach does not align with statute, which directs us to use the CPI-U

[198] 31 CFR part 356, Appendix B. *https://www.ecfr.gov/current/title-31/subtitle-B/chapter-II/subchapter-A/part-356#ap31.2.356_135.b*.

value from the first month of the relevant period and makes no reference to an alternate calculated value. Specifically, section 1847A(i)(3)(F) of the Act defines the rebate period CPI-U as, with respect to the applicable calendar quarter, "the greater of the benchmark period CPI-U and the consumer price index for all urban consumers (United States city average) for *the first month of the calendar quarter that is two calendar quarters prior* to such described calendar quarter" (emphasis added). We also considered calculating our own inflation factor rather than using the BLS reported CPI-U data; however, it is impracticable for us to administer a CPI-U survey and calculate an alternate CPI-U index. Finally, we considered using the previous month for which CPI-U data are available but this approach is less consistent with statute, which as noted previously specifies that we use the CPI-U value from the calendar quarter that is 2 calendar quarters prior to the relevant quarter. We are not proposing these alternative options for the reasons described.

d. Clarification of Date of Receipt for Rebate Reports

As stated in the CY 2025 PFS final rule (89 FR 98264) which was effective on January 1, 2025 and appeared in the December 8, 2024 Federal Register, § 427.500 defines the date of receipt as the calendar day following the day on which a report of a rebate amount (as set forth in § 427.501(b) through (d) and § 427.502(b) and (c)) is made available to the manufacturer of a Part B rebatable drug by CMS. The "date of receipt" starts the clock for calculation of deadlines at multiple points in the rebate reporting process, including for manufacturer submission of a suggestion of error and for payment of rebate amounts owed. For example, as set forth in § 427.505(a), a rebate amount owed is due no later than "the 30th calendar day after the date of receipt of information regarding the rebate amount[.]"

For clarity and transparency, we are making technical corrections to the examples provided in the CY 2025 PFS final rule of the calculation of due dates based on the "date of receipt". In the CY 2025 PFS final rule (89 FR 98265), we provided examples of the "date of receipt", including: (1) "if the Preliminary Rebate Report is provided on May 31, 2026, then

June 1, 2026, will be the date of receipt and, therefore, day 1 of the 10-calendar-day period to submit a Suggestion of Error. In this example, Suggestions of Error would be due by 11:59 p.m. PT on June 10, 2026[]"; and (2) "if the Rebate Report is provided on June 30, 2026, then July 1, 2026, would be the date of receipt and therefore day 1 of the 30-calendar-day payment period; payment would be due no later than 11:59 p.m. PT on July 30, 2026." We are correcting these examples to be consistent with the definition of "date of receipt" in § 427.500. Specifically, in each example provided, the "date of receipt" should be day zero of the relevant calendar period, not day one. Therefore, if the Preliminary Rebate Report is provided on May 31, 2026, then June 1, 2026, will be the "date of receipt" and day zero of the 10-calendar-day period to submit a Suggestion of Error, such that Suggestions of Error would be due by 11:59 p.m. PT on June 11, 2026. Likewise, if a Rebate Report is provided on June 30, 2026, then July 1, 2026, will be the "date of receipt" and day zero of the 30-calendar-day payment period, such that payment would be due no later than 11:59 p.m. PT on July 31, 2026.

e. Enforcement of Manufacturer Payment of Rebate Amounts (§ 427.600)

In accordance with section 1847A(i)(1)(B) of the Act, the manufacturer of a Part B rebatable drug is required to provide a rebate equal to the rebate amount specified in section 1847A(i)(3) of the Act for the rebatable drug for the calendar quarter not later than 30 days after receipt of the rebate amount from CMS. Section 1847A(i)(7) of the Act gives us the authority to impose a civil money penalty (CMP) equal to at least 125 percent of the rebate amount for each drug for each applicable calendar quarter on a manufacturer that fails to pay the rebate amount for each rebatable Part B drug. Subpart G implements this section of the Act and establishes the procedures for determining and collecting a CMP.

We are clarifying here that the imposition of CMPs under section 1847A(i)(7) of the Act, in accordance with § 427.600, is not the exclusive remedy for a manufacturer's failure to comply with its rebate payment obligations described in § 427.505(a), nor the exclusive remedy for other conduct that may impact obligations, such as rebate amounts owed, under the Part B Inflation

Rebate Program. For example, whether imposing CMPs under section 1847A(i)(7) of the Act or not, when warranted, we may refer manufacturers to the Department of Justice, the Department of the Treasury, and/or the Department of Health and Human Services Office of Inspector General for further review and investigation.

3. Medicare Part D Drug Rebates for Certain Drugs and Biologicals with Prices that Increase Faster than the Rate of Inflation

a. Definitions (§ 428.20)

As stated in the CY 2025 final rule (89 FR 98276), we codified the definition of "applicable period CPI-U" at § 428.20 as "with respect to an applicable period, the CPI-U for the first month of such applicable period (that is, October)" based on the definition set forth in section 1860D-14B(g)(5) of the Act. The BLS did not release CPI-U survey data for October 2025 due to a lapse in appropriations.[199] As a result of the October 2025 CPI-U data being unavailable, multiple interested parties, including drug companies and a pharmaceutical industry trade association, requested that we clarify in a timely manner how we would calculate inflation rebates that would otherwise use the October 2025 CPI-U data. We acknowledge that the missing October CPI-U data impacts Preliminary Rebate Reports and Rebate Reports for the applicable period that runs from October 2025-September 2026. The current in-effect regulation at § 428.20 does not address our inability to retrieve CPI-U index level information from BLS. To provide clarity on how to gap fill the missing October CPI-U data, we propose to amend § 428.20 to include, "in the case where the first month's CPI-U data is unavailable, we will use the first month for which CPI-U data are available following the month for which CPI-U data are unavailable." As applied in the case of missing October 2025 CPI-U data, CMS would use November 2025 CPI-U data.

b. Identification of Benchmark Period CPI-U (§ 428.202(e))

---

[199] BLS, *https://www.bls.gov/cpi/additional-resources/2025-federal-government-shutdown-impact-cpi.htm#:%7E:text=Yes.,in%20appropriations%E2%80%9D%20will%20be%20included*.

Section 1860D-14B of the Act provides that for each Part D rebatable drug, CMS will identify the benchmark period CPI-U as described at § 428.202(e)(1) and (2) and subject to paragraphs (e)(3) through (5). Specifically, under section 1860D-14B(g)(4) and as discussed in § 428.202(e)(1), for a Part D rebatable drug first approved or licensed by the FDA on or before October 1, 2021, the benchmark period CPI-U is the CPI-U for January 2021. Additionally, under section 1860D-14B(b)(5)(C) of the Act and as described at § 428.202(e)(2), for a subsequently approved drug, the benchmark period CPI-U is the CPI-U for January of the first calendar year beginning after a drug's first marketed date as stated under section 1860D-14B(b)(5)(A) of the Act. Under section 1860D-14B(b)(5)(C) of the Act and as described at § 428.202(e)(5) when a Part D rebatable drug is no longer considered to be a selected drug, the benchmark period CPI-U is the CPI-U for January of the last calendar year of such price applicability period. Due to the BLS not releasing CPI-U survey data for October 2025, we recognized a need to adopt a gap filling methodology in the event that any future CPI-U data are not released. As a result of the October 2025 CPI-U data being unavailable, multiple interested parties, including drug companies and a pharmaceutical industry trade association, requested that we clarify in a timely manner how we would calculate inflation rebates that would otherwise use the October 2025 CPI-U data. To respond to these inquiries and to promote transparency, as well as to align with the HPMS memo released on March 6, 2026,[200] we propose to amend § 428.202 by adding paragraph (e)(6) to state, when CPI-U data are unavailable, CMS will use the first month for which CPI-U data are available following the month for which CPI-U data are unavailable. In using the first month of CPI-U data available, this proposed approach most closely aligns with section 1860D-14B(g)(5) of the Act.

As an alternative to the proposal at § 428.202(e)(6), we considered using the Treasury Department's index number according to the index contingency provisions for Treasury Inflation-Protected Securities, which is based on the last available 12-month change in the CPI-

[200] https://www.cms.gov/files/document/cpi-u-gap-filling-memo-final-508.pdf.

U. This alternative approach does not align with statute, which directs CMS to use the CPI-U value from the first month of the relevant period. We also considered calculating our own inflation factor rather than using the BLS reported CPI-U; however, it is impracticable for us to administer a CPI-U survey and calculate an alternate CPI-U index. Finally, we considered using the previous month with available CPI-U data, but this approach is less consistent with statute, which directs CMS to use the CPI-U value from the first month of the relevant period. The previous month's CPI-U data would not fall within the relevant period. We are not proposing these alternative options for the reasons described.

c. Exclusion of 340B Acquired Units from Part D Rebatable Drugs (§ 428.203(b)(2) and (c))

Section 1860D-14B(b)(1)(B) of the Act requires that beginning with the plan year 2026, when calculating the total rebate amount to be paid by a manufacturer for a Part D rebatable drug, CMS shall exclude from the total number of units for a Part D rebatable drug, for an applicable period, those units for which a manufacturer provides a discount under the 340B Program. In the CY 2025 PFS final rule (89 FR 98278 through 98279), we finalized the proposal at § 428.201(a) to codify the total rebate amount calculation methodology described in section 40 of the revised Medicare Part D Drug Inflation Rebate Guidance,[201] which provides that the total Part D drug inflation rebate amount is equal to the per unit Part D drug inflation rebate amount, as determined under § 428.202(a), multiplied by the total number of units of a Part D rebatable drug dispensed under Part D and covered by Part D plan sponsors, as determined in accordance with § 428.203. In the CY 2025 PFS final rule (89 FR 98593), we also finalized the proposal at § 428.203(b)(2)(i), to exclude from the total number of units determined under § 428.203(a), units for which a manufacturer provided a discount under the 340B Program ("340B units"). We also finalized the proposal at § 428.203(b)(2)(ii) to determine the total number of 340B units by using data reflecting the total number of units of a Part D rebatable drug for which a discount was

[201] See: *https://www.cms.gov/files/document/medicare-part-d-inflation-rebate-program-revised-guidance.pdf*.

provided under the 340B Program and that were dispensed during the applicable period. As we stated in the CY 2025 PFS final rule (89 FR 98289) and CY 2026 PFS final rule (90 FR 49740), because this exclusion requirement starts after the first quarter of the applicable period that begins on October 1, 2025, the exclusion of 340B units will only apply for the last 3 quarters of such applicable period. That is, we are excluding 340B units from the total number of units for a Part D rebatable drug starting with claims with dates of service on or after January 1, 2026.

As we stated in the CY 2025 PFS final rule (89 FR 98289) and the CY 2026 PFS final rule (90 FR 49740), data on which units dispensed under Part D and covered by Part D plan sponsors were purchased under the 340B Program is unavailable from the data sources specified at section 1860D-14B(d) of the Act (that is, information submitted by manufacturers, States, and Part D plan sponsors), and we do not currently have access to this data through other means. We understand that the 340B status of a Part D drug is usually not known by the dispenser at the point-of-sale, and that 340B covered entities (hereinafter "covered entities") typically identify the 340B status of a Part D drug retrospectively. Because the covered entity and CMS do not exchange dispensed Part D drug information confirming the 340B status of a Part D rebatable drug, we are unable to precisely identify 340B units at the claim-level based solely on Part D claims submitted to us by the covered entity (or a contract pharmacy operating on behalf of the covered entity) at this time. For these reasons, in the CY 2026 PFS final rule (90 FR 49747), we adopted a claims-based methodology (described in the CY 2026 PFS final rule and hereinafter as "Prescriber-Pharmacy Methodology") that we leverage to exclude 340B units from the total number of units of a Part D rebatable drug dispensed under Part D and covered by Part D plan sponsors during an applicable period, starting on January 1, 2026. Additionally, we adopted our proposal to establish a voluntary Medicare Part D Claims Data 340B Repository ("340B repository") to collect data about 340B units voluntarily submitted by covered entities (90 FR 49750). The data submitted to the 340B repository will not be used to calculate inflation rebates unless and until we propose and finalize a policy to use such data to exclude 340B units from

rebate calculations.

(1) Claims-Based Methodology to Remove 340B Units from Rebate Calculations

As finalized in the CY 2026 PFS final rule (90 FR 49741 through 49749), to implement the exclusion required by section 1860D-14B(b)(1)(B) of the Act and described in § 428.203(b)(2), under the Prescriber-Pharmacy Methodology, beginning on January 1, 2026, we remove 340B units from the Part D inflation rebate calculations by evaluating whether a Prescription Drug Event (PDE) record is potentially 340B-eligible based on (1) the affiliation of the National Provider Identifier (NPI) of the prescriber associated with that PDE record with a registered covered entity, and (2) the designation of the dispensing pharmacy associated with that PDE record as a 340B contract pharmacy. If the NPI of the prescriber associated with the PDE record is affiliated with a registered covered entity for a given month, and the dispensing pharmacy is a contract pharmacy associated with such covered entity for the same month, the PDE record is considered as potentially 340B-eligible, and the units associated with that PDE record are removed from Part D inflation rebate calculations. We refer readers to the CY 2026 PFS final rule for a more detailed explanation of the Prescriber-Pharmacy Methodology (90 FR 49741 through 49749).

In the CY 2026 PFS proposed rule (90 FR 32639 through 32641), we acknowledged that the 340B Office of Pharmacy Affairs Information System (OPAIS) database, which the Prescriber-Pharmacy Methodology relies on, may not list all pharmacies that dispense 340B-eligible drugs, including covered entities that have "in-house" pharmacies that are not registered in the 340B OPAIS database or 340B-eligible AIDS Drug Assistance Programs (ADAPs)[202] (also considered covered entities) that collect rebates to receive 340B discounts instead of receiving such discount at the time of purchase from a contract pharmacy registered in the 340B

[202] ADAPs are State- and territory-operated Ryan White HIV/AIDS Program grantees that provide FDA-approved medications (including, in some States, medications beyond those used to treat HIV/AIDS) to low-income people living with HIV/AIDS. Under section 340B(a)(4)(E) of the PHS Act, ADAPs are eligible to be enrolled with the 340B Program as covered entities, and HRSA has affirmed that any individual registered in an ADAP covered entity will be considered to meet the 340B patient definition. See: *https://www.hrsa.gov/sites/default/files/hrsa/opa/patient-entity-eligibility-10-24-96.pdf*.

OPAIS database. We solicited comments on whether and how to account for this limitation. Similar to the acknowledgments we made in the proposed rule, we received comments stating that the Prescriber-Pharmacy Methodology may underrepresent 340B claims from Ryan White (RW) clinics and ADAPs. To address this, some commenters recommended that we use an alternative methodology to identify these claims. In the CY 2026 PFS final rule (90 FR 49747), we adopted modifications to the Prescriber-Pharmacy Methodology aimed at improving our ability to identify 340B claims associated with RW clinics, but we did not adopt modifications to the Prescriber-Pharmacy Methodology to address the limitations relating to ADAP claims. Our prior preliminary analyses suggested not modifying the Prescriber-Pharmacy Methodology to address the limitations relating to ADAP claims would have minimal impact. Specifically, the percentage of 340B units identified for drugs commonly covered by ADAPs, such as antiretrovirals, was comparable to the average percentage of 340B units identified overall across all drug classes, indicating no meaningful differential. In the CY 2026 PFS final rule (90 FR 49747), we stated that we may consider methodological refinements in the future to further address commenters' feedback on ADAPs.

Since publishing the CY 2026 PFS final rule, we have reviewed additional evidence relating to the need to adjust the Prescriber-Pharmacy Methodology to sufficiently identify units of drugs for which a manufacturer provided a discount under the 340B Program to account for ADAP enrollees. Consequently, we have become aware of evidence suggesting that, in contrast to our statement in the CY 2026 PFS final rule, the percentage of 340B units identified for drugs commonly covered by ADAPs, such as antiretrovirals, may be higher than the average percentage of 340B units identified overall. One study found that, using 2012 data from Walgreens, (1) antivirals were 10 times more likely to be dispensed through the 340B Program and specialty medications[203] were more than 20 times more likely to be dispensed through the

[203] The authors of the study defined "specialty drugs" as those "generally considered to be high value; high-touch—for example, medications that require temperature control or other special handling, and medications that require

340B Program compared to all drugs dispensed; and, (2) nearly 80 percent of all specialty medications dispensed under the 340B Program were antiretrovirals indicated for HIV/AIDS.[204] This study hypothesized that these results can be at least partially explained by the types of covered entities participating in contract pharmacy arrangements with Walgreens in 2012, that is, covered entities that disproportionately treat people with HIV/AIDs. Additionally, a Congressional Budget Office (CBO) study published September 2025 found that the majority of spending on anti-infective drugs (including HIV/AIDS treatments) purchased through the 340B Program in 2021 occurred at Federal grantee sites, including ADAPs.[205] In addition to other evidence reviewed, these data points suggest that Federal grantee sites, including ADAPs, may significantly contribute to the percentage of 340B claims for antiretrovirals, that this percentage may be higher than for other drug classes, and that without methodological refinement to fully account for 340B claims dispensed to ADAP enrollees, the Prescriber-Pharmacy Methodology may under-identify 340B units for drug classes such as antiretrovirals to a greater extent than previously assumed during the CY 2026 rulemaking cycle. Based on this review, we have determined it is appropriate, in this proposed rule, to reevaluate whether methodological refinements need to be made to the Prescriber-Pharmacy Methodology. We do not believe that adoption of the Prescriber-Pharmacy Methodology as described in the CY 2026 PFS final rule established significant reliance interests that would prevent us from modifying the Prescriber-Pharmacy Methodology. Given that Rebate Reports impacted by the Prescriber-Pharmacy Methodology (that is, Rebate Reports for applicable periods beginning October 1, 2025) have not yet been issued, CMS believes that any reliance interests that may relate to use of the Prescriber-Pharmacy Methodology would not be outweighed by the need to implement a more accurate methodology. Additionally, as we stated earlier, we provided notice to interested parties in the

---

ongoing management by a physician or pharmacists specialized in the relevant condition; or complex—for example, biotechnology products or orphan drugs; or some combination of the above."

[204] Clark BL, Hou J, Chou CH, Huang ES, Conti R. The 340B discount program: outpatient prescription dispensing patterns through contract pharmacies in 2012. Health Aff (Millwood). 2014 Nov;33(11):2012-7. doi: 10.1377/hlthaff.2014.0833. PMID: 25367997; PMCID: PMC4545491.

[205] CBO, Growth in the 340B Drug Pricing Program, September 9, 2025. *https://www.cbo.gov/publication/60661*.

CY 2026 PFS final rule (90 FR 49747) that we may consider methodological refinements in the future to further address commenters' feedback relating to ADAPs.

As part of this reevaluation, we revisited comments we received on the CY 2026 PFS proposed rule. In particular, we revisited comments that explained the unique nature of ADAPs compared to other covered entity types, and the limitations in the Prescriber-Pharmacy Methodology's ability to identify PDE records for ADAP enrollees as 340B-eligible. As one commenter explained, the Prescriber-Pharmacy Methodology may under-identify 340B-eligible PDE records for ADAP enrollees for two reasons. First, PDE records for ADAP enrollees would typically not meet the first criterion of the Prescriber-Pharmacy Methodology (that is, that the prescriber with the NPI listed on the PDE record provides care at a covered entity). ADAPs are not providers, and a patient enrolled in an ADAP is typically prescribed medications by a provider not affiliated with the ADAP. Therefore, for a PDE record for an ADAP enrollee, the prescriber NPI on the PDE record will not be affiliated with the covered entity that claimed the 340B price for such dispense (that is, the ADAP). Second, the majority of ADAPs access 340B pricing via a rebate model.[206] These ADAPs allow their enrollees to fill medications at a broad network of pharmacies that may not be registered in the OPAIS database as contract pharmacies. A PDE record for an ADAP enrollee will thus not meet the second criterion of the Prescriber-Pharmacy Methodology (that is, that the pharmacy NPI on the PDE record is a contract pharmacy for the same covered entity that the prescriber NPI is affiliated with).

After further review of the additional evidence as discussed above and revisiting comments we received on the CY 2026 PFS proposed rule, we conducted a more comprehensive analysis to assess whether the existing Prescriber-Pharmacy Methodology adequately identifies 340B-eligible drugs obtained through ADAPs for Medicare Part D enrollees. The analysis was conducted in two parts. The first reexamined the preliminary analyses described in the CY 2026

---

[206] "Notice Regarding Section 602 of the Veterans Health Care Act of 1992 — Rebate Option." 63 FR 35239. See: *https://www.govinfo.gov/content/pkg/FR-1998-06-29/pdf/98-17142.pdf*.

PFS final rule (90 FR 49747) assessing whether the Prescriber-Pharmacy Methodology systematically under-identifies drugs used in the treatment of HIV/AIDS as 340B-eligible relative to all other drugs, and it built upon this analysis by examining whether the Prescriber-Pharmacy Methodology under-identifies drugs used in the treatment of HIV/AIDS as 340B-eligible for ADAP enrollees specifically. We identified ADAP enrollees using the Coordination of Benefits (COB)-Other Health Insurance (OHI) file—specifically the COB-OHI Supplemental Record file—using a Supplemental Type Code that flags enrollees that have supplemental ADAP coverage.[207] This analysis reaffirmed our preliminary findings that the Prescriber-Pharmacy Methodology identifies drugs used in the treatment of HIV/AIDS at a percentage close to the overall Part D average for all drug classes. However, when the analysis was isolated to ADAP enrollees only, we found that the Prescriber-Pharmacy Methodology identified drugs used in the treatment of HIV/AIDS as 340B-eligible at a significantly lower percentage than was identified for Part D beneficiaries overall. This finding is contrary to expectations given that ADAPs are eligible to be enrolled with the 340B Program as covered entities, and that HRSA has affirmed that any individual registered in an ADAP will be considered to meet the 340B patient definition (as described earlier in this section). Further, this under-identification of 340B units for ADAP enrollees could impact the completeness and accuracy of data used for Part D inflation rebate calculations for certain drug classes such as antiretrovirals, if not sufficiently addressed.

The second part of the analysis examined how a modification to the Prescriber-Pharmacy Methodology would identify drugs used in the treatment of HIV/AIDS as 340B-eligible compared to the existing Prescriber-Pharmacy Methodology. We analyzed the impact on the overall percentage of identified Part D 340B units for both antiretrovirals and all other drug classes if CMS were to consider all Part D units for ADAP enrollees as 340B-eligible. This

---

[207] As explained in the Plan Communication User Guide for Medicare Advantage Prescription Drug Plans (February 27, 2026), the Supplemental Record file lists other health insurance that is supplemental to, that is, pays after, Part D. The Supplemental Type Code indicates the type of supplemental insurance contained in the record. *https://www.cms.gov/files/document/mapd-plan-communications-user-guide-v19-0-march-2026.pdf*.

analysis of the modification to the Prescriber-Pharmacy Methodology to treat all ADAP units as 340B-eligible determined that: (1) for certain drug classes, specifically antiretroviral medications used in the treatment of HIV/AIDS, a modification to account for ADAP enrollees would result in a meaningful increase in the number of rebatable units identified as 340B-eligible, and (2) for all other drug classes, the modification would not have a substantial impact on the percentage of Part D units identified as 340B-eligible. Based on the additional evidence reviewed and subsequent analyses demonstrating the extent to which relevant PDE records for ADAP enrollees would be under-identified as 340B-eligible, we now concur with comments on the CY 2026 PFS proposed rule that we revisited. We agree with the commenters' assertion that a modification to the Prescriber-Pharmacy Methodology is needed to fully account for 340B-eligible units for ADAP enrollees. Where the ADAP acts as a payor of the Part D medication, we would consider all Part D units for ADAP enrollees as 340B-eligible. Such units would be removed from the total number of units and total rebate amount for a Part D rebatable drug as described in the Preliminary Rebate Report and Rebate Report detailed at § 428.401(b) and (c), respectively.

Specifically, we are proposing the following modification to the Prescriber-Pharmacy Methodology: CMS would identify PDE records for beneficiaries who have ADAP supplemental coverage as listed in the COB-OHI Supplemental Record file using the Supplemental Type Code that flags enrollees that have supplemental ADAP coverage. CMS would then exclude all units associated with those PDE records from Part D inflation rebate calculations.

If a beneficiary included in the COB-OHI Supplemental Record file is identified as having supplemental insurance from an ADAP at the time a Part D drug was dispensed to such beneficiary during the applicable period, we would designate the units as 340B-eligible and remove the associated units from the inflation rebate calculation. Because State ADAP formularies can vary, and because we will not have State-specific insight regarding an ADAP's

formulary coverage for a specific beneficiary's claims dispensed in a specific State, we would treat all PDE records dispensed for a beneficiary identified as having ADAP supplemental insurance on the COB-OHI file as 340B-eligible and remove the units associated with these PDE records. Since some of the ADAP enrollees identified in the proposed modification to the Prescriber-Pharmacy Methodology may already have Part D units identified as 340B-eligible using the existing Prescriber-Pharmacy Methodology, counting all ADAP enrollees' units identified under the proposed modification as 340B-eligible could potentially double-count 340B-eligible units. To avoid double-counting, we would identify units that were already flagged as 340B-eligible using the existing Prescriber-Pharmacy Methodology and exclude those from the count of ADAP 340B-eligible units identified under the proposed modification.

CMS acknowledges that this approach may result in an overestimation of 340B-eligible units for ADAP enrollees. Notwithstanding this limitation, CMS has determined that treating all Part D drugs dispensed to ADAP enrollees as 340B-eligible is appropriate for the following reasons: (1) the manner in which 340B discounts are realized for 340B-eligible ADAP units varies among State ADAP programs, and (2) variability in drug coverage across State-specific drug formularies presents significant challenges in developing a single, uniformly applicable methodology capable of accurately identifying 340B eligibility on a drug-by-drug or program-by-program basis. Further, in CMS' analysis of the proposed modification to the Prescriber-Pharmacy Methodology, and the corresponding treatment of all ADAP enrollee units as 340B-eligible, CMS determined that: (1) for certain drug classes, specifically antiretroviral medications used in the treatment of HIV/AIDS, the proposed modification would result in a meaningful increase in the percentage of Part D rebatable units identified as 340B-eligible, and (2) for all other drug classes, the proposed modification would not have a substantial impact on the percentage of units identified as 340B-eligible if all ADAP enrollee units were treated as 340B-eligible. In other words, CMS' analysis indicates, for the majority of drug classes with exception of antiretroviral medications used in the treatment of HIV/AIDS, treating all ADAP

enrollee units as 340B eligible is expected to have minimal or no impact on the identification of 340B-eligible units from the Prescriber-Pharmacy Methodology. These findings demonstrate that the modification to the Prescriber-Pharmacy Methodology is narrowly and appropriately targeted towards antiretroviral medications used in the treatment of HIV/AIDS, which aligns with the evidence described earlier in this section suggesting that the percentage of 340B units identified for antiretrovirals may be higher than the average percentage of 340B units identified overall. In light of these considerations, CMS has determined that a broad, programmatic approach to identifying 340B-eligible ADAP units is preferable to a more granular methodology that may yield inconsistent or inaccurate results. If adopted, the modification to the Prescriber-Pharmacy Methodology proposed herein would be effective for Rebate Reports issued for the applicable period that begins October 1, 2025, and subsequent applicable periods.

We solicit comments on this proposal.

(2) Medicare Part D Claims Data 340B Repository

In the Medicare Part D Drug Inflation Rebates Paid by Manufacturers: Initial Memorandum, Implementation of Section 1860D-14B of Social Security Act, and Solicitation of Comment ("initial Medicare Part D Drug Inflation Rebate Guidance"),[208] CMS solicited comments on the best mechanism to identify 340B units dispensed under Part D to exclude units from Part D inflation rebate calculations. Interested parties recommended that CMS create a mechanism through which covered entities would retrospectively submit data to CMS identifying 340B-purchased drugs dispensed under Part D and urged that this mechanism allow covered entities to submit these data directly to CMS, rather than through claims that dispensers submit via Part D plan sponsors. In response to these recommendations, we solicited comments in the CY 2025 PFS proposed rule (89 FR 61971 through 61972) on a 340B repository. As highlighted in the CY 2025 final rule (89 FR 98292), many commenters expressed strong support for a 340B repository. In the CY 2026 PFS proposed rule (90 FR 32641 through 32644),

[208] See: *https://www.cms.gov/files/document/medicare-part-d-inflation-rebate-program-initial-guidance.pdf*.

we proposed to establish a 340B repository, and as described in the CY 2026 PFS final rule (90 FR 49749), many commenters supported this proposal to establish a 340B repository.

In the CY 2026 PFS final rule (90 FR 49750), we established a 340B repository to receive voluntary submissions from covered entities of certain data elements associated with Part D claims for which the covered entity dispensed (directly or indirectly, including via retrospective replenishment and contract pharmacy arrangements) units of a drug for which a manufacturer provides a discount under the 340B Program ("Part D 340B claims"). We established the 340B repository to allow for assessment of such data for potential use in identifying units of Part D rebatable drugs for which a manufacturer provided a discount under the 340B Program in a future applicable period. We established that covered entities will be allowed to submit data on units of Part D 340B claims beginning in 2026 to begin testing the usability of the 340B repository. We are currently working to operationalize the 340B repository to allow covered entities to begin submitting data on 340B units of Part D rebatable drugs and expect the 340B repository to launch in Fall 2026. Once the 340B repository launches in Fall 2026, we will begin testing the usability of data voluntarily submitted by covered entities, starting with claims with dates of service in 2026. Covered entities that voluntarily submit data to the 340B repository need to follow the processes and requirements that CMS has established for voluntary reporting starting in 2026 and the associated information collection currently approved under OMB control number 0938-1485.

In the CY 2026 PFS final rule (90 FR 49750), we strongly encouraged all covered entities to submit data elements to the 340B repository during the 2026 testing period, noting that this participation would allow for robust testing of data quality and completeness and provide an opportunity for covered entities to develop and test their data submission processes. We also noted that we would address the possibility of requiring covered entities to report data elements to the 340B repository in future years in future rulemaking and that we were actively considering proposing mandatory reporting to the 340B repository in the near future.

We are now proposing at § 428.203(c) to require providers and suppliers that are covered entities as defined under § 10.3 (hereinafter collectively "340B providers" unless otherwise noted) to submit Part D 340B data to the 340B repository beginning in 2027. Such reporting would fulfill a 340B provider's obligation to provide access to documentation relating to covered Part D drugs written or ordered by such 340B provider to maintain enrollment in Medicare, as we are proposing at § 424.516(f)(4). We describe these proposals in further detail in sections III.F.3.c.2.a. through III.F.3.c.2.c. of this proposed rule.

(a) Background: Requirement for Physicians, Other Suppliers, and Providers to Maintain and Provide Access to Documentation

Section 1866(j)(1)(A) of the Act requires the Secretary to establish a process for the enrollment of providers and suppliers into the Medicare program. The overarching purpose of the enrollment process is to help confirm that providers seeking to bill Medicare for services and items furnished to Medicare beneficiaries meet all applicable Federal and State requirements to do so. The process is, to an extent, a "gatekeeper" that prevents unqualified and potentially fraudulent individuals and entities from entering and inappropriately billing Medicare. Since 2006, we have undertaken rulemaking efforts to implement enrollment procedures. These regulations are generally codified in 42 CFR part 424, subpart P. They address, among other things, requirements that providers must meet to obtain and maintain Medicare billing privileges.

Section 6406(a) of the Patient Protection and Affordable Care Act (ACA) amended section 1842(h) of the Act by adding a new paragraph which establishes that the Secretary may revoke enrollment, for a period of not more than one year for each act, for a physician or supplier if such physician or supplier fails to maintain and, upon request of the Secretary, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by such physician or supplier under Title XVIII of the Act, as specified by the Secretary.

In addition, section 6406(b)(3) of the ACA amended section 1866(a)(1) of the Act to require that providers maintain and, upon request of the Secretary, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by the provider, as specified by the Secretary.

To implement section 6406 of the ACA, on May 5, 2010, CMS published an interim final rule titled "Medicare and Medicaid Programs; Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements; and Changes in Provider Agreements," (75 FR 24437) which amended § 424.516(f) to specify requirements for, among other things, documentation and access to documentation related to certain orders and referrals. We clarified in that rulemaking that the documentation includes both written and electronic documentation. CMS also amended § 424.535(a)(10) to establish that CMS may revoke enrollment, for a period of not more than one year for each act of noncompliance, for a provider or a supplier if such provider or supplier fails to meet the requirements of § 424.516(f). CMS finalized the interim final rule in an April 27, 2012 final rule titled "Medicare and Medicaid Programs; Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements; and Changes in Provider Agreements" (77 FR 25284).

(b) Proposal to Require Providers and Suppliers that Are Covered Entities to Submit Documentation Relating to Part D *340B* Claims (§§ 424.516(f)(4), 424.535(a)(1), and 428.203(c))

To inform policy development for this rulemaking, we reviewed and considered the comments received on the CY 2026 PFS proposed rule. In this feedback, many commenters suggested that we require covered entities and/or their contractors to report data to a 340B repository. We agree. To ensure robust data submissions in 2027 to determine if data submitted to the 340B repository could be used reliably in the future to remove 340B units from Part D inflation rebate calculations in accordance with section 1860D-14B(b)(1)(B) of the Act, we

believe it necessary to transition from voluntary submission to requiring 340B provider participation in the 340B repository.

We are therefore proposing at § 424.516(f)(4) that a provider or supplier that is a covered entity as defined at § 10.3 would be required to maintain and provide access to documentation as set forth at proposed § 428.203(c). We are proposing this requirement in accordance with sections 1866(a)(1)(X) and 1842(h)(9) of the Act. We note that we are proposing to designate our proposal at § 424.516(f)(4) rather than § 424.516(f)(3) because we are reserving § 424.516(f)(3) for use in separate CMS rulemaking. If this proposal is finalized, CMS would reserve the right to revoke, in accordance with existing § 424.535(a)(10), a currently enrolled provider or supplier's Medicare enrollment and any corresponding provider agreement or supplier agreement for failure to comply with the requirements for maintaining and providing access to documentation specified in proposed § 424.516(f)(4). Although we acknowledge that § 424.516(f) has historically set forth documentation requirements for providers and suppliers with respect to their Part A and Part B services, the statutory authorities underlying that provision, sections 1842(h)(9) and 1866(a)(1)(X) of the Act, do not expressly limit documentation requirements to services furnished under Part A and Part B. Sections 1842(h)(9) and 1866(a)(1)(X) of the Act collectively set forth that providers and suppliers must maintain and provide access to documentation relating to "items or services written or ordered by the provider *under this title*, as specified by the Secretary" (emphasis added). Both sections 1842(h)(9) and 1866(a)(1)(X) of the Act fall under Title XVIII (that is, the Medicare statute), which inherently includes Part D. As such, requiring providers and suppliers to maintain and provide access to documentation related to covered Part D drugs written or ordered by a provider or supplier is consistent with sections 1866(a)(1)(X) and 1842(h)(9) of the Act. By transitioning from voluntary submission to mandatory participation in the 340B repository, CMS would be able to ensure more complete and reliable data submissions, thereby improving its ability to accurately assess potential future use of the 340B repository to exclude 340B units from Part D rebate

calculations, consistent with its obligations under section 1860D-14B(b)(1)(B) of the Act.

At § 428.203(c), we propose the documentation to which a 340B provider must provide access, as well as the timeframe within which such access must be provided, for the provider or supplier to fulfill their obligations set forth in the proposed § 424.516(f)(4). Proposed § 428.203(c)(1) would require that, beginning with claims with a date of service on or after January 1, 2027, a provider or supplier that is a covered entity as defined at § 10.3 must submit the data elements associated with each claim for a covered Part D drug billed to Medicare Part D for which such covered entity or its contractor(s) (such as contract pharmacies) dispensed units of a drug for which a manufacturer provides a discount under the 340B Program to such covered entity. This requirement would apply, for example, to claims for units of a drug covered under Part D and dispensed by contract pharmacies that the covered entity, its contractors, or its third-party administrators identify as 340B-eligible and for which the covered entity obtains a 340B discount, including through retrospective replenishment models. This requirement would also apply, for example, to claims for units of a drug covered under Part D and dispensed by the covered entity's in-house pharmacy.

Specifically, we are proposing to require that a provider or supplier that is a covered entity as defined at § 10.3 must submit the following data elements associated with each claim for units of a covered Part D drug billed to Medicare by such covered entity or its contractor(s) (such as contract pharmacies) for which a manufacturer provides a discount under the 340B Program to such covered entity: (1) Date of Service (that is, the date the prescription was filled by the pharmacy); (2) Prescription or Service Reference Number; (3) Fill Number (that is, the code indicating whether the prescription is an original or a refill; if a refill, the code indicates the refill number); (4) Dispensing Pharmacy NPI; and (5) NDC-11. Additionally, we are proposing at § 428.203(c)(2) that, in addition to submitting the data elements set forth in proposed § 428.203(c)(1), a provider or supplier that is a covered entity as defined at § 10.3 must submit its 340B ID and name as designated in the 340B OPAIS database.

We understand that reporting the data proposed at § 428.203(c) may impose new operational demands on 340B providers, potentially requiring the development of reporting processes where none currently exist and that 340B providers will need time to develop a process for collecting the 340B data elements to submit to the 340B repository and prepare the data in a form and manner prescribed by CMS. Additionally, given the variety in the scope of provider types and organizations that participate in the 340B Program, we recognize the amount of preparation time to submit data varies. We propose at § 428.203(c)(3) to require that 340B providers report data on a quarterly basis (though they may choose to submit more frequently) within 1 calendar quarter following the close of the relevant calendar quarter. For example, for claims with dates of service between October 1, 2027, through December 31, 2027, 340B providers would submit the data elements from Part D 340B claims to the 340B repository no later than March 31, 2028. Quarterly submissions are necessary so CMS has timely information to assess the reliability of the data for potential future use in removing 340B units from Part D inflation rebate calculations. In addition, quarterly submissions may minimize the burden on 340B providers by reducing the amount of data in each submission and the amount of quality assurance necessitated for each submission. We solicit comments on this proposal.

Specifically, at § 428.203(c)(3), we are proposing that the data elements and information set forth in § 428.203(c)(1) and (c)(2) must be submitted on a quarterly basis and in a form and manner specified by us in accordance with the following timelines: data elements and information associated with claims with dates of service during the first calendar quarter must be submitted by the close of the second calendar quarter; data elements and information associated with claims with dates of service during the second calendar quarter must be submitted by the close of the third calendar quarter; data elements and information associated with claims with dates of service during the third calendar quarter must be submitted by the close of the fourth calendar quarter; and data elements and information associated with claims with dates of service during the fourth calendar quarter must be submitted by the close of the first calendar quarter of

the immediately following calendar year.

These are the same data elements, information, and timing requirements that are specified in the CY 2026 PFS final rule (90 FR 49750) establishing the 340B repository with voluntary submission.

We note that we are issuing a revised collection of information (0938-1485) titled "Information Collection Request (ICR) for the Medicare Prescription Drug Inflation Rebate Program under sections 11101 and 11102 of the Inflation Reduction Act (IRA)" (CMS-10930, OMB 0938-1485) alongside this proposed rule to reflect the burden associated with a mandatory submission to the 340B repository. We are working to operationalize the 340B repository in a way that minimizes burden on 340B providers and have engaged with a range of interested parties to consider the technical requirements that would facilitate lower burden for submission to the 340B repository. See section V.B.2. of this proposed rule for an updated estimate of burden associated with the collection of data for the 340B repository. The ICR contains more details regarding how covered entities would submit data to the 340B repository.

Under this current proposal, the data submitted to the 340B repository would not be used to calculate inflation rebates. We will continue to use the Prescriber-Pharmacy Methodology to remove 340B units from Part D inflation rebate calculations. Any future proposal to use the data reported to the 340B repository to remove 340B units from Part D inflation rebate calculations would undergo notice-and-comment rulemaking. We intend to analyze the data submitted to the 340B repository under this proposal to determine if they could be used reliably in the future to remove 340B units from Part D inflation rebate calculations in accordance with section 1860D-14B(b)(1)(B) of the Act. We would match the stored data elements in the 340B repository to PDE transactions for each Part D rebatable drug dispensed during the applicable period and would evaluate 340B repository data for: (1) data integrity, and (2) submission frequency and completeness across covered entity types and geographies, including through comparison to claims identified under the claims-based methodology adopted in the CY 2026 PFS final rule to

exclude 340B units starting on January 1, 2026, from Part D inflation rebates. Note, we understand the importance of maintaining the confidentiality of data submitted to the 340B repository, and this data would not be made available to external parties, including manufacturers and Part D plan sponsors.

We solicit comments on the proposal at § 424.516(f)(4) that a provider or supplier that is a covered entity as defined at § 10.3 would be required to submit to CMS the documentation set forth at proposed § 428.203(c)(1) and (2) relating to covered Part D drugs written or ordered by such provider or supplier and comply with the submission requirements set forth at § 428.203(c)(3) and (4). We also solicit comments on the documentation and timing requirements proposed at § 428.203(c) to which a provider or supplier that is a covered entity would be required to adhere to fulfill their obligation at proposed § 424.516(f)(4). We also solicit comments on the scope of Part D 340B claims for which a provider or supplier that is a covered entity as defined at § 10.3 must submit data elements under the proposed regulation text.

(c) Submitting Part D 340B Claims Data to the 340B Repository (§ 428.203(c))

We expect that the 340B repository will be operational by Fall 2026 for voluntary submissions from covered entities, as we adopted in the CY 2026 PFS final rule (90 FR 49748). As we stated earlier in this section, we are now proposing to require all 340B providers to submit certain data elements associated with Part D 340B claims beginning in 2027. We strongly encourage 340B providers to begin submitting data to the 340B repository voluntarily in 2026 to test operational processes, as we are proposing here to adopt the requirement that 340B providers submit data elements from their Part D 340B claims starting in 2027. The rest of this section proposes the form and manner by which, starting in 2027, pursuant to the proposed § 428.203(c), 340B providers would submit data to the 340B repository.

As stated in section III.F.3.c.b., under the 340B mandatory reporting proposal, the data elements and information set forth in paragraphs (c)(1) and (2) of § 428.203 would be submitted on a quarterly basis. We propose here that we would rely upon the completeness and accuracy of

the data submitted by 340B providers to the 340B repository, consistent with the 340B provider requirement to certify the accuracy of such submissions described below, to consider all data elements received by the 340B repository to be associated with Part D 340B claims. That is, CMS would rely on the accuracy and completeness of the submitted, certified data to the 340B repository to verify the 340B status of a claim.

We solicit comments on this proposal.

We also propose, as part of every submission, to require 340B providers (or an individual or contractor with the delegated authority as an authorized representative of the 340B provider to perform the certification) to certify that the data elements from all claims submitted to the 340B repository are from verified 340B claims and, to the best of the 340B provider's knowledge, its submissions include all Part D 340B claims for the 340B provider at the time of submission for the relevant period. 340B providers or their authorized representative would be required to certify the completeness and accuracy of the data submitted and to certify that the submitter is authorized to submit on behalf of the 340B provider.

We solicit comments on this proposal.

In the CY 2026 PFS final rule (90 FR 49750), describing the proposal for voluntary data submission, we noted that we understand covered entities typically contract with vendors, such as 340B third-party administrators (TPAs), to determine 340B-eligibility of claims using data submitted by covered entities and their contract pharmacies. We continue to acknowledge these contracts and, therefore, we propose that 340B providers could arrange for TPAs or other vendors to submit the required data elements to the 340B repository on their behalf. 340B providers would ultimately be responsible for the accuracy of the data submitted to the 340B repository, even if a 340B provider has an arrangement with a vendor to submit on its behalf.

We solicit comments on this proposal.

In section III.F.3.c.b., we proposed to require that 340B providers report data on a quarterly basis. Here, we separately propose that 340B providers would have additional time to

submit data to reflect a revision to the 340B determination of claims with dates of service throughout an applicable period. A revision could come in one of two forms: (1) resubmission of data for a claim that the 340B provider previously submitted to the 340B repository in error or with errors in the requested data fields, or (2) new submission of data for a claim for a drug that the 340B provider had previously determined was not purchased under the 340B Program, but later identified was purchased under such program. In instances where the 340B provider submits Part D 340B claims data to the repository that is either (1) incomplete or (2) contains invalid data, we may inform the 340B provider of such error and request that the 340B provider resolve and resubmit the Part D 340B claims data in order to process the submission successfully. As noted in the CY 2026 PFS final rule (90 FR 49754), we will provide details on the process and timing for covered entities to submit revised data to the 340B repository after the end of the reporting period in the future, and we anticipate that this same timing would apply in 2027 when 340B providers would be required to submit Part D 340B data to the 340B repository. Specifically, at § 428.203(c)(4), we are proposing that data elements and information submitted in accordance with paragraph (c)(3) of such section that is either incomplete or contains invalid data must be resubmitted at a later time in a form and manner specified by CMS.

We solicit comments on this proposal.

d. Clarification of Date of Receipt for Rebate Reports

As stated in the CY 2025 PFS final rule (89 FR 98305) which was effective on January 1, 2025 and appeared in the December 8, 2024 Federal Register, § 428.400 defines the date of receipt as the calendar day following the day in which a report of a rebate amount (as set forth in § 428.401(b), (c), and (d) and § 428.402(b) and (c)) is made available to the manufacturer of a Part D rebatable drug by CMS. The date of receipt starts the clock for calculation of deadlines at multiple points in the rebate reporting process, including for manufacturer submission of a suggestion of error and for payment of rebate amounts owed. For example, as set forth in § 428.405(a)(1), a rebate amount owed is due no later than "the 30th calendar day after the date

of receipt of information regarding the rebate amount."

For clarity and transparency, we are making technical corrections to the examples provided in CY 2025 PFS final rule of the calculation of due dates based on the "date of receipt". In the CY 2025 PFS final rule (89 FR 98306), we provided examples of the "date of receipt", including: (1) "if the Preliminary Rebate Report is provided on May 31, 2026, then June 1, 2026, will be the date of receipt and, therefore, day one of the 10-calendar-day period to submit a Suggestion of Error; the Suggestion of Error would be due by 11:59 p.m. PT on June 10, 2026[]"; and (2) "if the Rebate Report is provided on June 30, 2026, then July 1, 2026, would be the date of receipt and therefore day one of the 30-calendar-day payment period; payment would be due no later than 11:59 p.m. PT on July 30, 2026." We are correcting these examples to be consistent with the definition of "date of receipt" in § 428.400. Specifically, in each example provided, the "date of receipt" should be day 0 of the relevant calendar period, not day one. Therefore, if the Preliminary Rebate Report is provided on May 31, 2026, then June 1, 2026, will be the "date of receipt" and day zero of the 10-calendar-day period to submit a Suggestion of Error, such that Suggestions of Error would be due by 11:59 p.m. PT on June 11, 2026. Likewise, if a Rebate Report is provided on June 30, 2026, then July 1, 2026, will be the date of receipt and day zero of the 30-calendar-day payment period, such that payment would be due no later than 11:59 p.m. PT on July 31, 2026.

e. Enforcement of Manufacturer Payment of Rebate Amounts (§ 428.500)

In accordance with section 1860D-14B(a)(2) of the Act, the manufacturer of a Part D rebatable drug is required to provide a rebate equal to the rebate amount specified in section 1860D-14B(b) for the rebatable drug for the applicable period within 30 calendar days after receipt of the rebate amount from CMS. Section 1860D-14B(e) of the Act gives us the authority to impose a CMP equal to 125 percent of the rebate amount specified at section 1860D-14B(b) for each drug for each applicable period on a manufacturer that fails to pay the specified rebate amount. Subpart F implements this section of the Act and establishes the procedures for

determining and collecting a CMP.

We are clarifying here that the imposition of CMPs under section 1860D-14B(e) of the Act, in accordance with § 428.500, is not the exclusive remedy for a manufacturer's failure to comply with its rebate payment obligations described in § 428.405(a), nor the exclusive remedy for other conduct that may impact obligations, such as rebate amounts owed, under the Part D Inflation Rebate Program. For example, whether imposing CMPs under section 1860D-14B(e) of the Act or not, when we deem it appropriate, we may refer manufacturers to the Department of Justice, the Department of the Treasury, and/or the Department of Health and Human Services Office of Inspector General for further review and investigation.

G. Medicare Shared Savings Program

1. Executive Summary and Background

a. Purpose

As of January 1, 2026, the Medicare Shared Savings Program (Shared Savings Program) has 511 accountable care organizations (ACOs) with over 700,000 healthcare providers and organizations providing care to over 12.6 million assigned beneficiaries.[209] Eligible groups of providers and suppliers, such as physicians, hospitals, and other health care providers, may participate in the Shared Savings Program by forming or joining an ACO and in so doing agree to become accountable for the total cost and quality of care provided to an assigned population of Medicare FFS beneficiaries[210] (herein also referred to as "Original Medicare beneficiaries"). Under the Shared Savings Program, providers and suppliers that participate in an ACO continue to receive Original Medicare (OM) payments under Parts A and B,[211] and the ACO may be eligible to receive a shared savings payment if it meets specified quality and savings requirements, and in some instances may be required to share in losses if it increases healthcare spending.

As part of our effort to align spending and value in OM, we are focused on developing policies that would grow the number of health care providers and beneficiaries in accountable care relationships and grow savings to the Medicare Trust Funds. To achieve these goals, we are proposing changes to the Shared Savings Program and seeking comments on potential future policy developments in several requests for information, informed by the following strategic objectives:

---

[209] See "Shared Savings Program Fast Facts – As of January 1, 2026", available at *https://www.cms.gov/files/document/2026-shared-savings-program-fast-facts.pdf*.

[210] "Medicare fee-for-service beneficiary" is defined under section 1899(h)(3) of the Act, and a related definition was codified at 42 CFR 425.20.

[211] Over time, in Shared Savings Program rulemaking, we have used various phrases to refer to payments under the original Medicare fee-for-service program. Herein, we sometimes refer to Medicare fee-for-service (FFS) payments under Parts A and B as "Original Medicare payments." More generally, we use the terms "Traditional Medicare" and "Original Medicare" interchangeably and consider the terms to be synonymous.

- Strengthen financial incentives to participate and drive savings while minimizing "gaming"[212] opportunities in the Shared Savings Program.

- Grow participation in the Shared Savings Program through more meaningful participation and through beneficiary engagement, including beneficiary incentives.

- Simplify Shared Savings Program requirements and reduce participant burden in the Shared Savings Program, including through advancing ACO use of digital quality measures.

More specifically, our proposed changes to the Shared Savings Program's financial methodology would strengthen financial incentives for ACOs to participate in the program while mitigating selection issues and benchmark rebasing concerns. Our proposed changes to the Shared Savings Program's beneficiary assignment methodology would expand the population of Medicare FFS beneficiaries for which ACOs are accountable for quality and cost of care, while minimizing potential gaming opportunities in connection with the assignment methodology, and aligning Shared Savings Program policies. Under proposed changes to the Shared Savings Program quality performance standard and other quality reporting requirements, we would advance ACO use of digital quality measures and reduce participant burden. Our proposal to allow flexibility for all Shared Savings Program ACOs to reduce or eliminate Part B cost sharing for eligible beneficiaries, and therefore expand availability of this flexibility beyond ACOs participating in the prepaid shared savings payment option (which we propose to discontinue), is intended to increase beneficiary engagement. Our proposed changes to simplify the Shared Savings Program Certified Electronic Health Record Technology (CEHRT) use requirements and beneficiary information notice requirements would reduce burden for ACOs. Other modifications to the Shared Savings Program regulations addressed in this proposed rule include: proposed changes to the definition of primary care services for the purpose of determining beneficiary assignment, and proposed modifications to definitions of experienced and

[212] For instance, in section III.G.2.a of this proposed rule, we describe the potential for Shared Savings Program assignment policies to be exploited in a manner that results in differences in outcomes that could advantage the ACO's financial performance.

inexperienced with performance-based risk Medicare ACO initiatives used in determining an ACO's eligibility for participation options, and proposed changes the determining quarterly payment amounts received by eligible ACOs participating under the Advance Investment Payment (AIP) option. Further, through this proposed rule, we seek comment on specialty care in the Shared Savings Program. We provide a more detailed summary of the proposed changes to the Shared Savings Program and the topics on which we seek comment in a Request for Information (RFI) in section III.G.1.c. of this proposed rule.

b. Statutory and Regulatory Background on the Shared Savings Program

On March 23, 2010, the Patient Protection and Affordable Care Act (Pub. L. 111–148) was enacted, followed by enactment of the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) on March 30, 2010, which amended certain provisions of the Patient Protection and Affordable Care Act (hereinafter collectively referred to as "the Affordable Care Act"). Section 3022 of the Affordable Care Act amended title XVIII of the Act (42 U.S.C. 1395 et seq.) by adding section 1899 of the Act to establish the Medicare Shared Savings Program to facilitate coordination and cooperation among health care providers to improve the quality of care for Medicare FFS beneficiaries and reduce the rate of growth in expenditures under Medicare Parts A and B. (See 42 U.S.C. 1395jjj.)

Section 1899 of the Act has been amended through subsequent legislation. The requirements for assignment of Medicare FFS beneficiaries to ACOs participating under the program were amended by the 21st Century Cures Act (Pub. L. 114–255). The Bipartisan Budget Act of 2018 (Pub. L. 115–123), further amended section 1899 of the Act to provide for the following: expanded use of telehealth services by physicians or practitioners participating in an applicable ACO to furnish services to prospectively assigned beneficiaries; greater flexibility in the assignment of Medicare FFS beneficiaries to ACOs by allowing ACOs in tracks under retrospective beneficiary assignment a choice of prospective assignment for the agreement period; permitting Medicare FFS beneficiaries to voluntarily identify an ACO professional as

their primary care provider and requiring that such beneficiaries be notified of the ability to make and change such identification, and mandating that any such voluntary identification will supersede claims-based assignment; and allowing ACOs under certain two-sided models to establish CMS-approved beneficiary incentive programs.

The Shared Savings Program regulations are codified at 42 CFR part 425. The final rule establishing the Shared Savings Program appeared in the November 2, 2011, **Federal Register** (Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations; final rule (76 FR 67802) (hereinafter referred to as the "November 2011 final rule")). A subsequent update to the program rules appeared in the June 9, 2015, **Federal Register** (Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations final rule (80 FR 32692) (hereinafter referred to as the "June 2015 final rule")). The final rule entitled "Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations—Revised Benchmark Rebasing Methodology, Facilitating Transition to Performance-Based Risk, and Administrative Finality of Financial Calculations," which addressed changes related to the program's financial benchmark methodology, appeared in the June 10, 2016, **Federal Register** (81 FR 37950) (hereinafter referred to as the "June 2016 final rule"). A final rule, "Medicare Program: Medicare Shared Savings Program; Accountable Care Organizations—Pathways to Success and Extreme and Uncontrollable Circumstances Policies for Performance Year 2017," appeared in the December 31, 2018, **Federal Register** ((83 FR 67816) (hereinafter referred to as the "December 2018 final rule")).

In the interim final rule with comment period (IFC) entitled "Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency," which was effective on the March 31, 2020 date of display and appeared in the April 6, 2020, **Federal Register (**85 FR 19230) (hereinafter referred to as the "March 31, 2020 COVID-19 IFC"), and the IFC entitled "Medicare and Medicaid Programs; Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the

COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program," which was effective on May 8, 2020, and appeared in the May 8, 2020, **Federal Register** (85 FR 27550) (hereinafter referred to as the "May 8, 2020 COVID-19 IFC"), we updated quality requirements, financial calculations, eligibility requirements, and assignment methodology due to the to the public health emergency (PHE) for coronavirus disease 2019 (COVID-19).

We have also made use of the annual CY PFS rules to address quality reporting for the Shared Savings Program and certain other issues. For summaries of certain policies finalized in prior PFS rules, refer to the CY 2019 PFS final rule (also referred to as the "November 2018 final rule") (83 FR 59452), CY 2020 PFS final rule (84 FR 62568), the CY 2021 PFS final rule (85 FR 84717), the CY 2022 PFS final rule (86 FR 65253 and 65254), the CY 2023 PFS final rule (87 FR 69779 and 69780), the CY 2024 PFS final rule (88 FR 79094 and 79095), the CY 2025 PFS final rule (89 FR 98082 and 98083), and the CY 2026 PFS final rule (90 FR 49757 through 49759). In the CY 2026 PFS final rule (90 FR 49757 through 49836), we finalized changes to Shared Savings Program policies, including to: limit participation in a one-sided model to an ACO's first agreement period under the BASIC track's glide path (if eligible), for a maximum of 5 PYs instead of 7 PYs; modify the Shared Savings Program eligibility and financial reconciliation requirements in connection with the statutory requirement that ACOs have at least 5,000 assigned Medicare FFS beneficiaries; make changes to the Shared Savings Program quality performance standard and other quality reporting requirements; expand the application of the Shared Savings Program quality and finance extreme and uncontrollable circumstances (EUC) policies to an ACO that is affected by an EUC due to a cyberattack, including ransomware/malware, as determined by the Quality Payment Program; and to make changes to other programmatic areas, including changes to Shared Savings Program eligibility requirements and change request procedures, updates to the beneficiary assignment methodology

to revise the definition of primary care services to align with payment policy changes, and to revise the Shared Savings Program's quality reporting monitoring policies.

Aside from CY PFS rulemaking, we also note that in a final rule entitled "Medicare Program: Mitigating the Impact of Significant, Anomalous, and Highly Suspect Billing Activity on Medicare Shared Savings Program Financial Calculations in Calendar Year 2023," which was effective on October 15, 2024, and appeared in the September 27, 2024, **Federal Register** (89 FR 79152) (hereinafter referred to as the "SAHS billing activity final rule"), we finalized an approach to address the SAHS billing activity CMS identified for CY 2023 to protect the accuracy, fairness, and integrity of Shared Savings Program financial calculations.

Policies applicable to Shared Savings Program ACOs for purposes of quality reporting for other programs have also continued to evolve based on changes in statute, such as the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114–10), which established the Quality Payment Program. In the CY 2017 Quality Payment Program final rule with comment period (81 FR 77008), we established regulations for the MIPS and Advanced APMs and related policies applicable to eligible clinicians who participate in APMs, including the Shared Savings Program. We have also made updates to policies under the Quality Payment Program through the annual CY PFS rules.

c. Summary of Shared Savings Program Proposals

In sections III.G.2. through III.G.9. of this proposed rule, we propose modifications to the Shared Savings Program's policies. As a general summary, we are proposing the following changes to Shared Savings Program policies to:

- Revise policies for determining beneficiary assignment under the Shared Savings Program (section III.G.2. of this proposed rule):

++ Exclude from assignment calculations allowed charges for primary care services billed through a non-ACO Taxpayer Identification Number (TIN) by an ACO professional used in assignment (section III.G.2.a.(2)(a) of this proposed rule).

++ Modify assignment eligibility criteria and prospective assignment exclusion criteria based on Medicare enrollment status (section III.G.2.a.(2)(b) of this proposed rule).

++ Revise the definition of primary care services used in Shared Savings Program beneficiary assignment (section III.G.2.b. of this proposed rule).

● Revise the quality performance standard and other quality reporting requirements, including the following (section III.G.3. of this proposed rule):

++ Extend the availability of the MIPS CQMs collection type and the MIPS CQM reporting incentive for Shared Savings Program ACOs (section III.G.3.b. of this proposed rule).

++ Extend the scoring of Shared Savings Program ACOs reporting Medicare CQMs using flat benchmarks (section III.G.3.c. of this proposed rule).

++ Address Shared Savings Program ACOs' challenges with meeting the MIPS data completeness requirement (section III.G.3.d. of this proposed rule):

-- Revise the Shared Savings Program quality reporting requirements beginning in PY 2026 (section III.G.3.d.(2) of this proposed rule).

-- Establish the Medicare eCQMs collection type for Shared Savings Program ACOs (section III.G.3.d.(3) of this proposed rule).

-- Revise the definition of a "Beneficiary Eligible for Medicare CQMs" (section III.G.3.d.(4) of this proposed rule).

++ Revise the Shared Savings Program scoring policy for excluded APP Plus measures and APP Plus measures that lack a benchmark (section III.G.3.e. of this proposed rule).

++ Update the APP Plus quality measure set (section III.G.3.f. of this proposed rule).

● Revise Shared Savings Program CEHRT use requirements (section III.G.4. of this proposed rule).

++ Simplify Shared Savings Program CEHRT use requirements (section III.G.4.b. of this proposed rule).

-- Meet Shared Savings Program CEHRT use requirement by reporting at least one ACO-reported measure through the eCQMs or Medicare eCQMs collection types (section III.G.4.b.(1) of this proposed rule).

-- Meet Shared Savings Program CEHRT use requirements by attesting to using FHIR capabilities in certified health IT to support reporting of at least one of the five ACO-reported measures (section III.G.4.b.(2) of this proposed rule).

-- Meet Shared Savings Program CEHRT use requirements by attesting to one of the three ACO CEHRT use metrics (section III.G.4.b.(3) of this proposed rule).

-- Revise public reporting requirements (section III.G.4.b.(4) of this proposed rule).

-- Require compliance with Shared Savings Program CEHRT use requirements (section III.G.4.b.(5) of this proposed rule).

-- Confirm no impact on current Shared Savings Program quality or MIPS scoring policies or process (section III.G.4.b.(6) of this proposed rule).

++ Request information on applying electronic prior authorization measures to Shared Savings Program ACOs (section III.G.4.c. of this proposed rule).

● Revise policies for the Shared Savings Program's financial methodology, including the following (section III.G.5. of this proposed rule):

++ Propose changes to the Shared Savings Program financial methodology to encourage additional savings in two-sided risk (section III.G.5.c. of this proposed rule):

-- Increase the sharing rate under Level E of the BASIC track (section III.G.5.c.(1) of this proposed rule).

-- Reduce the maximum weight on the regional adjustment for ACOs under the ENHANCED track (section III.G.5.c.(2) of this proposed rule) for ACOs that are lower spending compared to their regional service area.

++ Increase the prior savings adjustment by increasing the scaling factor (section III.G.5.d. of this proposed rule).

++ Risk adjust the 5 percent cap on upward adjustments to the historical benchmark (section III.G.5.e. of this proposed rule).

++ Incentivize new participation through a growth adjustment to the historical benchmark (section III.G.5.f. of this proposed rule).

++ Reform the Accountable Care Prospective Trend (ACPT) component of the benchmark update factor (section III.G.5.g. of this proposed rule).

- Increase beneficiary engagement by allowing ACOs to reduce or eliminate Part B cost sharing for beneficiaries (section III.G.6.a. of this proposed rule), and discontinue availability of the option for prepaid shared savings (section III.G.6.b. of this proposed rule).

- Modify the calculation methodology for setting quarterly advance investment payment amounts and revise the terminology on allowable uses of advance investment payments (section III.G.7. of this proposed rule).

- Revise the approach to determining whether an ACO is experienced or inexperienced with performance-based risk Medicare ACO initiatives (section III.G.8. of this proposed rule).

- Modify Shared Savings Program beneficiary notification requirements (section III.G.9. of this proposed rule):

++ Revise distribution timing of standardized written notices (section III.G.9.b.(1) of this proposed rule).

++ Remove the beneficiary follow-up notice (section III.G.9.b.(2) of this proposed rule).

Additionally, in section II.D. of this proposed rule there is a proposal to replace office/outpatient evaluation and management (O/O E/M) visit complexity add-on code, HCPCS code G2211 with modifiers that would allow for differential payment for ACO participants.

Finally, we are requesting information on potential future policy developments, including: (1) the transition to Fast Healthcare Interoperability Resources®-based quality measurement in the Shared Savings Program (section II.E. of this proposed rule); (2) potential approaches to more effectively integrate and meaningfully engage specialty care in the Shared

Savings Program (section III.G.10. of this proposed rule); and (3) potential approaches to introducing primary care–focused capitated payment arrangements in the Shared Savings Program (section II.E. of this proposed rule).

Taken together, the Shared Savings Program proposals in this proposed rule are projected to reduce Trust Fund expenditures by $5.5 billion in total through the end of the 10-year period 2027 through 2036, ranging from approximately $8.9 billion lower spending at the 10th percentile to $2.3 billion lower spending at the 90th percentile, as described in the Regulatory Impact Analysis in section VII. of this proposed rule.

Certain policies, including both existing policies and proposed new policies described in this proposed rule, rely upon the authority granted in section 1899(i)(3) of the Act to use other payment models that the Secretary determines will improve the quality and efficiency of items and services furnished under the Medicare program, and that do not result in program expenditures greater than those that would result under the statutory payment model. The following proposals require the use of our authority under section 1899(i) of the Act: modifications to the ACPT component of the three-way blended benchmark update factor (described in section III.G.5.g. of this proposed rule); discontinuing availability of the option for prepaid shared savings (described in section III.G.6.b. of this proposed rule); and changes to the calculation methodology for quarterly advance investment payments (described in section III.G.7. of this proposed rule). As described in the Regulatory Impact Analysis in section VII. and elsewhere in this proposed rule, these proposed changes to the Shared Savings Program are expected to improve the quality and efficiency of care under the Medicare program and are not expected to result in a situation in which the payment methodology under the Shared Savings Program, including all policies we have adopted under the authority of section 1899(i) of the Act, results in more spending under the program than would have resulted under the statutory payment methodology in section 1899(d) of the Act.

We will continue to reexamine this projection in the future to ensure that an alternative payment model does not result in additional program expenditures and so continues to satisfy the requirement under section 1899(i)(3)(B) of the Act. If we later determine that the payment model that includes policies established under section 1899(i)(3) of the Act no longer meets this requirement, we will undertake notice and comment rulemaking to adjust the payment model to ensure continued compliance with the statutory requirements.

d. PY 2027 Application Cycle Flexibility

Some of the proposed financial methodology changes described in section III.G. of this proposed rule, if finalized, may be consequential for ACOs' decisions to enter an agreement period under Level E of the BASIC track or the ENHANCED track. We anticipate a significant number of renewal applications for the January 1, 2027 agreement period start date. There are currently 96 ACOs that entered an agreement period beginning on January 1, 2022, that would need to apply to renew to continue their participation in the Shared Savings Program by entering an agreement period beginning on January 1, 2027. Considering the timing of CY PFS rulemaking and the Shared Savings Program application cycle for the January 1, 2027 start date (occurring in CY 2026), ACO applicants would have notice of the proposed changes after the deadline for submitting their applications to continue their participation. Additionally, under a previously established timeline for application actions and deadlines, the application cycle would require ACO applicants to finalize their selection of track/level of participation by early September 2026,[213] which is before the CY 2027 PFS final rule will likely be issued. ACO applicants will have to make their final selection between the BASIC track and ENHANCED track before the CY 2027 PFS rule is finalized. To mitigate the potential impact on ACO applicants in making their final selection of track/level of participation in the Shared Savings Program, we anticipate providing ACOs applying for an agreement start date of January 1, 2027,

[213] See CMS, Medicare Shared Savings Program, "Key Application Actions and Deadlines For Agreement Periods Beginning on February 1, 2027", available at *https://www.cms.gov/files/document/*X EI*key-application-actions-deadlines.pdf.*

with a time limited opportunity to change their final selection between the BASIC track and ENHANCED track (if eligible). We also note that an ACO applicant that has not submitted an application for a January 1, 2027 agreement start date as of the date of display of this proposed rule that wishes to enter a new agreement in the Shared Savings Program, may apply to enter a new agreement period beginning on January 1, 2028 during the application cycle occurring in CY 2027.

2. Beneficiary Assignment Methodology

a. Proposed Modifications to the Shared Savings Program Assignment Methodology

(1) Background

Under section 1899(b)(2)(A) of the Act, an ACO must "be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it." As defined in section 1899(h)(3) of the Act and in the Shared Savings Program's regulations at § 425.20, the term "Medicare fee-for-service beneficiary" means an individual who is enrolled in the original Medicare FFS program under Parts A and B and is not enrolled in a Medicare Advantage (MA) plan under Part C, an eligible organization under section 1876 of the Act, or a Program of All-Inclusive Care for the Elderly (PACE) program under section 1894 of the Act. Section 1899(c)(1) of the Act, as amended by the 21st Century Cures Act (Pub. L. 114-255) and the Bipartisan Budget Act of 2018 (Pub. L. 115-123), provides that the Secretary shall determine an appropriate method to assign Medicare FFS beneficiaries to an ACO based on their utilization of primary care services provided by physicians in the ACO who are ACO professionals and, in the case of PYs beginning on or after January 1, 2019, services provided by a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC). In the context of the Shared Savings Program, "assignment" (as defined in § 425.20) refers to an operational process by which we determine whether a beneficiary has chosen to receive a sufficient level of certain primary care services from physicians and other health care practitioners associated with a specific ACO so that the ACO may be appropriately designated as exercising basic responsibility for that

beneficiary's care during a given benchmark year or PY.[214] We refer to the process by which we determine assignment under section 1899(c)(1) of the Act as "claims-based assignment".

Further, under section 1899(c)(2)(B) of the Act, a non-claims-based process for voluntary alignment applies to all Shared Savings Program ACOs and is used to supplement claims-based assignment. In accordance with section 1899(c)(2)(B)(iii) of the Act, voluntary alignment supersedes claims-based assignment.

The regulations governing the assignment methodology under the Shared Savings Program, with provisions on claims-based assignment and voluntary alignment, are in 42 CFR part 425, subpart E. In the sections that follow we provide additional regulatory background about the Shared Savings Program's stepwise claims-based assignment methodology (section III.G.2.a.(1)(a) of this proposed rule) and criteria based on Medicare enrollment status that we use to determine a beneficiary's eligibility for assignment (section III.G.2.a.(1)(b) of this proposed rule), provide an overview of assignment-based program operations (section III.G.2.a.(1)(c) of this proposed rule), and describe beneficiaries excluded from the assigned population under the current assignment methodology (section III.G.2.a.(1)(d) of this proposed rule).

(a) Background on Step-wise Assignment Methodology

As we have described in the CY 2024 PFS final rule (88 FR 79136), under claims-based assignment, we determine a Medicare FFS beneficiary is assigned to an ACO if the beneficiary meets the criteria in § 425.401(a) to be eligible for assignment to an ACO, and the beneficiary's utilization of primary care services[215] meets the criteria established under the assignment methodology specified in § 425.402 (specifying the basic assignment methodology) and

---

[214] As we have explained in earlier rulemaking (see 88 FR 79136; see also 76 FR 67851, and 83 FR 67863), the term "assignment" for purposes of the Shared Savings Program in no way implies any limits, restrictions, or diminishment of the rights of Medicare FFS beneficiaries to exercise freedom of choice in the physicians and other health care practitioners from whom they receive covered services.

[215] As described in section III.G.2.b. of this proposed rule, we define primary care services for purposes of the Shared Savings Program in § 425.20 as a set of services identified by HCPCS codes and CPT codes, as specified under § 425.400(c).

§ 425.404 (specifying special assignment conditions for ACOs including FQHCs and RHCs). Section 425.402 specifies a step-wise assignment methodology for determining an ACO's assigned beneficiary population based on beneficiaries' use of primary care services. Section 425.402(b) of the Shared Savings Program regulations specifies the step-wise methodology we use to assign Medicare FFS beneficiaries to an ACO based on available claims information, for PY 2016 and subsequent PYs. In accordance with § 425.404(b), for PYs starting on January 1, 2019, and subsequent PYs, under the assignment methodology in § 425.402, we treat a service reported on an FQHC or RHC claim as a primary care service performed by a primary care physician.

The Shared Savings Program step-wise assignment process is offered in two similar, but distinct, claims-based assignment methodologies: prospective assignment as specified under § 425.400(a)(3); and preliminary prospective assignment with retrospective reconciliation as specified under § 425.400(a)(2). Consistent with the requirements of section 1899(c)(2)(A) of the Act, we offer all Shared Savings Program ACOs the opportunity to select their assignment methodology annually, starting with agreement periods beginning on July 1, 2019, in accordance with §§ 425.400(a)(4)(ii) and 425.226(a)(1). We use the same step-wise assignment methodology under § 425.402 to assign beneficiaries to ACOs under prospective assignment and ACOs under preliminary prospective assignment with retrospective reconciliation.

The step-wise assignment methodology was initially established with the November 2011 final rule and was modified through subsequent rulemaking. For a discussion of the relevant background and related considerations, we refer readers to the November 2011 final rule (76 FR 67853 through 67858), June 2015 final rule (see 80 FR 32699 through 32701, and 32748 through 32755), CY 2023 PFS final rule (87 FR 69825 through 69829), and the CY 2024 PFS final rule (88 FR 79136 through 79163). We have detailed how we perform claims-based assignment in programmatic material, including publicly available specifications documents. See, for example, Medicare Shared Savings Program, "Shared Savings and Losses, Assignment

and Quality Performance Standard Methodology Specifications" (April 2026, Version #14), available at *https://www.cms.gov/files/document/medicare-shared-savings-program-shared-savings-losses-assignment-methodology-specifications-version.pdf-0* (Section 2.3 Claims-Based Assignment).

In the discussion that follows, we first describe our use of the ACO participant list to identify primary care services billed by ACO professionals and CMS certification numbers (CCNs) used in the assignment methodology, and then we describe the steps of the claims-based assignment process.

(i) Use of ACO Participant List to Identify Primary Care Services Billed by ACO Professionals and CCNs Used in Assignment Calculations

As we described in the CY 2023 PFS final rule (87 FR 69825), under the Shared Savings Program, ACOs are accountable for the quality, cost, and overall care of the Medicare FFS beneficiaries that are assigned to the ACO (§ 425.100(a)). ACOs are formed by one or more "ACO participants," which are responsible for managing and coordinating care for the assigned beneficiary population. The Shared Savings Program regulations define "ACO participant" at § 425.20 as an entity identified by a Medicare-enrolled billing Taxpayer Identification Number (TIN) through which one or more "ACO providers/suppliers" (as defined at § 425.20) bill Medicare, that alone or together with one or more other ACO participants compose an ACO, and that is included on the list of ACO participants that is required under § 425.118 (herein "ACO participant list"). An "ACO provider/supplier" is an individual or entity that: (1) is a provider (as defined at § 400.202) or supplier (as defined at § 400.202); (2) is enrolled in Medicare; (3) bills for items and services furnished to Medicare FFS beneficiaries during the agreement period under a Medicare billing number assigned to the TIN of an ACO participant in accordance with applicable Medicare regulations; and (4) is included on the list of ACO providers/suppliers that

is required under § 425.118 (herein "ACO provider/supplier list").[216] We require each ACO to execute contractual agreements with each of its ACO participants ("ACO participant agreements"), to ensure that the ACO participant and each ACO provider/supplier billing through the TIN of the ACO participant agree to the requirements of the Shared Savings Program (see 87 FR 69825, and see also § 425.116).

As we explained in the CY 2023 PFS final rule (87 FR 69825 through 69826), under § 425.118(a), an ACO must maintain, update, and submit to us an accurate and complete list identifying each ACO participant (including its Medicare-enrolled TIN) and each ACO provider/supplier (including its National Provider Identifier (NPI), CCN, or other identifier). More specifically, an ACO must submit a draft ACO participant list before the start of an agreement period and before each performance year thereafter. In accordance with § 425.118(a)(3), the ACO must certify the accuracy of its ACO participant list before the start of its agreement period and before each performance year thereafter. An ACO must maintain and periodically update its ACO participant list. For additional background on development and maintenance of the ACO participant list we refer readers to the CY 2023 PFS final rule at 87 FR 69826, and CY 2026 PFS final rule at 90 FR 49775 through 49778.

More generally, in accordance with § 425.102(a), an ACO may be formed from the following ACO participants or combinations of ACO participants: (1) ACO professionals in group practice arrangements; (2) networks of individual practices of ACO professionals; (3) partnerships or joint venture arrangements between hospitals and ACO professionals; (4) hospitals employing ACO professionals; (5) Critical Access Hospitals (CAHs) that bill under Method II (as described in § 413.70(b)(3)); (6) RHCs; (7) FQHCs; and (8) teaching hospitals that have elected under § 415.160 to receive payment on a reasonable cost basis for the direct

[216] For additional background on development and maintenance of the ACO provider/supplier list, we refer readers to the CY 2023 PFS final rule at 87 FR 69826.

medical and surgical services of their physicians (herein referred to as electing teaching amendment (ETA) hospitals).

Under § 425.20, "ACO professional" is defined to mean an individual who is Medicare-enrolled and bills for items and services furnished to Medicare FFS beneficiaries under a Medicare billing number assigned to the TIN of an ACO participant in accordance with applicable Medicare regulations and who is either of the following: (1) a physician legally authorized to practice medicine and surgery by the State in which he or she performs such function or action; or (2) a practitioner who is a physician assistant (PA), a nurse practitioner (NP), or a clinical nurse specialist (CNS).[217] As detailed in section III.G.2.a.(1)(ii) of this proposed rule, the stepwise assignment methodology considers primary care services furnished by the following ACO professionals: primary care physicians (as defined in § 425.20), physicians with specialty designations included in § 425.402(c), and non-physician ACO professionals (NPs, PAs, CNSs) (herein collectively referred to as "ACO professionals used in assignment" for brevity).

Under the claims-based assignment process we identify allowed charges for a beneficiary's primary care services received in an ACO (furnished by ACO professionals used in assignment billing through the TIN of an ACO participant or an FQHC, RHC, Method II CAH, or ETA hospital identified by a CCN enrolled under the TIN of an ACO participant), in any other ACO, or other individual practitioners, or groups of practitioners identified by Medicare-enrolled billing TINs or CCNs that are not participating in the Shared Savings Program. We use the ACO participant list certified by the ACO to identify ACO professionals used in assignment that are billing primary care services, and to identify CCNs enrolled under the TIN of an ACO participant, for purposes of performing claims-based assignment for the PY, and, if applicable,

[217] Sometimes we refer to NPs, PAs, and CNSs who are ACO professionals in the ACO as "non-physician ACO professionals".

assignment for the ACO's benchmark years in the case of establishing or adjusting the ACO's historical benchmark under subpart G (see § 425.652(a)).

We use different approaches to identifying primary care services furnished by ACO professionals and CCNs enrolled under the TIN of an ACO participant. Because of the billing relationship between an ACO professional and an ACO participant, any claims for primary care services billed by an ACO professional through the TIN of an ACO participant would be used for assignment. We note that operationally we identify an ACO professional based on the physician's or non-physician practitioner's NPI. As we explained in the CY 2023 PFS final rule (87 FR 69826), for purposes of beneficiary assignment, we identify claims for services furnished by Method II CAHs, ETA hospitals, FQHCs, and RHCs using the CCN assigned to the facility. Section 425.402(f) includes provisions on how we identify services furnished by FQHCs, RHCs, Method II CAHs, and ETA hospitals, based on CCNs enrolled under the TIN of an ACO participant, for purposes for beneficiary assignment for PY 2023 and subsequent PYs. Under this approach, we use the Provider Enrollment, Chain, and Ownership System (PECOS) to determine the CCNs for all FQHCs, RHCs, Method II CAHs, and ETA hospitals enrolled under the TIN of an ACO participant prior to the start of performance year, and periodically during the performance year, and account for changes in CCN enrollment status during the PY.[218] We also note that the claims data used for assignment for FQHCs, RHCs, Method II CAHs, and ETA hospitals are limited to outpatient facility claims, and have specified in program specifications additional steps we use to identify data on outpatient facility claims for these four provider types.[219]

As specified in § 425.306, each ACO participant that submits claims for services used to determine the ACO's assigned population under subpart E of part 425 must be exclusive to one

---

[218] We refer readers to the discussion in the CY 2023 PFS final rule at 87 FR 69825 through 69829.

[219] See Medicare Shared Savings Program, "Shared Savings and Losses, Assignment and Quality Performance Standard Methodology Specifications" (April 2026, Version #14), available at *https://www.cms.gov/files/document/medicare-shared-savings-program-shared-savings-losses-assignment-methodology-specifications-version.pdf-0* (Appendix D: Outpatient Facility Claims Used in Beneficiary Assignment).

Shared Savings Program ACO. In initially establishing exclusivity requirements for ACO participants in the November 2011 final rule (76 FR 67811), we explained that individual NPIs are free to participate in multiple ACOs if they bill under several different TINs. We explained that when providers whose services are the basis of assignment bill under two or more TINs, each TIN would be exclusive to only one ACO, assuming both TINs have both joined as participants, but the provider billing under the TINs would not have to be exclusive to one ACO. In the February 2016 proposed rule (81 FR 5824, 5849), we recognized there may be cases where a beneficiary is receiving primary care services from ACO participants in multiple ACOs or from both ACO participants and non-ACO providers and suppliers. We explained that in such cases, the composition of each ACO is important in determining whether the beneficiary is assigned to an ACO at all, and in determining to which ACO (among several) the beneficiary may be assigned. As we explained in the CY 2023 PFS final rule (87 FR 69828), our policies for accounting for changes in CCN enrollment status, for identifying services furnished by FQHCs, RHCs, Method II CAHs, and ETA hospitals for purposes of beneficiary assignment, reflect our operational approach to treat CCNs in a similar fashion to ACO participant TINs and not allow a CCN to switch between ACOs during the performance year (see § 425.402(f)(3)(iii)). In earlier rulemaking, we have not more generally sought to address the impact on assignment of an ACO professional used in assignment (NPI) billing primary care services for a beneficiary through an ACO participant TIN and non-ACO TIN, and related policy considerations.

(ii) Steps of the Claims-Based Assignment Process

In each step of the claims-based assignment process, we determine whether the allowed charges for a beneficiary's primary care services in an ACO are greater than allowed charges for the beneficiary's primary care services in any other ACO, or other individual practitioners, or groups of practitioners identified by Medicare-enrolled billing TINs or CCNs that are not participating in the Shared Savings Program (that is, a non-ACO individual or group TIN or non-ACO CCN). In doing so, we determine which ACO or non-ACO entity provided a beneficiary's

plurality of allowed charges for primary care services for purposes of assignment. Herein, for brevity, we sometimes refer to this stage of the assignment process as "plurality competition".[220]

To follow is a summary of the steps used in the claims-based assignment methodology under § 425.402(b):

In accordance with § 425.402(b)(1), as a "pre-step" to the first and second step of the claims-based assignment process, CMS identifies all beneficiaries who had at least one primary care service during the applicable assignment window[221] with a physician who is an ACO professional in the ACO and who is a primary care physician as defined under § 425.20 or has one of the primary specialty designations specified in § 425.402(c). This pre-step is designed to satisfy the statutory requirement under section 1899(c)(1) of the Act that beneficiaries be assigned to an ACO based on their use of primary care services furnished by physicians participating in the ACO. Beneficiaries who meet the pre-step requirement are then assigned to an ACO through either the first or second step of the assignment methodology specified in § 425.402(b)(3) and (b)(4).

As described in § 425.402(b)(2), for beneficiaries who meet the pre-step requirement under § 425.402(b)(1), CMS identifies all primary care services furnished by ACO professionals of that ACO who are primary care physicians as defined under § 425.20, non-physician ACO professionals, and physicians with specialty designations included in § 425.402(c) during the applicable assignment window. This provision reflects an operational step necessary to identify the sum of allowed charges for primary care services for a beneficiary received in an ACO (furnished by ACO professionals used in assignment billing through the TIN of an ACO

---

[220] We have infrequently made references to "competition" in claims-based assignment in earlier rulemaking. See, for example, 85 FR 84790 (in describing observations based on internal analysis of the rate at which beneficiaries are assigned to an ACO and subsequently not assigned to that ACO), and 89 FR 98197 through 98198 (in generally referring to the ACOs included in the claims-based assignment competition).

[221] As defined in § 425.20, "assignment window" means the 12-month period used to assign beneficiaries to an ACO, or to identify assignable beneficiaries, or both. As we explained in the CY 2024 PFS final rule (88 FR 79137, see also 83 FR 67860), the assignment window for ACOs under prospective assignment is a 12-month period offset from the calendar year (for example, October through September preceding the calendar year), while for ACOs under preliminary prospective assignment with retrospective reconciliation, the assignment window is the 12-month period based on the calendar year.

participant or CCNs enrolled under the TIN of an ACO participant), as compared to any other ACO, non-ACO CCN, or non-ACO individual or group TIN, for determining the outcome of the plurality competition under step 1 and step 2 of the assignment methodology.

Under the first step of the assignment process, specified at § 425.402(b)(3), a beneficiary who is eligible for assignment and meets the pre-step requirement is assigned to an ACO if the allowed charges for primary care services furnished to the beneficiary during the assignment window by primary care physicians who are ACO professionals and non-physician ACO professionals in the ACO are greater than the allowed charges for primary care services furnished during the assignment window by primary care physicians, NPs, PAs, or CNSs who are ACO professionals in any other ACO, or not affiliated with any ACO and identified by a Medicare-enrolled billing TIN (that is, a non-ACO CCN, or non-ACO individual or group TIN).

The second step of the assignment methodology, specified at § 425.402(b)(4), applies to the remainder of the beneficiaries who are eligible for assignment and meet the pre-step requirement, who have not had a primary care service rendered during the assignment window by any primary care physician, NP, PA, or CNS, either inside or outside the ACO. The beneficiary will be assigned to an ACO if the allowed charges for primary care services furnished to the beneficiary during the assignment window by physicians who are ACO professionals with specialty designations specified in § 425.402(c) are greater than the allowed charges for primary care services furnished during the assignment window by physicians with such specialty designations who are ACO professionals in any other ACO, or who are unaffiliated with an ACO and are identified by a Medicare-enrolled billing TIN (that is, a non-ACO CCN, or non-ACO individual or group TIN).

For PY 2025 and subsequent PYs, as specified in § 425.402(b)(5), we employ a third step to assign eligible Medicare FFS beneficiaries who are not identified by the “pre-step” criterion specified under § 425.402(b)(1). In this step, we identify all beneficiaries who had at least one primary care service with a non-physician ACO professional in the ACO during the applicable

assignment window, and had at least one primary care service with a physician who is an ACO professional in the ACO and who is a primary care physician or who has one of the primary specialty designations included in § 425.402(c) during the applicable expanded window for assignment (see § 425.402(b)(5)(i) through (ii)).[222] As described in § 425.402(b)(5)(iii), for a beneficiary meeting the aforementioned criteria in § 425.402(b)(5)(ii), we identify all primary care services furnished by ACO professionals in the ACO who are primary care physicians, non-physician ACO professionals, and physicians with specialty designations included in § 425.402(c) during the applicable expanded window for assignment. The identification of primary care services described in § 425.402(b)(5)(iii) serves as an operational step which is similar to the step described in § 425.402(b)(2). This operational step is necessary to identify the sum of allowed charges for primary care services for a beneficiary received in an ACO (furnished by ACO professionals used in assignment billing through the TIN of an ACO participant or CCNs enrolled under the TIN of an ACO participant), as compared to any other ACO, non-ACO CCN, or non-ACO individual or group TIN, for determining the outcome of the plurality competition under step 3.

In accordance with § 425.402(b)(5)(iv), a beneficiary identified in § 425.402(b)(5)(ii) who is eligible for assignment is assigned to an ACO if the allowed charges for primary care services furnished to the beneficiary by ACO professionals in the ACO who are primary care physicians, physicians with specialty designations included in § 425.402(c), or non-physician ACO professionals during the applicable expanded window for assignment are greater than the allowed charges for primary care services furnished by primary care physicians, physicians with specialty designations included in § 425.402(c), NPs, PAs, and CNSs who are ACO professionals in any other ACO, or not affiliated with any ACO and identified by a Medicare-enrolled billing TIN (that is, a non-ACO CCN, or non-ACO individual or group TIN).

---

[222] As defined in § 425.20, "expanded window for assignment" means the 24-month period used to assign beneficiaries to an ACO, or to identify assignable beneficiaries, or both that includes the applicable 12-month assignment window and the preceding 12 months.

As previously described, under § 425.402(b)(3), (b)(4), (b)(5)(iv), the plurality competition which occurs in each step of assignment compares allowed charges for primary care services furnished to a beneficiary by certain ACO professionals in an ACO with allowed charges for primary care services furnished by the same type of health care providers who are either (1) ACO professionals in any other ACO, or (2) not affiliated with any ACO and identified by a Medicare-enrolled billing TIN. Under the existing provisions, for purposes of plurality competition, we attribute to a non-ACO TIN the allowed charges for primary care services for a beneficiary furnished by an ACO professional that are billed through the non-ACO TIN. In determining the outcome of plurality competition for a beneficiary we consider both: (1) allowed charges for primary care services for the beneficiary received inside the ACO (furnished by an ACO professional or FQHC, RHC, Method II CAH or ETA hospital that has enrolled under the TIN of an ACO participant), and (2) allowed charges for primary care services for the same beneficiary being billed by the same ACO professional outside the ACO to a non-ACO TIN. As a result, a beneficiary may be identified as receiving the plurality of their primary care services outside an ACO based on a difference in the TIN to which the services are being billed by their health care provider who is an ACO professional used in assignment. Under these circumstances, when the plurality of allowed charges for primary care services is attributed to a non-ACO TIN, the ACO whose ACO professionals are furnishing services to the beneficiary would not be held accountable for the beneficiary's quality and cost of care.

(b) Background on Criteria Based on Medicare Enrollment Status Use to Identify Beneficiaries Eligible for Assignment and the Assignable Beneficiary Population

With the June 2015 final rule (see 80 FR 32743 through 32746, 32774 through 32775, and 32840 through 32841), we added § 425.401, establishing criteria for a beneficiary to be assigned to an ACO, which included assignment eligibility criteria under § 425.401(a), and

exclusion criteria for prospectively assigned beneficiaries under § 425.401(b).[223] These criteria included requirements based on a beneficiary's Medicare enrollment status. Additional background on considerations in establishing the assignment eligibility criteria and prospective assignment exclusion criteria based on Medicare enrollment status is provided in section III.G.2.a.(2)(b) of this proposed rule.

In subsequent rulemaking, we finalized amendments to § 425.401(b) introductory text, to apply the prospective assignment exclusion criteria in determining beneficiaries that would remain prospectively assigned at the end of CY 2019 to an ACO participating in a 6-month PY or performance period during 2019. Refer to the CY 2019 PFS final rule at 83 FR 59946 through 59947, and 60093; and the December 2018 final rule at 83 FR 67951, and 68069. We note that the criteria for determining a beneficiary's eligibility for assignment under § 425.401(a), and the prospective assignment exclusion criteria specified under § 425.401(b)(1) through (3), have remained unchanged since being finalized with the June 2015 final rule.

Currently, in accordance with § 425.401(a), a beneficiary may be assigned to an ACO under the assignment methodology in §§ 425.402 and 425.404, for a performance or benchmark year, if the beneficiary meets all of the following criteria during the assignment window:

(1) Has at least 1 month of Part A and Part B enrollment, and does not have any months of Part A only or Part B only enrollment.

(2) Does not have any months of Medicare group (private) health plan enrollment.

(3) Is not assigned to any other Medicare shared savings initiative.

(4) Lives in the United States (U.S.) or U.S. territories and possessions, based on the most recent available data in our beneficiary records regarding the beneficiary's residence at the end of the assignment window.

---

[223] We also refer readers to the related discussion in the proposed rule entitled "Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations", which appeared in the December 8, 2014 **Federal Register** (79 FR 72760, 72790 through 72792, and 72811).

If a beneficiary meets the above criteria, and then is assigned to an ACO that is participating under prospective assignment, the beneficiary may be later excluded from the ACO's prospective assignment list if they no longer meet these eligibility criteria. In accordance with § 425.401(b), a beneficiary is excluded from the prospective assignment list of an ACO that is participating under prospective assignment under § 425.400(a)(3) at the end of a performance or benchmark year and quarterly during each PY consistent with § 425.400(a)(3)(ii), if the beneficiary meets any of the following criteria during the performance or benchmark year:[224]

(1) Does not have at least 1 month of Part A and Part B enrollment, and has any months of Part A only or Part B only enrollment.

(2) Has any months of Medicare group (private) health plan enrollment.

(3) Did not live in the U.S. or U.S. territories and possessions, based on the most recent available data in our beneficiary records regarding the beneficiary's residency at the end of the year.

We have also applied the eligibility criteria established at § 425.401(a) and the prospective assignment exclusion criteria at § 425.401(b) in determining whether a beneficiary is eligible to be assigned to an ACO through voluntary alignment. We refer readers to discussions in earlier rulemaking (see 81 FR 80501 through 80510, 83 FR 59959 through 59964, and 89 FR 98097 through 98101), on the establishment of and modifications to these policies. With the CY 2025 PFS final rule (89 FR 98097 through 98101), we finalized the voluntary alignment policies applicable for PY 2025 and subsequent PYs under § 425.402(e)(2)(iii).

In accordance with § 425.402(e)(2)(iii)(A), among other conditions that must be satisfied for a beneficiary to be prospectively assigned to an ACO through voluntary alignment for PY 2025 and subsequent PYs, the beneficiary must meet the eligibility criteria established at § 425.401(a), and must not be excluded by the criteria at § 425.401(b). Further, as specified

---

[224] We note the introductory text of § 425.401(b) includes a reference to applicability of the prospective assignment exclusion criteria for determining assignment to ACOs participating under a 6-month performance year or performance period during CY 2019, under § 425.609(b)(1)(ii) and (c)(1)(ii).

under § 425.402(e)(2)(iii)(A), the exclusion criteria at § 425.401(b) apply for purposes of determining beneficiary eligibility for voluntary alignment to an ACO based on the beneficiary's designation of an ACO professional as responsible for coordinating their overall care under § 425.402(e), regardless of the ACO's assignment methodology selection under § 425.226(a)(1).

There is currently asymmetry in the requirements used to identify the ACO assigned population under criteria in § 425.401 based on Medicare enrollment status, and the broader "assignable beneficiary" population (as defined in § 425.20), used in determining factors based on national and regional Medicare FFS expenditures.[225] As we have explained in earlier rulemaking, the assignable population is a subset of the larger population of Medicare FFS beneficiaries (see, for example, 88 FR 79138). Under our operational approach to identifying the assignable beneficiary population, we require that the beneficiary have at least 1 month of Part A and Part B enrollment and no Medicare group health plan enrollment (including MA) during that same month during the applicable 12-month assignment window. In comparison, for a beneficiary to be eligible to be assigned to an ACO under the criteria in § 425.401(a)(1) through (2) the beneficiary must: (1) have at least 1 month of Part A and Part B enrollment, and not have any months of Part A only or Part B only enrollment during the assignment window; and (2) not have any months of Medicare group (private) health plan enrollment during the assignment window. As a result, beneficiaries with one or more month of Part A only or Part B only enrollment, or Medicare group health plan enrollment during the assignment window could be included in the assignable beneficiary population, while beneficiaries with such Medicare enrollment status are ineligible for assignment to an ACO.

With the June 2016 final rule (see 81 FR 37985 through 37989), we established the use of the assignable population, rather than the broader Medicare FFS population in certain financial calculations based on national and regional FFS expenditures. In the June 2016 final rule

[225] With the June 2016 final rule (see, for example, 81 FR 37985 through 37989, and 38013), we finalized the definition for "assignable beneficiary" under § 425.20, which we subsequently amended with the CY 2024 PFS final rule (88 FR 79143 through 79144, and 79162 through 79163).

(81 FR 37961), we explained that this approach to use the assignable population ensured these calculations were based on beneficiaries that have some chance of being assigned to the ACO. We also clarified that some beneficiaries who meet the definition of ''assignable beneficiary'' will ultimately be excluded from assignment to an ACO for purposes of determining the ACO's benchmark year or PY expenditures because they fail to meet the assignment criteria specified under § 425.401(a). In subsequent rulemaking we have established policies to ensure alignment between the assigned and assignable populations[226] or calculations based on these populations.[227] However, we did not previously seek to address the differences in Medicare enrollment status of beneficiaries in the assignable population and the assigned population.

(c) Overview of Assignment-Based Program Operations

Various Shared Savings Program operations are based on the ACO's assigned population, or consider the size of the ACO's assigned population, as described in prior rulemaking (see, for example, 88 FR 79137 through 79138). To follow is a summary of these policies, including references to proposed changes to Shared Savings Program policies elsewhere in section III.G. of this proposed rule.

Various aspects of the Shared Savings Program's financial methodology under subpart G depend on the size or composition of the ACO's assigned population, including calculating the ACO's benchmark and performance year expenditures, and adjusting and updating the ACO's benchmark. For each performance year, we determine whether the estimated average per capita Medicare Parts A and B FFS expenditures for Medicare FFS beneficiaries assigned to the ACO are above or below the ACO's updated benchmark, to determine whether the ACO qualifies for a shared savings payment or is responsible for sharing losses with CMS (as applicable)

---

[226] We refer readers to the CY 2024 PFS final rule (88 FR 79136 through 79163), in which we finalized use of an expanded window for assignment in both step 3 of the assignment methodology, and the definition of an assignable beneficiary, which we explained was necessary to maintain symmetry between the two approaches (see, for example, 88 FR 79158).

[227] We refer readers the CY 2023 PFS final rule (87 FR 69929 through 69932), in which we finalized modifications to our methodology for calculating county FFS expenditures to provide for the use of separate assignment windows for ACOs depending on their selected assignment methodology, to address and protect against bias in the calculations.

(§§ 425.605(a) and 425.610(a)). In computing an ACO's historical benchmark, we determine the per capita Parts A and B FFS expenditures for beneficiaries that would have been assigned to the ACO in any of the 3 most recent years prior to the start of the ACO's agreement period, in accordance with § 425.652(a) and (c). In benchmark calculations, the assigned population is the basis for determining the ACO's regional service area used in calculating the two-way blend of national and regional growth rates applied in trending and updating the ACO's benchmark (§ 425.652(a)(5)(iv)–(v), and (b)(2)), and the regional adjustment to the benchmark (§ 425.656). The assigned population is also used in calculating a proration factor applied in the prior savings adjustment (§ 425.658(b)(3)), and in determining an ACO's eligibility for and the amount of the population adjustment to the historical benchmark (§ 425.662(b)). The average prospective HCC risk scores for the ACO's assigned beneficiaries are used to risk adjust the ACO's benchmark expenditures (§§ 425.652(a)(3) and (10); 425.605(a)(1); 425.610(a)(2)), and other benchmark calculations (see, for example, § 425.656(b)(3) and (4) on calculating the regional adjustment, and § 425.660(b)(4) on calculating the ACPT component of the three-way blended benchmark update factor). As another example, as described in section III.G.5.e of this proposed rule, we are proposing to risk adjust the 5 percent cap on upward adjustments to the benchmark, based on average CMS-HCC risk scores for the ACO's assigned beneficiary population. In addition, we use the size of the ACO's assigned population in other financial calculations, including: determining the MSR/MLR threshold based on the ACO's number of assigned beneficiaries (§§ 425.605(b)(2)(i)(C) and 425.610(b)(1)(iii)); determining the eligibility of a low revenue ACO participating in the BASIC track for an opportunity to share in savings even if it does not meet the MSR (§ 425.605(h)); and determining the applicability of an alternative performance payment limit or loss recoupment limit for an ACO with fewer than 5,000 assigned beneficiaries in any benchmark year (§§ 425.605(i) and 425.610(l)).

The size of the ACO's assigned population is the basis for our determinations related to participation requirements and payment methodologies. For instance, we evaluate whether an

ACO meets the requirement to have at least 5,000 assigned beneficiaries to be eligible to participate in the Shared Savings Program (§§ 425.110 and 425.600(h)(3)). We also use the ACO's number of assigned beneficiaries in repayment mechanism amount calculations (§ 425.204(f)), and in determining expenditures based on the ACO's assigned population when identifying if the ACO is a high revenue or low revenue ACO (as defined under § 425.20) for purposes of determining an ACO's eligibility for the Advance Investment Payment option (§ 425.630(b)(4)).

The ACO's assigned population informs the amount of quarterly advance investment payments (§ 425.630(b) and (f)) and prepaid shared savings (§ 425.640(f) and (h)) for eligible ACOs. Elsewhere in this proposed rule we are proposing to amend the quarterly advance investment payment calculation methodology (section III.G.7.) and discontinue availability of the option for prepaid shared savings (section III.G.6.b.).

The assigned population is central to other programmatic areas, including quality and financial extreme and uncontrollable circumstances policies (see § 425.512(c)(1)(i); see also §§ 425.605(f)(1)–(2) and 425.610(i)(1)–(2)), and CMS's provision of beneficiary-identifiable data and aggregate reports to ACOs under subpart H.

(d) Beneficiaries Excluded from the Assigned Population under the Current Assignment Methodology Based on the Assignment Calculations and Medicare Enrollment Status

As previously noted in the background discussion in section III.G.2.a.(1) of this proposed rule, current policies exclude beneficiaries from assignment when, for example, a non-ACO TIN is determined to provide the plurality of a beneficiary's primary care services as a result of ACO professionals billing primary care services for the beneficiary inside and outside the ACO, or when we determine a beneficiary is ineligible for assignment based on Medicare enrollment status. Our estimates, based on simulations using PY 2024 data, suggest the former leads to approximately 97,800 beneficiary person years not being assigned to an ACO due to non-ACO TIN being identified as providing the plurality of the beneficiary's primary care services, and the

latter leads to approximately 248,000 beneficiary person years not being assigned due only to their Medicare enrollment status.[228]

We are currently seeking approaches to expand the population of Medicare FFS beneficiaries for which ACOs are accountable for quality and cost of care. ACOs provide high-quality care to people with Medicare, and they are a critical tool to help Make America Healthy Again by supporting whole person care that addresses prevention, chronic illness and the root causes of disease, and achieving savings for the Medicare Trust Funds.[229] As described in section III.G.1.a. of this proposed rule, as part of our effort to align spending and value in OM, we are focused on developing policies that would grow the number of Medicare FFS beneficiaries in accountable care relationships and grow savings to the Medicare Trust Funds.

Since PY 2024, we have seen the number of beneficiaries assigned to Shared Savings Program ACOs steadily increase.[230] As of January 1, 2024, 10.8 million beneficiaries were initially assigned to 480 ACOs. As of January 1, 2025, 11.2 million beneficiaries were initially assigned to 477 Shared Savings Program ACOs. As of January 1, 2026, Shared Savings Program ACOs are serving 12.6 million beneficiaries that were initially assigned to 511 ACOs, a 12.3 percent increase from 2025, and the largest number ever served by the Shared Savings Program.[231] However, the number of beneficiaries assigned to Shared Savings Program ACOs remains a fraction of the larger OM population. Based on an internal analysis, for PY 2024,

---

[228] Person years represents the sum of fractions of the year during which beneficiaries were enrolled in one of four Medicare enrollment types (ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, and aged/non-dual eligible Medicare and Medicaid beneficiaries). In section III.G.2.a.(2)(b) of this proposed rule, we describe in greater detail our consideration of Shared Savings Program-eligible months in identifying beneficiaries eligible for assignment.

[229] See CMS, Fact Sheet, "2026 Medicare Accountable Care Organization Initiatives Participation Highlights" (February 4, 2026), available at *https://www.cms.gov/newsroom/fact-sheets/2026-medicare-accountable-care-organization-initiatives-participation-highlights.*

[230] See "Shared Savings Program Fast Facts – As of January 1, 2026", available at *https://www.cms.gov/files/document/2026-shared-savings-program-fast-facts.pdf* (specifying the count of beneficiaries initially assigned to ACOs for each performance year). Performance year specific "Fast Facts" are available through the Medicare Shared Savings Program website, Program Data web page at *https://www.cms.gov/medicare/payment/fee-for-service-providers/shared-savings-program-ssp-acos/data*. See also the "Fast Facts Archives" (zip file), available at https://www.cms.gov/files/zip/fast-facts-archives.zip.

[231] CMS, Fact Sheet, "2026 Medicare Accountable Care Organization Initiatives Participation Highlights" (February 4, 2026), available at *https://www.cms.gov/newsroom/fact-sheets/2026-medicare-accountable-care-organization-initiatives-participation-highlights*.

about one-third (10.3 million) of the OM population (30.8 million) was assigned to an ACO participating under the Shared Savings Program.[232,233]

Our proposals to modify the Shared Savings Program assignment policies on plurality competition and assignment eligibility criteria based on Medicare enrollment status represent an opportunity to make meaningful steps toward achieving our stated goals around growing the number of Medicare FFS beneficiaries involved in accountable care relationships and also to further strengthen Shared Savings Program policies. Regarding the latter, as described further in section III.G.2.a.(2)(a) of this proposed rule, our proposed changes to assignment calculations would reduce the potential for ACO professionals' billing patterns inside and outside the ACO for the care of the same beneficiaries to result in differences in assignment outcomes that advantage the ACO's financial performance. As described in section III.G.2.a.(2)(b) of this proposed rule, our proposed changes to the assignment eligibility criteria and prospective assignment exclusion criteria based on Medicare enrollment status to align with the approach to identifying the assignable population would allow for greater symmetry between the ACO assigned population and the assignable population, and help ensure consistency between Shared Savings Program calculations used in determining ACO financial performance.

(2) Proposed Revisions

(a) Proposal to Exclude from Assignment Calculations Allowed Charges for Primary Care Services Billed Through a Non-ACO TIN by an ACO Professional Used in Assignment

As described in section III.G.2.a.(1)(a)(ii) of this proposed rule, in claims-based assignment calculations for a beneficiary we consider allowed charges for primary care services furnished by an ACO professional billed through an ACO participant TIN (that is, inside the

---

[232] See, for example, Medicare Shared Savings Program, Performance Year Financial and Quality Results, Public Use File for PY 2024, available at *https://data.cms.gov/medicare-shared-savings-program/performance-year-financial-and-quality-results* (including a variable "Total Assigned Beneficiaries", specifying number of assigned beneficiaries for PY 2024, which summed across ACOs reconciled for PY 2024 totals 10,326,340).

[233] For purposes of this analysis, the total population of 30.8 million includes all beneficiaries with at least 1 month of Part A and Part B enrollment and no Medicare group (private) health plan enrollment (including MA) in that same month during the year.

ACO), and allowed charges for primary care services furnished by the same ACO professional billed through a non-ACO TIN (that is, outside the ACO). Under current assignment polices, it is possible that a beneficiary may not be assigned to an ACO, despite choosing to receive care from the same physician or non-physician practitioner, only because of a difference in the TIN through which the services are being billed.

We propose to amend the Shared Savings Program assignment methodology to address the circumstance under which ACO professionals used in assignment bill primary care services for a beneficiary through an ACO participant TIN and non-ACO TIN. More specifically, we propose to remove from assignment calculations for purposes of plurality competition in step 1 under § 425.402(b)(3), step 2 under § 425.402(b)(4), and step 3 under § 425.402(b)(5)(iv), allowed charges for primary care services billed through a non-ACO TIN by an ACO professional used in assignment.

This proposed change would only impact the determination of assignment under the Shared Savings Program, and would not change how assigned beneficiary expenditures are calculated under the Shared Savings Program's financial methodology, for a benchmark year (in accordance with § 425.652(a)) or performance year (in accordance with §§ 425.605(a) and 425.610(a)). Under this proposal, assigned beneficiary expenditures for purposes of Shared Savings Program financial calculations would continue to include payment amounts for primary care services furnished to an assigned beneficiary billed through an ACO participant or non-ACO TIN, among other payment amounts.

We also note that under this proposed approach, ACO professionals may continue to bill under several different TINs, such as ACO participants in multiple ACOs or both ACO participants and non-ACO providers and suppliers. This proposed change would not impact an ACO professional's ability to receive FFS payment for primary care services billed through an ACO participant or non-ACO TIN.

We provide the following hypothetical examples to illustrate the outcome of plurality competition under the current approach and the proposed revised approach. In these illustrations, for simplicity, we assume the beneficiary meets the assignment eligibility criteria and therefore could be assigned to an ACO based on the outcome of plurality competition.

As one example, consider a beneficiary for which ACO professionals used in assignment billed primary care services through an ACO participant in ACO A and a non-ACO TIN, and the sum of allowed charges for this beneficiary for these services is greater for the billings through the non-ACO TIN than through the ACO. For instance, ACO professionals billed primary care services through an ACO participant in ACO A, resulting in allowed charges of $100 for each of three services, totaling $300. For this same beneficiary, ACO professionals in ACO A also billed primary care services to a non-ACO TIN, resulting in allowed charges of $100 for each of four services, totaling $400. Under our existing policy, we would determine that the non-ACO TIN provided the plurality of the beneficiary's primary care services, because it provided the greatest amount of allowed charges for the beneficiary, and as a result the beneficiary would not be assigned to ACO A. Under the proposed approach, we would exclude from plurality competition the allowed charges of $400 which the ACO professionals in ACO A billed through the non-ACO TIN. As a result, under the proposed approach, ACO A would be determined to have provided the plurality of allowed charges for primary care services for the beneficiary, and we would assign the beneficiary to ACO A.

As a second example, consider a beneficiary for which ACO professionals used in assignment billed primary care services through ACO participants in two different ACOs (ACO A and ACO B), and a non-ACO TIN, and the sum of allowed charges for this beneficiary for these services is greater for the billings through the non-ACO TIN than through either ACO. For instance, ACO professionals billed primary care services for the beneficiary through an ACO participant in ACO A, resulting in allowed charges of $100 for each of three services, totaling $300. These ACO professionals also billed primary care services for the beneficiary through an

ACO participant in ACO B, resulting in allowed charges of $100 for each of two services, totaling $200. These same ACO professionals billed primary care services for the beneficiary to a non-ACO TIN, resulting in allowed charges of $100 for each of four services, totaling $400. Under our existing policy, we would determine that the non-ACO TIN provided the plurality of the beneficiary's primary care services, and as a result the beneficiary would not be assigned to an ACO. Under the proposed approach, we would exclude from plurality competition the allowed charges of $400 which the ACO professionals in ACO A and ACO B billed through the non-ACO TIN. As a result, we would decide the outcome of plurality competition between ACO A ($300 in allowed charges) and ACO B ($200 in allowed charges), and determine that ACO A provided the plurality of allowed charges for primary care services for the beneficiary, and we would assign the beneficiary to ACO A.

As a third example, consider a beneficiary for which an ACO professional used in assignment billed primary care services through an ACO participant in ACO A and a non-ACO TIN, and for which other health care providers unaffiliated with an ACO are also billing primary care services for the beneficiary through a non-ACO TIN, and the sum of allowed charges for this beneficiary for these services is greater for the billings through the non-ACO TIN than the ACO. For instance, an ACO professional billed primary care services through an ACO participant in ACO A, resulting in allowed charges of $100 for each of three services, totaling $300. For this same beneficiary, an ACO professional in ACO A also billed primary care services to a non-ACO TIN, resulting in allowed charges of $100 for one service. Additionally, allowed charges of $100 for each of five services, totaling $500, were billed through the non-ACO TIN by a primary care physician who is unaffiliated with any ACO. Under our existing policy, we would determine that the non-ACO TIN provided the plurality of allowed charges for primary care services for the beneficiary, and as a result the beneficiary would not be assigned to ACO A. Under the proposed approach, we would exclude from plurality competition the allowed charges of $100 which the ACO professional billed through the non-ACO TIN. In this

hypothetical example, the outcome of plurality competition would not change under the proposed approach, as we would still determine that the non-ACO TIN provided the plurality of allowed charges for primary care services for the beneficiary, and the beneficiary would not be assigned to ACO A.

We note that if an ACO professional bills under ACO participants in multiple ACOs, but not to a non-ACO TIN, we do not anticipate the proposed change would impact the outcome of the plurality competition (compared to our current approach).

As illustrated in the examples above, this proposed approach would reduce the likelihood that we would determine the beneficiary's plurality of allowed charges for primary care services to be attributed to a non-ACO TIN or non-ACO CCN and increase the likelihood that a beneficiary is assigned to an ACO. Based on our simulations of this proposed approach described in section III.G.2.a.(2)(c) of this proposed rule, we observed that nearly all ACOs (462 of 476 ACOs or 97 percent) would experience a relatively small increase in their assigned population (less than 1 percent growth). We observed the remaining 3 percent of ACOs would experience growth in their assigned population ranging from 4 percent to 12 percent. We also observed that on average the beneficiaries added to assignment with this proposed change have higher cost and higher risk scores. This latter point highlights that the existing assignment methodology includes vulnerabilities that could lead ACOs, ACO participants or their ACO professionals to avoid at-risk beneficiaries (as defined in § 425.20). We explore related considerations in the discussion that follows.

Shared Savings Program policies include certain safeguards against ACO avoidance of at-risk beneficiaries. Specifically, section 1899(d)(3) of the Act, and related regulations under § 425.316(b), authorize us to monitor for ACO avoidance of at-risk beneficiaries. If we discover that an ACO has engaged in the avoidance of at-risk beneficiaries, we can impose remedial action or terminate the ACO, in accordance with § 425.316(b)(2).

There may be multiple possible pathways for an ACO to engage in strategic patient risk selection.[234] In recent years, we have engaged in monitoring to identify potential patient risk selection behavior by ACOs. Our monitoring and compliance processes for identifying and addressing ACO avoidance of at-risk beneficiaries can be resource intensive. We believe that the proposed change to determining the outcome of plurality competition within the assignment methodology would allow for a more efficient solution to mitigate a mechanism for ACOs, ACO participants, or their ACO professionals to avoid accountability for the quality and cost of care for high-cost at-risk beneficiaries. A pattern of billing by ACO professionals used in assignment resulting in a population of relatively higher costs beneficiaries not being assigned to the ACO could provide a mechanism for the ACO to achieve lower PY expenditures as compared to its historical benchmark, thereby potentially increasing its savings or decreasing its losses. An ACO avoiding assignment of high-cost beneficiaries under the Shared Savings Program reduces the cost effectiveness of coordinated care and shared savings initiatives, limiting savings for the Trust Funds, and potentially limiting improvements in quality of care and outcomes that could result for the patient. We are concerned that the provisions addressing avoidance of at-risk beneficiaries under section 1899(d)(3) of the Act and § 425.316(b), entail an ACO-specific analysis which may not serve as an adequate deterrent against the aforementioned concerns about ACO professionals billing patterns for the care of the same beneficiaries resulting in differences in assignment outcomes that advantage the ACO's financial performance. In comparison, the proposed approach to modifying plurality competition would result in a program-wide change which would be implemented with each assignment run, which we believe will largely resolve our concerns.

We believe the proposal to exclude from assignment calculations allowed charges for primary care services furnished by an ACO professional used in assignment billed through a

---

[234] See, for example, McWilliams JM, et al. "Savings or Selection? Initial Spending Reductions in the Medicare Shared Savings Program and Considerations for Reform." *Milbank Q.* 2020 Sep;98(3):847-907, available at https://onlinelibrary.wiley.com/doi/10.1111/1468-0009.12468.

non-ACO TIN offers a tailored approach to reduce the potential for ACO professionals' billing patterns, inside and outside the ACO for care of the same beneficiaries, to result in differences in assignment outcomes that advantage the ACO's financial performance. We recognize that the proposed approach could result in assignment of beneficiaries for which ACO professionals may be billing a greater amount of primary care services through non-ACO TINs, compared to ACO participant TINs. We recognize there could be appropriate billings by ACO professionals through multiple different TINs (inside and outside the ACO) for services furnished to a beneficiary, such as a result of the physician or non-physician practitioner working in more than one practice location, or reflective of multiple employment arrangements. Nonetheless, we believe it is appropriate to assign the beneficiary to an ACO under such circumstances. We believe that beneficiaries added to ACOs' assigned populations under the proposed changes in assignment would benefit from better care coordination and quality improvement activities through ACOs participating under Shared Savings Program requirements, and the proposed changes to assignment are estimated to result in higher net Federal savings (as described in section III.G.2.a.(2)(c) of this proposed rule). These potential benefits outweigh potential concerns that this approach minimizes our consideration of billing arrangements of ACO professionals through non-ACO TINs.

We acknowledge a possibility that ACOs, ACO participants, or their ACO professionals, and non-ACO TINs may have relied on the existing program policy to structure arrangements in which ACO professionals bill inside and outside the ACO for the care of the same beneficiary. However, we do not believe any such reliance interests outweigh our concerns about the potential for ACOs and other providers/suppliers to exploit a vulnerability with the existing Shared Savings Program assignment methodology, and the potential benefits for beneficiaries and the Trust Funds of the proposed modifications to the plurality competition, as we describe elsewhere in section III.G.2.a. of this proposed rule.

We propose to apply this revised approach to determining assignment for the PY starting on January 1, 2028, and subsequent PYs. We discuss the proposed timing of applicability further in section III.G.2.a.(2)(d) of this proposed rule, including use of the same assignment rules in determining beneficiary assignment for purposes of benchmark calculations as would apply in the PY.

We propose to revise and republish § 425.402(b)(3), (b)(4), and (b)(5)(iv), with new provisions added to steps 1, 2, and 3 of the claims-based assignment methodology (respectively). As proposed, these provisions would continue to specify the existing approach to comparing allowed charges for primary care services furnished to a beneficiary by certain ACO professionals in an ACO with allowed charges for primary care services furnished by the same type of health care providers who are either (1) ACO professionals in any other ACO, or (2) not affiliated with any ACO and identified by a Medicare-enrolled billing TIN. We propose to revise these paragraphs to add provisions, applicable for performance year 2028 and subsequent performance years, specifying how we identify and exclude from assignment allowed charges for primary care services billed by an ACO professional used in assignment under a Medicare-enrolled billing TIN unaffiliated with any ACO (for brevity referred to in the proposed regulation as a "non-ACO TIN") during the applicable assignment window. To follow is a summary of the proposed amendments to § 425.402(b)(3), (b)(4), and (b)(5)(iv).

We propose to revise § 425.402(b)(3), specifying assignment step 1 as follows:

- We propose to specify the existing provisions of assignment step 1 under paragraph (b)(3) in new paragraph (b)(3)(i), and also redesignate existing paragraphs (b)(3)(i) and (ii) as paragraphs (b)(3)(i)(A) and (B) (respectively).

- Under new paragraph (b)(3)(ii), we propose to specify that for performance year 2028 and subsequent performance years, if an ACO professional for which we identify a primary care service under § 425.402(b)(2) also bills primary care services under a Medicare-enrolled billing TIN unaffiliated with any ACO, then we would exclude from consideration in assignment under

proposed new § 425.402(b)(3)(i) the allowed charges for primary care services billed by the ACO professional under the non-ACO TIN during the applicable assignment window.

We propose to revise § 425.402(b)(4), specifying *assignment* step 2 as follows:

- We propose to specify the existing provisions of assignment step 2 under paragraph (b)(4) in new paragraph (b)(4)(i), and also redesignate existing paragraphs (b)(4)(i) and (ii) as paragraphs (b)(4)(i)(A) and (B) (respectively).

- Under new paragraph (b)(4)(ii), we propose to specify that for performance year 2028 and subsequent performance years, if an ACO professional for which we identify a primary care service under § 425.402(b)(2) also bills primary care services under a Medicare-enrolled billing TIN unaffiliated with any ACO, then we would exclude from consideration in assignment under proposed new § 425.402(b)(4)(i) the allowed charges for primary care services billed by the ACO professional under the non-ACO TIN during the applicable assignment window.

We propose to revise § 425.402(b)(5)(iv), the provision of assignment step 3 in which we determine which ACO or non-ACO entity provided a beneficiary's plurality of allowed charges for primary care services, as follows:

- We propose to specify the existing provisions of under paragraph (b)(5)(iv) in new paragraph (b)(5)(iv)(A), and also redesignate existing paragraphs (b)(5)(iv)(A) and (B) as paragraphs (b)(5)(iv)(A)(*1*) and (*2*) (respectively).

- Under new paragraph (b)(5)(iv)(B), we propose to specify that for performance year 2028 and subsequent performance years, if an ACO professional for which we identify a primary care service under § 425.402(b)(5)(iii) also bills primary care services under a Medicare-enrolled billing TIN unaffiliated with any ACO, then we would exclude from consideration in assignment under proposed new § 425.402(b)(5)(iv)(A) the allowed charges for primary care services billed by the ACO professional under the non-ACO TIN during the applicable expanded window for assignment.

As we have described in section III.G.2.a.(1) of this proposed rule, in determining claims-based assignment, we consider allowed charges for primary care services billed through physicians and non-physician practitioners, as well as FQHCs, RHCs, Method II CAHs, and ETA hospitals (as identified by CCN). The more general language of the proposed new provisions of the regulations in § 425.402(b)(3), (b)(4), and (b)(5)(iv) describing exclusion from assignment calculations of allowed charges for primary care services billed by an ACO professional (physicians and non-physician practitioners) used in assignment through a non-ACO TIN is inclusive of primary care services billed through a non-ACO CCN enrolled under the non-ACO TIN. To the extent the ACO professional is billing primary care services through an ACO participant TIN and a non-ACO CCN, this proposed approach would also exclude from plurality competition the allowed charges billed through the non-ACO CCN.

We seek comment on the proposed change to the step-wise assignment methodology under which we would exclude allowed charges for primary care services billed through a non-ACO TIN by an ACO professional used in assignment, and related proposed changes to the Shared Savings Program regulations at § 425.402(b)(3) (applicable to step 1), (b)(4) (applicable to step 2), and (b)(5)(iv) (applicable to step 3), as revised and republished. We seek comment on the proposal to apply this approach in determining Shared Savings Program assignment for the PY starting on January 1, 2028, and subsequent PYs.

(b) Proposal to Modify Assignment Eligibility Criteria and Prospective Assignment Exclusion Criteria Based on Medicare Enrollment Status

In this section, we provide additional background on the development of the Shared Savings Program's assignment eligibility criteria and prospective assignment exclusion criteria; revisit key considerations informing the development of our existing policies, and discuss factors informing our proposal to modify these policies; and describe our proposal to modify the assignment eligibility criteria and prospective assignment exclusion criteria based on Medicare enrollment status.

As we explained in the December 2014 proposed rule (79 FR 72790 through 72791) and June 2015 final rule (80 FR 32743 through 32744), the assignment eligibility criteria we proposed and finalized were consistent with criteria we established to operationalize the Shared Savings Program's assignment methodology finalized with the November 2011 final rule. We referenced a detailed specifications document, which included information regarding the beneficiary assignment process, that we made available to the public on the CMS website.[235,236]

In the December 2014 proposed rule (79 FR 72791), we explained that to determine whether a beneficiary is eligible to be assigned to an ACO, we must have information about the beneficiary's Medicare enrollment status. We explained that as required by section 1899(h)(3) of the Act, and consistent with the definition of Medicare FFS beneficiary in § 425.20, only beneficiaries enrolled in traditional Medicare FFS under Parts A and B are eligible to be assigned to an ACO participating in the Shared Savings Program. In the December 2014 proposed rule (79 FR 72791), we proposed that beneficiaries who have coverage under only one of these parts (Part A or Part B) would not be eligible to be assigned to an ACO, because of the statutory definition for Medicare FFS beneficiary and because an important objective of the Shared Savings Program is to help align incentives between Part A and Part B.

Further, in the December 2014 proposed rule (79 FR 72791), we explained that beneficiaries enrolled in a group health plan including beneficiaries enrolled in MA plans under

---

[235] Between May 2012 and December 2014, CMS issued and updated the initial versions of the Shared Savings Program's "Shared Savings and Losses and Assignment Methodology Specifications", which included specifications for beneficiary assignment and the shared savings and losses calculations under the program. The specifications, and the CMS webpage where the document has been posted, have been updated over time. The earlier versions of the document are maintained in the ACO Management System (ACO-MS) Knowledge Library (accessible to ACOs) at *https://acoms.cms.gov/knowledge-management/view/8320*. The "Shared Savings and Losses, Assignment and Quality Performance Standard Methodology Specifications" documents for current years are available on "Program Guidance & Specifications" webpage of the Shared Savings Program's website at *https://www.cms.gov/medicare/payment/fee-for-service-providers/shared-savings-program-ssp-acos/guidance-regulations*.

[236] The Physician Group Practice (PGP) demonstration, authorized under section 1866A of the Act, was implemented by CMS from April 2005 through March 2010, and served as a model for many aspects of the Shared Savings Program (see, for example, 76 FR 67833). Although not expressly stated in earlier rulemaking, the assignment eligibility criteria initially established under the Shared Savings Program closely tracked the parameters for the assignment methodology under the PGP demonstration. See for example, Kautter, J. et al. (RTI International), "Physician Group Practice Demonstration Bonus Methodology Specifications" (December 20, 2004), available at *https://www.cms.gov/priorities/innovation/files/x/pgp-payment.pdf* (Section 3.1 Assignment Criteria, pages 9-10).

Part C, eligible organizations under section 1876 of the Act, and Programs of All-Inclusive Care for the Elderly (PACE) under section 1894 of the Act are also not eligible to be assigned. In the June 2015 final rule (80 FR 32745), we summarized and responded to comments suggesting that the criterion that a beneficiary not have any months of Medicare group (private) health plan enrollment during the assignment window be revised to not more than 3 to 6 months, to account for certain situations where beneficiaries, such as dual eligible beneficiaries, might change, enroll in or disenroll from plans more frequently. The comments explained that this would allow such beneficiaries to remain attributed to the ACO. In our response we explained that section 1899(c) of the Act requires the Secretary to determine an appropriate method to assign Medicare FFS beneficiaries to an ACO. We then explained that as required by section 1899(c) of the Act, and consistent with the definition of Medicare FFS beneficiary under section 1899(h)(3) of the Act and § 425.20 of the Shared Savings Program regulations, our policy provided that only beneficiaries enrolled in traditional Medicare FFS under Parts A and B are eligible to be assigned to an ACO participating in the Shared Savings Program. We explained our belief that such policy was consistent with these requirements because under such approach only beneficiaries enrolled in traditional Medicare FFS under Parts A and B "throughout the full performance year" would be eligible to be assigned to an ACO. At the time, we declined to revise our policy in response to the commenters' concerns, but specified our plan to consider this issue further, and potentially address the issue in future rulemaking. We have not revisited these topics in subsequent rulemaking.

We have continued to consider our approach to determining the eligibility of Medicare FFS beneficiaries for assignment. In considering whether to propose revising our approach, we revisited key considerations informing the development of these policies.

The first consideration informing the development of our eligibility criteria was consistency with the definition of a Medicare FFS beneficiary under section 1899(h)(3) of the Act. While we maintain that our existing policies for determining eligibility for assignment are

consistent with such definition, we acknowledge that these eligibility criteria potentially operate to exclude from eligibility for assignment beneficiaries that may satisfy this definition.

Section 1899(h)(3) of the Act defines a "Medicare fee-for-service beneficiary" as an individual who is enrolled in the original Medicare FFS program under Parts A and B and is not enrolled in an MA plan under Part C, an eligible organization under section 1876 of the Act, or a PACE program under section 1894 of the Act. In the prior rulemaking discussed previously in this section, we adopted restrictive eligibility criteria under the assignment methodology we established under section 1899(c) of the Act. Under this approach, a beneficiary is eligible for assignment only if, during the 12-month assignment window (as defined under § 425.20, and described in section III.G.2.a.(1) of this proposed rule), the beneficiary has at least 1 month of Part A and Part B enrollment, but no month of Part A only or Part B only enrollment, and no month of Medicare group health plan enrollment. The requirements excluding from eligibility for assignment Medicare FFS beneficiaries that have a month of Part A only or Part B only enrollment, or Medicare group health plan enrollment during the assignment window are consistent with, but not required by, section 1899(h)(3) of the Act. In our response to comments included in the June 2015 final rule (80 FR 32745), we did not disagree that it could be permissible under section 1899(h)(3) of the Act for beneficiaries with some months of Medicare group health plan enrollment to be eligible for assignment by noting our intention to potentially address this issue in future rulemaking. Moreover, in earlier rulemaking, we did not specify that the more restrictive view we took towards identifying beneficiaries eligible to be assigned based on Medicare enrollment status was the only possible approach to operationalizing identification of a Medicare FFS beneficiary under the definition of section 1899(h)(3) of the Act for assignment under section 1899(c) of the Act.

The second consideration was that an objective of the Shared Savings Program is to help align incentives between Part A and Part B. The Shared Savings Program's financial methodology similarly reflects the alignment of Part A and Part B incentives and the

composition of the ACO's assigned population, in that we only consider expenditures for months during which the beneficiary was enrolled under both Parts A and B[237] in determining benchmark year and performance year expenditures. We acknowledge that the existing assignment eligibility criteria based on Medicare enrollment status, in which we require a beneficiary to have at least 1 month of Part A and Part B enrollment, but no month of Part A only or Part B only enrollment, and no month of Medicare group health plan enrollment during the assignment window, is not the only way to further the objective to align incentives between Parts A and B. For instance, this alignment would be achieved under an approach that allows for beneficiaries to be eligible for assignment if they have at least 1 month of Part A and B enrollment during the assignment window in combination with the existing approach to determining the beneficiary's expenditures for the same month(s) the beneficiary was enrolled in Part A and B.

Based on this reconsideration and to increase the number of Medicare FFS beneficiaries in accountable care relationships, we are proposing to expand the criteria for assignment eligibility to permit assignment of a Medicare FFS beneficiary with at least 1 month of Part A and Part B enrollment during the assignment window and no Medicare group health plan enrollment during that same month. We believe this proposed approach would retain consistency with section 1899(h)(3) of the Act and further the Shared Savings Program's stated objective of aligning incentives between Part A and Part B. This proposed modification to the assignment eligibility criteria and prospective assignment exclusion criteria would incrementally increase the assigned population and be aligned with our goal of growing the number of Medicare FFS beneficiaries involved in accountable care relationships (described in section III.G.2.a.(1)(d) of this proposed rule). Additionally, as we address in the following discussion, this proposed

---

[237] For a description of how CMS annualizes the assigned beneficiary's expenditures, refer to Medicare Shared Savings Program, "Shared Savings and Losses, Assignment and Quality Performance Standard Methodology Specifications" (April 2026, Version #14), available at *https://www.cms.gov/files/document/medicare-shared-savings-program-shared-savings-losses-assignment-methodology-specifications-version.pdf-0* (Section 3.1.2 Annualizing Assigned Beneficiary Expenditures).

approach to identifying beneficiaries eligible for assignment based on Medicare enrollment status would align with our use of Shared Savings Program-eligible months in identifying beneficiaries eligible for assignment and calculation of assigned beneficiary expenditures using months of Part A and B enrollment, and bring greater symmetry to program calculations based on the assigned and assignable populations.

In determining assignment, we identify a beneficiary's Shared Savings Program-eligible months, in which the beneficiary is alive on the first of the month, enrolled in both Parts A and B, and not enrolled in a Medicare group health plan.[238] This results in assignment of beneficiaries with between 1 and 12 months of Parts A and B enrollment, so long as the remaining criteria under § 425.401(a) are met. There are various reasons for beneficiaries currently eligible for assignment to have fewer than 12 months of Parts A and B enrollment, including the timing of when the beneficiary becomes eligible for Medicare, and if a beneficiary dies during the period. We also use Shared Savings Program-eligible months for assigned beneficiaries in other Shared Savings Program operations, including to assign a monthly enrollment status to the beneficiary according to four Medicare enrollment types (ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, aged/non-dual eligible Medicare and Medicaid beneficiaries) and to calculate beneficiary person years.[239,240] The proposed approach to identifying beneficiaries as eligible for assignment if they have at least 1 month of Part A and Part B enrollment and no Medicare group health plan enrollment during that

---

[238] In the June 2015 final rule (80 FR 32745), we specified that only beneficiaries enrolled in traditional Medicare FFS under Parts A and B "throughout the full performance year" are eligible to be assigned to an ACO. However, this statement from earlier rulemaking does not always accurately reflect the Shared Savings Program's assignment operations in which we allow for an eligible beneficiary who has fewer than 12 months of enrollment in Parts A and B to be assigned to an ACO.

[239] To calculate person years: We sum the number of Shared Savings Program-eligible months for each assigned beneficiary for each Medicare enrollment type; we then divide this number by 12 (the number of months in a calendar year).

[240] See Medicare Shared Savings Program, "Shared Savings and Losses, Assignment and Quality Performance Standard Methodology Specifications" (April 2026, Version #14), available at *https://www.cms.gov/files/document/medicare-shared-savings-program-shared-savings-losses-assignment-methodology-specifications-version.pdf-0* (Section 3.1. Calculating ACO-Assigned Beneficiary Expenditures).

same month during the assignment window, would effectively expand the population of assigned beneficiaries who have fewer than 12 months of Parts A and B enrollment.

Under our existing approach we determine, based on the point in time assignment is run, whether a beneficiary meets the assignment eligibility criteria or must be excluded from the assigned population based on the criteria specified under § 425.401. In doing so we consider the beneficiary's eligibility throughout the applicable assignment window for the assignment run, using the relevant data available on Medicare enrollment status, overlap in assignment with other Medicare shared savings initiatives, and other factors.[241] We would maintain this approach, based on the point in time assignment is run, in implementing the proposed revised assignment eligibility criteria and prospective assignment exclusion criteria.

We also note that for beneficiaries assigned under the proposed eligibility criteria based on Medicare enrollment status, we would apply the existing approach to determine expenditures used in benchmark year and performance year expenditure calculations in which we only consider expenditures for months during which the beneficiary was enrolled under both Parts A and B. That is, we would not consider expenditures for months in which the beneficiary was enrolled under Part A only or Part B only. We also note that the Shared Savings Program financial calculations do not consider Part C claims data. We believe this modified approach would remain consistent with the program's objective to hold ACOs accountable for the total cost of the beneficiary's care as based in Parts A and B expenditures.

As described in section III.G.2.a.(1)(b) of this proposed rule, the assignable beneficiary population (as defined in § 425.20) is a subset of the larger population of Medicare FFS beneficiaries, as defined under section 1899(h)(3) of the Act and § 425.20. Operationally, this population includes beneficiaries that have at least 1 month of Part A and Part B enrollment and

---

[241] The Medicare Shared Savings Program, "Shared Savings and Losses, Assignment and Quality Performance Standard Methodology Specifications" (April 2026, Version #14), includes among other information, selected characteristics of Shared Savings Program ACO reports for ACOs under preliminary prospective assignment with retrospective reconciliation and for ACOs under prospective assignment (see Appendix F, Tables 14 and 15.)

no Medicare group health plan enrollment during that same month during the applicable 12-month assignment window. This approach to identifying Medicare FFS beneficiaries who meet the criteria for inclusion in the assignable population is less restrictive compared to the existing assignment eligibility criteria and prospective assignment exclusion criteria based on Medicare enrollment status. Applying a similar approach to identifying Medicare FFS beneficiaries eligible for assignment could bring greater symmetry to the composition of the assignable beneficiary population and the assigned population and thereby allow for more comparable calculations between factors based on assignable beneficiary expenditures used in establishing, adjusting and updating the ACO's historical benchmark and factors based on the ACO's assigned population (including benchmark year and performance year expenditures).

As described in the Regulatory Impact Analysis, in section VII of this proposed rule, as enrollment in MA has grown over recent years,[242] so has the number of beneficiaries switching back to OM from MA.[243] Our current eligibility criteria based on Medicare enrollment status restricts and delays the eligibility of such beneficiaries for assignment to ACOs. Allowing beneficiaries with at least one month of Part A and Part B enrollment and no Medicare group health plan enrollment during that same month during the assignment window to be eligible for assignment would allow us to more accurately account for when this population qualifies as Medicare FFS beneficiaries and, in turn, is included in ACO assignment, and encompass various circumstances around the timing of a beneficiary's enrollment in Medicare and changes in enrollment that result in a beneficiary having one or more months of Part A only or Part B only

---

[242] See, for example, Data.CMS.gov, Medicare Enrollment Dashboard, Medicare Enrollment for March 2026, available at https://data.cms.gov/tools/medicare-enrollment-dashboard (showing yearly trend data for MA, FFS, and Total, from 2013 through 2025).

[243] See Xu L, et al. "Medicare Switching: Patterns Of Enrollment Growth In Medicare Advantage, 2006–22". *Health Affairs* (September 5, 2023), available at https://doi.org/10.1377/hlthaff.2023.00224 (finding only slightly increasing number of switchers from MA to OM over 2020 to 2023 compared to earlier years, and includes Exhibit 3 indicating higher rates of switching from MA to FFS for disabled beneficiaries, full dual eligible beneficiaries, and beneficiaries with >3 HCC diagnostic codes in 2022). See also, Mackleby G, Liu A, and Trish E. "Switching Medicare Plans Outside Open Enrollment Was Increasingly Common, Especially Among Sicker Enrollees, 2015–22". *Health Affairs* (February 2, 2026), available at https://www.healthaffairs.org/doi/10.1377/hlthaff.2025.00915 (among MA enrollees, finding compared with Medicare open enrollment period switchers, alternative enrollment period switchers tended to have higher risk scores and hospitalization rates before switching).

enrollment, or Medicare group health plan enrollment.[244] We also note that the population of beneficiaries transitioning between MA and OM are captured in the assignable beneficiary population. In this respect, the proposed approach to align the assignment eligibility criteria and prospective assignment exclusion criteria with the approach we use to identify the assignable beneficiary population based on Medicare enrollment status serves an important purpose in resolving the asymmetry between the assigned and assignable populations which has grown over time in light of changes to Medicare enrollment trends.

ACOs may rely on programmatic data included in program reports and data files we deliver to ACOs (described in section III.G.2.a.(2)(d) of this proposed rule) to understand their assigned population, and the reason for beneficiaries' ineligibility for assignment, among other factors. Additionally, ACOs may be accustomed to coordinating care, reporting quality measures, and considering approaches to lowering growth in expenditures for Medicare beneficiaries eligible for assignment, which presently includes beneficiaries with at least 1 month of Part A and Part B enrollment, but no month of Part A only or Part B only enrollment, and no month of Medicare group health plan enrollment during the assignment. As described in section III.G.2.a.(2)(d) of this proposed rule, we anticipate updating the Shared Savings Program's publicly available specification documents, programmatic resources, and program reports to include information that would help ACOs understand their assigned population and the population of beneficiaries eligible to be assigned under the proposed revised assignment methodology (if finalized). Although we recognize it may take ACOs time to update their data systems and models for analysis of Shared Savings Program data, we do not believe this potential concern outweighs the reasons for proposing this change described elsewhere in section III.G.2.a of this proposed rule. We note that the proposal to apply the changes to the

[244] We note that there are a multitude of factors impacting the timing for when a beneficiary enrolls in OM or a MA plan, and the timing of when a beneficiary may change to a different MA plan or switch back to OM. Information on initial enrollment in OM and timing for when a beneficiary can join, switch, drop or make changes in their MA plan, is included in the Medicare & You Handbook (2026), available at *https://www.medicare.gov/publications/10050-medicare-and-you.pdf*.

beneficiary assignment methodology for the PY starting on January 1, 2028, and subsequent PYs, provides time for ACOs to prepare for any related changes.

We propose to revise the assignment eligibility criteria and prospective assignment exclusion criteria based on Medicare enrollment status under § 425.401, and to apply the revised criteria in determining assignment for the PY starting on January 1, 2028, and subsequent PYs. We discuss the proposed timing of applicability further in section III.G.2.a.(2)(d) of this proposed rule, including use of the same assignment rules in determining beneficiary assignment for purposes of benchmark calculations as would apply in the PY. The following is a description of the proposed criteria for a beneficiary to be assigned to an ACO for a PY or benchmark year which would apply for the PY starting on January 1, 2028, and subsequent PYs. Later in this section of this proposed rule, we detail our proposal to revise and republish § 425.401, including to incorporate the following new provisions.

Under new § 425.401(a)(2), we propose to specify the beneficiary assignment eligibility criteria applicable for the PY starting on January 1, 2028, and subsequent PYs. Accordingly, we propose a beneficiary may be assigned to an ACO under the assignment methodology in §§ 425.402 and 425.404, for a performance or benchmark year, if the beneficiary meets all of the following criteria during the assignment window:

- Has at least 1 month of Part A and Part B enrollment and does not have Medicare group (private) health plan enrollment during that same month during the assignment window.
- Is not assigned to any other Medicare shared savings initiative.
- Lives in the U.S. or U.S. territories and possessions, based on the most recent available data in our beneficiary records regarding the beneficiary's residence at the end of the assignment window.

We note that under the proposed approach to revising the assignment eligibility criteria based on Medicare enrollment status, we would continue to apply the existing criteria which ensure that a beneficiary is not assigned to any other Medicare shared savings initiative

(consistent with § 425.401(a)(3)), and lives in the U.S. or U.S. territories and possessions (consistent with § 425.401(a)(4)).

Under new § 425.401(b)(2), we propose to specify the prospective assignment exclusion criteria applicable for the PY starting on January 1, 2028, and subsequent PYs. Accordingly, we propose a beneficiary would be excluded from the prospective assignment list of an ACO that is participating under prospective assignment under § 425.400(a)(3) at the end of a performance or benchmark year and quarterly during each PY consistent with § 425.400(a)(3)(ii) if the beneficiary meets any of the following criteria during the performance or benchmark year:[245]

- Does not have at least 1 month of Part A and Part B enrollment without Medicare group (private) health plan enrollment during that same month during the assignment window.
- Did not live in the U.S. or U.S. territories and possessions, based on the most recent available data in our beneficiary records regarding the beneficiary's residency at the end of the year.

We note that under the proposed approach to revising the prospective assignment exclusion criteria, we would continue to apply the existing criterion to exclude from prospective assignment a beneficiary that did not live in the U.S. or U.S. territories and possessions (consistent with § 425.401(b)(3)).

More generally, we note that the assignment eligibility criteria and prospective assignment exclusion criteria under § 425.401 apply in determining beneficiaries assigned under claims-based assignment and voluntary alignment. We anticipate the proposed changes in criteria based on Medicare enrollment status would increase the population assigned under both methods.

[245] We omitted from this description the reference to applicability of the prospective assignment exclusion criteria for determining assignment to ACOs participating under a 6-month PY or performance period during CY 2019, under § 425.609(b)(1)(ii) and (c)(1)(ii) which is otherwise retained for completeness in the introductory text of § 425.401(b) (under the proposed amendments).

We propose to revise and republish § 425.401, to specify the existing criteria for a beneficiary to be assigned to an ACO for a performance or benchmark year apply to PYs starting prior to January 1, 2028 (as applicable), and to specify the proposed criteria applicable for the performance year starting on January 1, 2028, and subsequent performance years. The following list summarizes the proposed amendments to § 425.401:

- We propose to add subject headings to the introductory text of paragraphs (a) and (b) of § 425.401 to specify the following: paragraph (a) includes provisions with "Assignment eligibility criteria"; and paragraph (b) includes provisions with "Prospective assignment exclusion criteria".

- We propose to revise § 425.401(a)(1) to specify the provisions with assignment eligibility criteria applicable for PYs starting prior to January 1, 2028 (as applicable), by making the following amendments:

++ Redesignating paragraphs (a)(1)(i) and (ii) as paragraphs (a)(1)(i)(A) and (B) (respectively), and redesignating paragraphs (a)(2) through (a)(4) as paragraphs (a)(1)(ii) through (a)(1)(iv) (respectively).

++ Adding the following heading to introductory text of paragraph (a)(1), specifying the timing of applicability for the provisions: "For performance years starting prior to January 1, 2028 (as applicable)".

- We propose to add new paragraph (a)(2) with the assignment eligibility criteria applicable for the performance year starting on January 1, 2028, and subsequent performance years (previously described in this section of this proposed rule).

- We propose to revise § 425.401(b)(1) to specify the provisions with prospective assignment exclusion criteria applicable for performance years starting prior to January 1, 2028 (as applicable), by making the following amendments:

++ Redesignating paragraphs (b)(1)(i) and (ii) as paragraphs (b)(1)(i)(A) and (B) (respectively), and redesignating paragraphs (b)(2) and (b)(3) as paragraphs (b)(1)(ii) and (b)(1)(iii) (respectively).

++ Adding the following heading to introductory text of paragraph (b)(1), specifying the timing of applicability for the provisions: "For performance years starting prior to January 1, 2028 (as applicable)".

- We propose to add new paragraph (b)(2) with the prospective assignment exclusion criteria applicable for the PY starting on January 1, 2028, and subsequent PYs (previously described in this section of this proposed rule).

We also propose a technical and conforming change to cross-references to provisions of § 425.401 within § 425.612(a)(1)(iv)(A)(*2*), which describes certain conditions under which we make payments for SNF services furnished to a beneficiary preliminarily prospectively assigned to an ACO for which a waiver of the SNF 3-day rule was approved.

We seek comment on the proposed changes under which we would apply modified assignment eligibility criteria and prospective assignment exclusion criteria based on a beneficiary's Medicare enrollment status in determining assignment to an ACO for the performance year starting on January 1, 2028, and subsequent PYs. Under the proposed approach more beneficiaries would be eligible for assignment, and remain prospectively assigned to ACOs, under both claims-based assignment and voluntary alignment, than under current program policies. We seek comment on the proposed amendments to § 425.401 (as revised and republished), specifying the assignment eligibility criteria and prospective assignment exclusion criteria that would apply by PY, and the proposed technical and conforming change to cross-references to provisions of § 425.401 within § 425.612(a)(1)(iv)(A)(2).

(c) Simulations to Understand the Potential Effect of Proposed Changes

We performed separate simulations to understand the potential effect for each of the proposed changes to the assignment methodology.

Using PY 2024 data we simulated the impact of the proposed approach to excluding from assignment calculations allowed charges for primary care services billed through a non-ACO TIN by an ACO professional used in assignment (described in section III.G.2.a.(2)(a) of this proposed rule). The simulation was performed using data for all 476 ACOs reconciled for PY 2024. For purposes of the simulation, we made multiple simplifying assumptions. This included treating all ACOs as if they were under preliminary prospective assignment with retrospective reconciliation for purposes of identifying the impact on assignment and simplicity of simulating benchmark assignment. Since the proposed change is to plurality competition we would anticipate a comparable impact if we performed the simulation using the off-set assignment window. For simulating financial impacts, we assumed all ACOs to be starting their first agreement period on January 1, 2024, to have benchmark years of BY 2021, 2022 and 2023, and applied an equal weight to each BY in benchmark calculations. In approximating the benchmark calculations under the simulations we applied the benchmarking methodology applicable for ACOs entering an agreement period beginning on January 1, 2024 under §§ 425.652 through 425.660, with several exceptions. In adjusting the benchmark to account for changes in severity and case mix of the assigned beneficiary between BY3 and PY 2024 under § 425.652(a)(10), we applied the approach to capping positive adjustments at 3 percent in accordance with §§ 425.605(a)(1)(i) and 425.610(a)(2)(i) rather than the demographic plus 3 percent cap specified under §§ 425.605(a)(1)(ii) and 425.610(a)(2)(ii). We also simulated the updated benchmark using a one-third weight for the ACPT component of the three-way blended update factor, although a one-sixth weight was applied in determining financial reconciliation for PY 2024, as described in section III.G.5.g of this proposed rule. In simulating the updated benchmark calculations we did not apply the existing guardrail policy specified in § 425.652(b)(5), which ensures that the use of the three-way blended update factor will not result in lower benchmarks than the two-way national-regional blended update factor in a way that poses higher financial risk for ACOs under two-sided models, or that could jeopardize an ACO's

continued participation in the Shared Savings Program under the financial performance monitoring policy described in § 425.316(d), or both.[246]

Under these simulations, we observed that the proposed change to the plurality competition would add over 97,800 assigned beneficiary person years to Shared Savings Program assignment (nearly 1 percent growth). In simulations, we found that 462 of 476 ACOs (or 97 percent) observed less than 1 percent growth, while the remaining 14 out of 476 ACOs (3 percent) experienced growth greater than 4 percent, including one ACO that observed growth as large as 12 percent.

Under simulations of the financial impacts, using PY 2024 data, we calculated ACOs' updated benchmark expenditures minus PY expenditures, to estimate impacts on gross savings/losses; with a resulting reduction in this amount indicating potentially lower shared savings, and greater liability for shared losses. We found that ACOs observed an average 3.90 percent decrease in per capita gross savings/losses ($355 per capita) and an average 3.92 percent decrease in aggregate gross savings/losses. Average reductions in gross savings/losses were driven by two factors: (1) the simulated assignment method tended to add relatively more beneficiaries in the PY (2024) than they added in the benchmark years (2021, 2022, 2023); and (2) the added beneficiaries were substantially higher cost and had higher risk scores than beneficiaries assigned to ACOs under the existing assignment methodology. These two factors combined mean that ACOs' average benchmark expenditures increased by a relatively smaller degree than their PY expenditures increased, resulting in lower gross savings/losses.

Using PY 2024 data, we simulated the impact of the proposed approach to revising the assignment eligibility criteria and prospective assignment exclusion criteria based on Medicare enrollment status (described in section III.G.2.a.(2)(b) of this proposed rule). For purposes of simulating the proposed changes to the prospective assignment exclusion criteria based on

[246] See 87 FR 69885.

Medicare enrollment status, it was important to recognize the ACO's selection of assignment methodology, to be able to accurately observe the impact of the proposed change. Therefore, we performed separate simulations for ACOs based on their selection of assignment methodology. For ACOs under preliminary prospective assignment with retrospective reconciliation, we simulated the proposed change to assignment eligibility criteria using a 12-month assignment window that aligned with PY 2024. For ACOs under prospective assignment, we simulated the proposed change to assignment eligibility criteria using an offset assignment window from October 2022 through September 2023. In both cases, we identified beneficiaries with at least 1 month of Part A and Part B enrollment and no Medicare group health plan enrollment (including MA) during that same month during the applicable assignment window as being eligible for assignment. For ACOs under prospective assignment we further simulated application of the modified exclusion criteria applied at the end of PY 2024 based on CY 2024 data (making certain simplifying assumptions). To remain prospectively assigned under the simulated modified Medicare enrollment status criteria, the beneficiary had at least 1 month of Part A and Part B enrollment and no Medicare group health plan enrollment during the same month, during CY 2024. For simulating financial impacts, we made the same assumptions as previously described in this discussion used to simulate the impact of the proposed changes to plurality competition, with respect to identifying benchmark years and related weights for ACOs, as well as the benchmarking methodology that was applied including the approach to adjusting and updating the historical benchmark.

Based on our simulations, across all ACOs for PY 2024, we observe an increase of approximately 248,000 (2.45 percent) assigned beneficiary person years resulting from the proposed modifications to the assignment eligibility criteria and prospective assignment exclusion criteria based on Medicare enrollment status. We observed differing impacts on the assigned population for ACOs under prospective assignment versus preliminary prospective assignment with retrospective reconciliation, with the assigned population (in terms of assigned

beneficiary person years) increasing with final assignment by 2.25 percent versus 2.57 percent respectively. This difference is explained by the type of beneficiaries that are being added with use of modified assignment eligibility criteria and prospective assignment exclusion criteria based on Medicare enrollment status. We observed that a larger share of beneficiaries that are initially prospectively assigned were removed from final assignment because they transition to and remain in a Medicare group health plan during the PY.

Under simulations of the financial impacts of modifying assignment criteria based on Medicare enrollment status, using PY 2024 data, we calculated ACOs' updated benchmark expenditures minus PY expenditures, to estimate impacts on gross savings/losses; with a resulting reduction in this amount indicating potentially lower shared savings, and greater liability for shared losses. We found that on average ACOs' PY per capita expenditures increased slightly more (by 0.60 percent) than benchmark per capita expenditures increased (by 0.43 percent), resulting in $20 lower average per capita gross savings/losses (-6.62 percent). Overall impacts on aggregate gross savings/losses were also negative but relatively smaller, decreasing average ACO gross savings/losses and program-wide gross savings/losses by 3.20 percent.

We observed differences in average expenditures and risk scores by Medicare enrollment type (ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, aged/non-dual eligible Medicare and Medicaid beneficiaries) among the beneficiary population added with the simulated changes in assignment compared to the population already assigned. Related findings are summarized in Table B-G1. Within the ESRD enrollment type, we observed a disproportionately higher number of additional beneficiaries compared to the other enrollment types. The added population of ESRD beneficiaries had, on average, largely similar per capita expenditures and lower average risk scores than already assigned ESRD beneficiaries. Within the disabled and aged/dual eligible enrollment types, the added populations of beneficiaries had, on average, higher per capita expenditures and higher average risk scores than the corresponding

populations of already assigned beneficiaries. Within the aged/non-dual eligible enrollment type, the added population of beneficiaries had, on average, slightly lower per capita expenditures and lower average risk scores than already assigned aged/non-dual eligible beneficiaries.

TABLE B-G1: SIMULATION OF PROPOSED CHANGES TO ASSIGNMENT ELIGIBILITY CRITERIA - NUMBER AND CHARACTERISTICS OF BENEFICIARIES ADDED FOR PY 2024

	Assigned Population under Existing Eligibility Criteria	Assigned Population Added with Proposed Medicare Enrollment Status Criteria	Percent Difference
Mean Assigned Person Years	**21,241.8**	**531.8**	**2.50%**
ESRD	75.6	6.1	8.03%
Disabled	1,448.2	85.9	5.93%
Aged/Dual	1,143.7	88.1	7.70%
Aged/Non-Dual	18,574.3	351.7	1.89%
Mean Per Capita Expenditures	**$13,256**	**$15,433**	**16.42%**
ESRD	$95,405	$92,714	-2.82%
Disabled	$12,657	$16,797	32.71%
Aged/Dual	$19,287	$23,435	21.51%
Aged/Non-Dual	$12,594	$12,570	-0.19%
Mean CMS-HCC Risk Score	**0.993**	**0.899**	**-9.47%**
ESRD	0.969	0.955	-1.38%
Disabled	0.966	1.122	16.15%
Aged/Dual	0.962	1.005	4.50%
Aged/Non-Dual	1.003	0.852	-15.08%

Note: The reported "Percent Difference" may slightly differ from manual recalculation using other values reported in the table due to rounding.

For additional analysis on estimated impacts, we also refer readers to the Regulatory Impact Analysis in section VII. of this proposed rule. In the Regulatory Impact Analysis of this proposed rule, we describe the estimated financial impact of the proposed change to exclude from assignment calculations allowed charges for primary care services billed through a non-ACO TIN by an ACO professional used in assignment (described in section III.G.2.a.(2)(a) of this proposed rule), and the proposed changes to assignment eligibility criteria and prospective assignment exclusion criteria (described in section III.G.2.a.(2)(b) of this proposed rule). We explain that in combination the proposed changes to assignment would be estimated to result in higher net Federal savings, although the policies may also marginally decrease the number of ACOs participating in the Shared Savings Program as a result of assignment of higher cost beneficiaries to ACOs and reduced gross savings, while also increasing overall the number of beneficiaries assigned to Shared Savings Program ACOs. The collective proposed changes represent an opportunity to grow the number of Medicare FFS beneficiaries involved in

accountable care relationships, and drive savings, which would advance us towards our goal to align spending and value in OM, and related strategic objectives (described in section III.G.1.a. of this proposed rule). The proposed change to assignment calculations (described in section III.G.2.a.(2)(a) of this proposed rule) would reduce the potential for differences in billing patterns by ACO professionals (inside and outside the ACO), for care of the same beneficiaries, to result in differences in assignment outcomes that advantage the ACO's financial performance, in particular billing that results in non-assignment of higher cost and higher risk beneficiaries. The proposed changes to assignment eligibility criteria and prospective assignment exclusion criteria based on Medicare enrollment status (described in section III.G.2.a.(2)(b) of this proposed rule), would allow for greater symmetry between the ACO assigned population and the assignable population, and help ensure consistency between Shared Savings Program calculations used in determining ACO financial performance. At this juncture, we believe the considerations outweigh the concern about the potential for attrition from the Shared Savings Program by ACOs unwilling to be held accountable for the quality and cost of care of this population of Medicare beneficiaries.

We also note that we did not simulate the potential impact of the proposed changes to the assignment methodology on ACO quality performance. We refer readers to section III.G.3. of this proposed rule for a discussion of proposed changes to the Shared Savings Program quality performance standard and other quality reporting requirements. Given the relatively small increases in ACOs' assigned populations that are likely to result under the proposed changes to the assignment methodology, we anticipate there would be minimal impact on ACOs' reporting of quality measures for the expanded population of beneficiaries.

We seek comment on the potential effects of the proposed changes to the assignment methodology on the composition of ACOs' assigned populations and ACOs' financial and quality performance. We also seek comment on the potential for these proposed changes to have unintended consequences for participation by ACOs, ACO participants, and ACO professionals,

including with respect to their ability to meet Shared Savings Program goals for an expanded population of assigned beneficiaries which would result under the proposed changes to the Shared Savings Program assignment methodology.

(d) Implementation of Proposed Revisions to the Beneficiary Assignment Methodology

As described in sections III.G.2.a.(2)(a) and (b) of this proposed rule, we are proposing changes to the Shared Savings Program beneficiary assignment methodology that would be applicable to all ACOs for the PY starting on January 1, 2028, and subsequent PYs. In this section of this proposed rule, we discuss impacts on certain program operations in additional detail, specifically: (1) the timing of applicability for the proposed approach in connection with the timing of the annual application cycle for ACOs to enter a new agreement period under the Shared Savings Program; (2) applicability of the proposed approach to determining benchmark assignment and relatedly adjustments to historical benchmark calculations for ACOs participating in an existing agreement period; and (3) considerations specific to program reports and data which we make available to ACOs.

Consistent with how we have implemented previous changes to the Shared Savings Program assignment methodology, we would use the revised methodology each time assignment is determined for a given benchmark year or PY and, as applicable, to determine the eligibility of ACOs applying to enter into or renew participation in the Shared Savings Program. Regarding the latter, applicant eligibility for PY 2027 will be determined during CY 2026. We would not be able to review public comments and decide whether to finalize the proposed changes in sufficient time to apply the revised criteria for PY 2027 applications. We use estimates for the ACO's benchmark year assignment in multiple determinations during Phase 1 of the application cycle, which concludes in mid-October 2026, before the CY 2027 PFS final rule will likely be issued.[247] This includes, determining whether an ACO applicant meets the requirement for

[247] See Medicare Shared Savings Program, Key Application Actions and Deadlines For Agreement Periods Beginning on January 1, 2027, available at https://www.cms.gov/files/document/key-application-actions-deadlines.pdf.

having at least 5,000 assigned beneficiaries (refer to § 425.110(a)(1) and (a)(3)), determining whether an ACO meets the definition of a low revenue ACO for purposes of eligibility for the Advance Investment Payment option (refer to § 425.630(b)(4)), and calculating the ACO's repayment mechanism amount (refer to § 425.204(f)). Additionally, we anticipate that the proposed revised approach to determining beneficiary assignment described in section III.G.2.a. of this proposed rule, if finalized, would require significant operational changes to the Shared Savings Program assignment methodology, which would take time to prepare in advance of initial use of the approach during the application process. For these reasons, we would not be able to apply the revised beneficiary assignment methodology for the PY starting on January 1, 2027, and we are proposing to apply this change beginning with the PY starting on January 1, 2028.

Additionally, we would apply the proposed revised approach (if finalized) to determining beneficiary assignment in establishing, adjusting, updating, and resetting historical benchmarks for ACOs entering new agreement periods beginning on January 1, 2028, and in subsequent years. Also consistent with how we have implemented previous changes to the assignment methodology, we would adjust benchmarks at the start of PY 2028 for all ACOs in agreement periods for which PY 2028 is a second or subsequent PY. Accordingly, the ACOs' benchmarks would reflect the use of the same assignment rules as would apply in the PY (refer to § 425.652(a)(9)).

In accordance with the Shared Savings Program regulations under subpart H, we provide ACOs with certain aggregate reports and beneficiary-identifiable claims data on the ACO's assigned beneficiary population, to conduct health care operations work. We are committed to maintaining transparency of Shared Savings Program by providing ACOs with data related to the determination of their assigned population, and providing ACOs with data on their assigned population to aid in their operations under the Shared Savings Program. Under § 425.704, we provide ACOs with monthly claim and claim line feed (CCLF) files with beneficiary-identifiable

data, which include Parts A, B, and D data.[248] Further, in accordance with § 425.702, we provide ACOs with Shared Savings Program reports which include aggregate and beneficiary-identifiable information on their assigned population near the start of each PY, during each quarter, and in conjunction with annual financial reconciliation.[249,250] We anticipate updating the Shared Savings Program's publicly available specification documents, programmatic resources, and program reports to include information that would help ACOs understand their assigned population and the population of beneficiaries eligible to be assigned under the revised assignment methodology (if finalized).

b. Proposed Revisions to the Definition of Primary Care Services used in Shared Savings Program Beneficiary Assignment

(1) Background

Section 1899(c)(1) of the Act, as amended by the 21st Century Cures Act and the Bipartisan Budget Act of 2018, provides that the Secretary shall determine an appropriate method to assign Medicare FFS beneficiaries to an ACO based on their utilization of primary care services provided by physicians in the ACO who are ACO professionals and, in the case of PYs beginning on or after January 1, 2019, services provided by a FQHC or RHC. However, the statute does not specify a list of services considered to be primary care services for purposes of beneficiary assignment.

In the November 2011 final rule (76 FR 67853), we established the initial list of services, identified by Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes, that we considered to be primary care services. In that final rule, we

---

[248] See for example, CMS, "Accountable Care Organization – Operational System (ACO-OS), Claim and Claim Line Feed (CCLF) Information Packet (IP)" (version 43.0, 5/13/2026), available at *https://www.cms.gov/files/document/cclf-information-packet.pdf*.

[249] See, for example, Medicare Shared Savings Program, "Shared Savings and Losses, Assignment and Quality Performance Standard Methodology Specifications" (April 2026, Version #14), available at *https://www.cms.gov/files/document/medicare-shared-savings-program-shared-savings-losses-assignment-methodology-specifications-version.pdf-0* (Appendix F: Report Descriptions).

[250] CMS has made publicly available the PY 2026 Shared Savings Program Report templates through the "Program Guidance & Specifications" webpage of the Shared Savings Program website, at *https://www.cms.gov/medicare/payment/fee-for-service-providers/shared-savings-program-ssp-acos/guidance-regulations*.

indicated that we intended to monitor CPT and HCPCS codes and would consider making changes to the definition of primary care services to add or delete codes used to identify primary care services if there were sufficient evidence that revisions were warranted. We have updated the list of primary care service codes in subsequent rulemaking (refer to 80 FR 32746 through 32748; 80 FR 71270 through 71273; 82 FR 53212 and 53213; 83 FR 59964 through 59968; 85 FR 27582 through 27586; 85 FR 84747 through 84756; 85 FR 84785 through 84793; 86 FR 65273 through 65279; 87 FR 69821 through 69825; 88 FR 79163 through 79174; 89 FR 98087 through 98101; 90 FR 49794 through 49797) to reflect additions or modifications to the codes that have been recognized for payment under the PFS and to incorporate other changes to the definition of primary care services for purposes of the Shared Savings Program. For the PY starting on January 1, 2025, and subsequent PYs, we defined primary care services for purposes of assigning beneficiaries to ACOs under § 425.402 at § 425.400(c)(1)(ix).

(2) Proposed Revisions

Based on continued review of the HCPCS and CPT codes that are currently used for payment under the PFS or that we are proposing to use for payment under the PFS starting in CY 2027, we have determined it would be appropriate to propose to amend the definition of primary care services used in the Shared Savings Program assignment methodology to include certain additional codes for the PY starting on January 1, 2027, and subsequent PYs, to remain consistent with billing and coding under the PFS.

We propose to specify a revised definition of primary care services used for assignment for the PY starting on January 1, 2027, and subsequent PYs in a new provision of the Shared Savings Program at § 425.400(c)(1)(xi) to include the list of HCPCS and CPT codes specified at § 425.400(c)(1)(x), as well as the following additions: Screening, Brief Intervention, and Referral to Treatment (SBIRT) (HCPCS codes G2011, G0396, and G0397), Vaccine Adverse Effects Management (HCPCS code GADV1), Advance Care Planning (HCPCS codes GACP1 and GACP2), if finalized under OM payment policy.

We propose to use the new provision at § 425.400(c)(1)(xi) for determining beneficiary assignment for the PY starting on January 1, 2027, and in subsequent PYs.

The following provides additional information about the CPT and HCPCS codes that we are proposing to add to the definition of primary care services used for purposes of beneficiary assignment:

- *Screening, Brief Intervention, and Referral to Treatment (HCPCS G2011, G0396, and G0397):* The purpose of the SBIRT program is to implement the screening, brief intervention, and referral to treatment public health model for children, adolescents, and/or adults in primary care and community health settings (for example, health centers, hospital systems, health maintenance organizations (HMOs), preferred-provider organizations (PPOs) health plans, Federally Qualified Health Centers (FQHC), behavioral health centers, pediatric health care providers, children's hospitals, etc.) and schools with a focus on screening for underage drinking, opioid use, and other substance use[251]. SBIRT[252] has three major components:

1) Screening: Screen or assess a patient for risky substance use behaviors with standardized assessment tools (known as Medicare Structured Assessment) to identify the appropriate level of care. Screening quickly assesses a patient's substance use severity and identifies the appropriate treatment level;

2) Brief Intervention: Brief intervention increases substance use insight and awareness and motivates behavioral change. Engage the patient in a short conversation to increase their awareness of risky substance use behaviors and provide feedback, motivation, and advice; and

3) Referral to Treatment: Refer patients whose assessment or screening shows a need for additional services to specialty care treatment using specific tools such as Alcohol Use Disorders Identification Test (AUDIT) Manual or Drug Abuse Screening Test (DAST).

---

[251] *https://www.samhsa.gov/substance-use/treatment/sbirt*.
[252] *https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/sbirt_factsheet_icn904084.pdf*.

These three codes include screening and counseling services similar to counseling and other evaluation and management services already included in the definition of primary care services used for purposes of assignment. In the CY 2019 PFS final rule (83 FR 59965 through 59969), we finalized the addition of HCPCS G0442 (*Annual alcohol misuse screening, 15 minutes*) and G0443 (*Alcohol misuse counseling*) to the definition of primary care services used for purposes of assignment. In the CY 2024 PFS final rule (88 FR 79163 through 79175) we finalized the addition of CPT codes 99406 and 99407 for smoking and tobacco-use cessation counseling services. We also finalized the inclusion of G2086, G2087, and G2088 for office-based opioid use disorder services in the definition of primary care services used for purposes of assignment. Since HCPCS codes G2011, G0396, and G0397 include screening and documentation related to alcohol misuse, similar to G0442 and G0443, we believe this supports the inclusion of these HCPCS codes in the definition of primary care services.

- *Vaccine Adverse Effects Management* (HCPCS code GADV1): In section II.E. of this proposed rule, we are proposing an add-on payment for diagnosis and management of a suspected vaccine adverse reaction for services going above and beyond those captured in an E/M visit. These services entail listening to patient concerns, answering questions, and building trust; selecting diagnosis strategies and conveying information in a manner specific to the clinical situation and individual patient needs; providing patients with appropriate resources; and planning with patients the treatment of symptoms of vaccine adverse effects. We propose that this add-on code, HCPCS code GADV1 (Office or other outpatient evaluation and management service(s) for the diagnosis and treatment of vaccine adverse effects, new or established patient; each 15 minutes personally performed by the physician or qualified healthcare professional (list separately in addition to CPT codes 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350)), would be payable when a physician or NPP: (1) establishes and documents a temporal relationship to vaccination, and (2) performs a medically appropriate assessment to rule out alternative causes. Since, as proposed,

this service is an add-on payment for diagnosis and management of a suspected vaccine adverse reaction for services going above and beyond those captured in an evaluation and management (E/M) visit we believe these services will likely be provided by the clinician that is responsible for the overall care of the beneficiary and should, therefore, be included in the definition of primary care services used for purposes of assignment.

We have, over time, proposed separate payment and coding in instances where E/M codes may not reflect all the services and resources required to furnish comprehensive, coordinated care management for certain categories of beneficiaries which were then incorporated into the definition of primary care services used for purposes of assignment (see, for example: Transitional Care Management (77 FR 68978 through 68994), Chronic Care Management (78 FR 43337 through 43343), Advance Care Planning (80 FR 70955 through 70959)). Similarly, we believe that the inclusion of GADV1 for the assessment and treatment of vaccine adverse effects represents services and resources supportive of the furnishing of comprehensive, coordinated care management that are not reflected in E/M codes and therefore should be included in the definition of primary care services used for purposes of assignment. Further, the valuation of this service is crosswalked to HCPCS code G2212, which is included in the definition of primary care services used for purposes of assignment.

- *Advance Care Planning* (HCPCS codes GACP1 and GACP2): As discussed in section II.G. of this proposed rule, we are proposing to create two new HCPCS codes to describe advance care planning services furnished by clinical staff under the direct supervision of the billing physician or other practitioner: HCPCS G-code GACP1 (*Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), first 20 minutes of clinical staff time with the patient, family member(s), directed by a treating physician or other treating qualified health care professional*) and GACP2 (*Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed),*

each additional 20 minutes with the patient, family member(s), directed by a treating physician or other treating qualified health care professional (List separately in addition to code for primary procedure)) and proposing that the existing CPT codes 99497 and 99498 would only be used to report time personally spent by the billing practitioner. We believe that this new coding would more accurately distinguish and value the work of the billing practitioners, from time that is spent by their clinical staff in the provision of advance care planning services. As discussed in section II.G of this proposed rule, CMS emphasizes that clinicians must not, under any circumstances, attempt to influence their patients' decisions with respect to ACP.

In the CY 2019 PFS final rule (83 FR 59965 through 59968), we finalized the inclusion of advance care planning CPT codes 99497 and 99498 in the definition of primary care services under the Shared Savings Program because the services provided as part of advance care planning include counseling and other E/M codes similar to the services included in Annual Wellness Visits and other E/M codes that are already included in the list of primary care services used for purposes of assignment. We continue to believe that the care billed under advance care planning CPT and HCPCS codes would be considered primary care, and as such, believe that the new proposed HCPCS that represent clinical time provided under direct supervision should be included in the definition of primary care services used for purposes of assignment.

As part of this revised definition of primary care services used for assigning beneficiaries at § 425.402, we propose to incorporate a provision at § 425.400(c)(1)(xi)(C), specifying that the primary care service codes for purposes of assigning beneficiaries include a CPT code identified by CMS that directly replaces a CPT code specified at § 425.400(c)(1)(xi)(A) or a HCPCS code specified at § 425.400(c)(1)(xi)(B), when the assignment window or expanded window for assignment (as defined at § 425.20) for a benchmark year or PY includes any day on or after the effective date of the replacement code for payment purposes under FFS Medicare.

We also propose a technical modification to the introductory text in § 425.400(c)(1)(x), to limit the applicability of that provision to the PY starting on January 1, 2026. This change is

necessary so that we can effectuate § 425.400(c)(1)(xi) as explained in this section of this proposed rule to apply for the PY starting on January 1, 2027, and subsequent PYs.

We seek comments on these proposed changes to the definition of primary care services used for assigning beneficiaries at § 425.400(c)(1)(xi) to Shared Savings Program ACOs for the PY starting on January 1, 2027, and subsequent PYs, and related technical change. We also seek comments on any other existing or new HCPCS or CPT codes proposed elsewhere in this proposed rule that we should consider adding to the definition of primary care services for purposes of assignment in future rulemaking.

3. Quality Performance Standard and Other Quality Reporting Requirements

a. Overview

Section 1899(b)(3)(C) of the Act states that the Secretary shall establish quality performance standards to assess the quality of care furnished by Shared Savings Program ACOs and seek to improve the quality of care furnished by Shared Savings Program ACOs over time by specifying higher standards, new measures, or both for purposes of assessing such quality of care. As we stated in the November 2011 final rule establishing the Shared Savings Program (76 FR 67872), our principal goal in selecting quality measures for Shared Savings Program ACOs has been to identify measures of success in the delivery of high-quality healthcare at the individual and population levels. In the November 2011 final rule, we established a quality measure set spanning four domains: patient experience of care, and wherever practicable, caregiver experience of care; care coordination/patient safety; preventative health; and at-risk population (76 FR 67872 through 67891). We have subsequently updated the measures that comprise the quality measure set for the Shared Savings Program through rulemaking in the CY 2015, 2016, 2017, 2019, 2021, 2023, 2024, 2025, and 2026 PFS final rules (79 FR 67907 through 67921, 80 FR 71263 through 71269, 81 FR 80484 through 80489, 83 FR 59708 through 59715, 85 FR 84733 through 84734, 87 FR 69860 through 69863, 88 FR 79112 through 79114, 89 FR 98124 through 98132, and 90 FR 49797 through 90 FR 49822, respectively).

b. Proposal to Extend the Availability of the MIPS CQMs Collection Type and the MIPS CQM Reporting Incentive for Shared Savings Program ACOs

(1) Background

In the CY 2025 PFS proposed rule, we proposed to streamline the collection types available for Shared Savings Program ACOs reporting the APM Performance Pathway (APP) Plus quality measure set to the eCQMs and Medicare CQMs collection types for PY 2025 and subsequent PYs (89 FR 61856 and 61857). We also stated that our proposal to establish the APP Plus quality measure set to align with the Adult Universal Foundation measure set should aim to prioritize the eCQMs collection type—the gold standard collection type that underlies the Digital Quality Measurement Strategic Roadmap (available at *https://ecqi.healthit.gov/sites/default/files/CMSdQMStrategicRoadmap_032822.pdf*)—and use Medicare CQMs as the transition step on our building-block approach for Shared Savings Program ACOs' progress to adopt digital quality measurement (89 FR 61838). As stated in the CY 2025 PFS final rule (89 FR 98107), many commenters expressed concern with the proposal to eliminate the MIPS CQMs collection type for Shared Savings Program ACOs beginning in PY 2025. These commenters stated that eliminating the MIPS CQMs collection type would cause administrative burden due to Shared Savings Program ACOs having disparate electronic health records (EHRs) and experiencing reporting challenges with the submission of the eCQMs collection type. Several commenters noted that their efforts and resources would need to focus on determining the best reporting approaches at the expense of innovations that support patients. Some commenters stressed the challenges related to prior investments made in MIPS CQM reporting infrastructure that would be wasted following the elimination of the MIPS CQM collection type. Several of these commenters stated that having limited notice from CMS that the MIPS CQMs collection type would not be available to Shared Savings Program ACOs reporting the APP Plus quality measure set provides Shared Savings Program ACOs with only a few months to pivot to another option if the proposal not to include MIPS CQMs in the APP Plus

quality measure set was finalized. One commenter objected to the exclusion of the MIPS CQMs collection type from the APP Plus quality measure set and stated MIPS CQMs allow Shared Savings Program ACOs to leverage multiple data sources beyond just electronic medical record (EMR) data, including claims data, as an important component to ensuring the accuracy and completeness of data reported. Lastly, many commenters encouraged us to consider extending the availability of the MIPS CQMs collection type for Shared Savings Program ACOs and requested that the collection type remain available for an additional 1 to 3 years (89 FR 98107).

In response to these comments, we stated in the CY 2025 PFS final rule (89 FR 98107) that we acknowledged commenters' feedback regarding the challenges associated with not having MIPS CQM available to Shared Savings Program ACOs as a collection type for reporting the APP Plus quality measure set. We agreed with commenters that additional time was needed for Shared Savings Program ACOs that have invested in MIPS CQMs to transition to eCQMs and that having MIPS CQMs as a reporting option would allow Shared Savings Program ACOs to gain experience with all payer quality measure data collection and reporting before MIPS CQMs are phased out as a collection type for Shared Savings Program ACOs. We also stated that we were aware that some Shared Savings Program ACOs had already contracted with vendors for the MIPS CQMs collection type at their own expense, and that for these Shared Savings Program ACOs, additional time to transition to the eCQMs collection type was desirable. In addition, we expressed our understanding that the MIPS CQMs collection type allows Shared Savings Program ACOs to leverage multiple data sources beyond just EMR data, thereby allowing for improved accuracy and completeness of data submitted with this collection type. For these reasons, we finalized in the CY 2025 PFS final rule that we would provide Shared Savings Program ACOs with the option to use the MIPS CQMs collection type for 2 additional PYs (that is, PYs 2025 and 2026) when reporting the APP Plus quality measure set. We stated that we believed making the MIPS CQMs collection type available for Shared Savings

Program ACOs for 2 additional PYs would fairly balance investments Shared Savings Program ACOs have already made with the MIPS CQMs collection type and CMS' long-term goals of adopting digital quality measurement. As finalized in the CY 2025 PFS final rule, the collection types available to Shared Savings Program ACOs reporting the APP Plus quality measure set for PY 2025 and subsequent years recognized the need for some Shared Savings Program ACOs to build the infrastructure, skills, knowledge, and expertise necessary to report all payer/all patient measures while incentivizing Shared Savings Program ACOs to transition to eCQMs (89 FR 98107). We also stated that MIPS CQMs would no longer be available starting in PY 2027 and that we would continue to monitor the uptake of collection types by Shared Savings Program ACOs in the coming years (89 FR 98107).

In the CY 2023 PFS final rule, we extended the incentive for reporting eCQMs/MIPS CQMs through PY 2024 to align with the timeline for sunsetting of the CMS Web Interface reporting option and to allow Shared Savings Program ACOs an additional year to gauge their performance on the eCQMs/MIPS CQMs before full reporting of the measures were required beginning in PY 2025 (87 FR 69836 through 69838 and 89 FR 98121). We originally adopted this incentive in the CY 2022 PFS final rule to encourage Shared Savings Program ACOs to begin the transition to eCQM/MIPS CQM reporting in PYs 2022 and 2023 (86 FR 65269).

To continue to align the reporting incentive with the MIPS CQMs collection type, in the CY 2025 PFS final rule (89 FR 98123 and 98124), we extended the reporting incentive to Shared Savings Program ACOs reporting MIPS CQMs in PYs 2025 and 2026 to further support Shared Savings Program ACOs in meeting the Shared Savings Program quality performance standard for sharing in savings at the maximum rate under its track.

Specifically, we finalized that for PYs 2025 and 2026, a Shared Savings Program ACO will meet the quality performance standard used to determine eligibility for maximum shared savings and to avoid maximum shared losses, if applicable:

- If the Shared Savings Program ACO reports all of the eCQMs/MIPS CQMs in the APP Plus quality measure set applicable for a PY, meeting the data completeness requirement at § 414.1340 for all eCQMs/MIPS CQMs, and;

- Achieves a quality performance score equivalent to or higher than the 10th percentile of the performance benchmark on at least one of the outcome measures in the APP Plus quality measure set, and;

- Achieves a quality performance score equivalent to or higher than the 40th percentile of the performance benchmark on at least one of the remaining measures in the APP Plus quality measure set.

Over the past 2 years, we have developed a greater understanding of the challenges Shared Savings Program ACOs face in reporting eCQMs and transitioning to digital quality measurement. Comments stated in the CY 2025 PFS final rule (89 FR 98107), responses to the RFI on deregulation and other forums, and feedback from Shared Savings Program ACOs and other interested parties expressed concerns about increased administrative burden and Shared Savings ACO's prior investments in MIPS CQM reporting infrastructure that would be wasted if the MIPS CQMs collection type was eliminated and encouraged CMS to preserve the MIPS CQMs collection type and the corresponding MIPS CQM reporting incentive during the transition to digital quality measurement. By extending the MIPS CQMs collection type and the corresponding MIPS CQM reporting incentive, Shared Savings Program ACOs could continue to utilize investments already made in MIPS CQM reporting infrastructure while taking steps towards making the full transition to digital quality measurement. After considering the feedback we received, we believe that the widespread adoption of the all payer/all patient collection types will require further time and support.

In the CY 2025 PFS final rule, we stated that we intend to fully transition to digital quality measurement in CMS quality reporting and value-based purchasing programs (89 FR 98106). We also reiterated the numerous benefits to using eCQMs, including their use of

electronic standards that reduce the burden of manual extraction and reporting for measured entities, their use of clinical data to assess the outcomes of treatment by measured entities, and their fostering of access to real-time data for point of care quality improvement and decision support (89 FR 98106).

We refer readers to the Fast Healthcare Interoperability Resources® (FHIR®)-Based Digital Quality Measurement in the Quality Payment Program and other CMS Quality Programs – RFI in section IV.A.4.c. of this proposed rule. In that section, we state that we are advancing quality measurement by transitioning existing quality measures and reporting processes to FHIR-based digital approaches and requesting public comment on the timeline for transitioning to FHIR-based quality measurement. We also state that we request input from interested parties, ahead of future policy decisions, on developing a phased transition to FHIR-based digital quality reporting for applicable measures (that is, the 5 eCQMs and Medicare eCQMs in the APP Plus quality measure set as proposed in section IV.A.4.b.(2) of this proposed rule) under which we would introduce a 2-year transition period beginning with PY 2028. During the transition period, existing quality reporting options for Shared Savings Program ACOs (that is, eCQMs, MIPS CQMs, Medicare CQMs, and the proposed Medicare eCQMs), would continue to be available while FHIR-based digital quality measure (dQM) options are introduced for selected measures. For Shared Savings Program ACOs, the transition to FHIR-based dQMs builds upon the existing eCQM reporting infrastructure used for the APP Plus quality measure set (including APP/APP Plus measure alignment and current electronic reporting approaches) while introducing FHIR-based specifications for dQMs and related software tools, such as the Measure Authoring Development Integrated Environment (MADiE), so that Shared Savings Program ACOs would have a feasible pathway to adopt FHIR-based quality measurement. Following this transition period, beginning with PY 2030, FHIR-based reporting would be required for those applicable measures that were available as FHIR-based dQM reporting options during the transition period. As discussed in section IV.A.4.c. of this proposed rule, by PY 2030, Shared Savings Program

ACOs would need to be prepared to report each applicable APP Plus measure via FHIR-based digital quality reporting where a FHIR-based dQM specification exists for that measure. For APP Plus measures that do not have FHIR-based dQM specifications following the transition period, Shared Savings Program ACOs would continue to use applicable existing reporting mechanisms (for example, MIPS CQMs, Medicare CQMs, eCQM reporting via QRDA files, and proposed Medicare eCQMs) until FHIR-based dQM options are developed and adopted through future rulemaking.

Table B-G2 illustrates the timeline for the transition to FHIR-based quality reporting for Shared Savings Program ACOs, as described in section IV.A.4.c. of this proposed rule, as well as potential future quality performance scoring considerations subject to future notice and comment rulemaking. We note that between January 21, 2026, and February 23, 2026, CMS posted and sought public comment on draft FHIR-based digital specifications for 49 eligible clinician dQMs. This posting of draft specifications included specifications for the 5 measures in the APP Plus quality measure set that currently are available under the eCQMs, MIPS CQMs, and Medicare CQMs collection types (*https://ecqi.healthit.gov/sites/default/files/FHIR-Public-Comment-Webinar-CMS-20260121.pdf*).

TABLE B-G2: IMPLEMENTATION TIMELINE AND MILESTONES FOR TRANSITION TO FHIR-BASED DIGITAL QUALITY MEASUREMENT FOR SHARED SAVINGS PROGRAM ACOS

Phase	Timeframe	Collection Types Available for Quality Reporting	Potential Future Scoring Considerations
Transition Period with FHIR-Based Reporting Options (Year 1)	PY 2028	**FHIR-based dQM reporting options:** • dQMs • Medicare dQMs **Non-FHIR-based reporting options:** • eCQMs • MIPS CQMs • Medicare CQMs • Medicare eCQMs (proposed)	**FHIR-based dQM reporting options:** Benchmarking policies and reporting incentives would be established through future notice and comment rulemaking **Medicare CQMs and Medicare eCQMs:** Flat benchmarks (proposed) **All other non-FHIR-based reporting options:** Consistent with MIPS benchmarking policies at § 414.1380(b)(1)(ii) Anticipate sunsetting the current MIPS CQM reporting incentives
Transition Period with FHIR-Based Reporting Options (Year 2)	PY 2029	**FHIR-based dQM reporting options:** • dQMs • Medicare dQMs **Non-FHIR-based reporting options:**	**FHIR-based dQM reporting options:** Benchmarking policies and reporting incentives would be established through future notice and comment rulemaking

		• eCQMs • MIPS CQMs • Medicare CQMs Medicare eCQMs (proposed)	**Medicare CQMs and Medicare eCQMs:** Flat benchmarks (proposed) **All other non-FHIR-based reporting options:** Consistent with MIPS benchmarking policies at § 414.1380(b)(1)(ii)
Mandatory FHIR-Based Reporting	PY 2030 and subsequent PYs	**FHIR-based dQM reporting options:** • dQMs • Medicare dQMs	Benchmarking policies would be established through future notice and comment rulemaking

(2) Proposed Revisions

In light of the concerns raised by Shared Savings Program ACOs and other interested parties, and our commitment to supporting Shared Savings Program ACOs in the transition to dQM reporting, we propose to extend the availability of the MIPS CQMs collection type for Shared Savings Program ACOs reporting the APP Plus quality measure set for PY 2027 and subsequent PYs. We believe that the removal of the MIPS CQMs collection type for ACOs during this transition would be disruptive considering there was a significant increase in the number of Shared Savings Program ACOs that reported MIPS CQMs in PY 2025 compared to PYs 2023 and 2024. Based on initial PY 2025 MIPS quality submission data, Shared Savings Program ACOs are continuing to report the APP Plus quality measure set using the MIPS CQMs collection type, where 140 out of 472 financially reconciled ACOs reported at least one MIPS CQM; whereas 33 out of 453 financially reconciled Shared Savings Program ACOs in PY 2023 and 36 out of 476 financially reconciled Shared Savings Program ACOs in PY 2024 reported at least one MIPS CQM.

Maintaining the availability of the MIPS CQMs collection type for PY 2027 and subsequent PYs would eliminate the administrative burden associated with Shared Savings Program ACOs changing their current quality reporting collection type to another collection type after PY 2026 when the MIPS CQMs collection type would no longer be available under the policy finalized in the CY 2025 PFS final rule (89 FR 98123) and would also allow Shared Savings Program ACOs to focus their resources and efforts on the transition to dQM reporting instead.

Subject to future notice and comment rulemaking, we anticipate sunsetting the MIPS CQMs collection type beginning in PY 2030, when FHIR-based reporting becomes mandatory for all the eCQMs and the proposed Medicare eCQMs in the APP Plus quality measure set. As discussed in the FHIR-Based Digital Quality Measurement in the Quality Payment Program and Other CMS Quality Programs – RFI in section IV.A.4.c. of this proposed rule, we are requesting feedback on the phased timeline for FHIR-based reporting which starts with a 2-year transition period followed by required FHIR-based reporting for applicable measures.

To continue to align the reporting incentive with the MIPS CQMs collection type, we propose to extend the reporting incentive to Shared Savings Program ACOs reporting MIPS CQMs for PY 2027 and subsequent PYs to further support Shared Savings Program ACOs in meeting the Shared Savings Program quality performance standard for sharing in savings at the maximum rate under its track. Specifically, we propose that for PY 2027 and subsequent PYs, a Shared Savings Program ACO will meet the quality performance standard used to determine eligibility for maximum shared savings and to avoid maximum shared losses, if applicable:

- If the Shared Savings Program ACO reports all of the eCQMs/MIPS CQMs in the APP Plus quality measure set applicable for a PY, meeting the data completeness requirement at § 414.1340 for all eCQMs/MIPS CQMs, and;
- Achieves a quality performance score equivalent to or higher than the 10th percentile of the performance benchmark on at least one of the outcome measures in the APP Plus quality measure set, and;
- Achieves a quality performance score equivalent to or higher than the 40th percentile of the performance benchmark on at least one of the remaining measures in the APP Plus quality measure set.

Based on a CMS analysis of PY 2024 Shared Savings Program ACO quality results, 26 Shared Savings Program ACOs reported MIPS CQMs and met the Shared Savings Program quality performance standard by meeting the criteria for the MIPS CQM reporting incentive,

through which they were eligible to receive maximum shared savings and avoid maximum shared losses (if applicable) for their track regardless of their quality score. These 26 Shared Savings Program ACOs did not achieve a quality score at or above the 40th percentile MIPS quality performance category score value, which is one of the pathways for meeting the quality performance standard, and therefore, would not have met the quality performance standard without the MIPS CQM reporting incentive.

We will continue to assess the appropriateness of having the MIPS CQMs collection type being an available collection type for Shared Savings Program ACOs along with the associated MIPS CQM reporting incentive. Subject to future notice and comment rulemaking, we anticipate sunsetting the MIPS CQM reporting incentive when we introduce the 2-year transition period beginning with PY 2028 during which the existing quality reporting options for Shared Savings Program ACOs (that is, eCQMs, MIPS CQMs, Medicare CQMs, and the proposed Medicare eCQMs) would continue to be available while FHIR-based dQM reporting options are introduced for selected measures (that is, the 5 eCQMs and the proposed Medicare eCQMs in the APP Plus quality measure set as proposed in section IV.A.4.b.(2) of this proposed rule).

We note that, in section III.G.3.d.(3) of this proposed rule, we are proposing to create the Medicare eCQMs collection type, which would be a new collection type for PY 2027 and subsequent PYs. As part of our proposal to extend the availability of the MIPS CQMs collection type and the MIPS CQM reporting incentive for PY 2027 and subsequent PYs, § 425.512(a) would contain the following information:

- Under paragraph (a)(2)(iv), we would specify that the paragraph applies to eCQMs/MIPS CQMs/Medicare CQMs/Medicare eCQMs.
- Under paragraph (a)(5)(i)(B), we would specify that the paragraph applies to PY 2025 and subsequent PYs.
- We would remove paragraph (a)(5)(i)(C).

- We would revise paragraph (a)(5)(iii)(C) to specify that it applies to eCQMs/MIPS CQMs/Medicare CQMs/Medicare eCQMs.

We are seeking public comments on our proposals to extend the availability of the MIPS CQMs collection type for Shared Savings Program ACOs and the MIPS CQM reporting incentive for PY 2027 and subsequent PYs.

c. Proposal to Extend the Scoring of Shared Savings Program ACOs Reporting Medicare CQMs Using Flat Benchmarks

(1) Background

In the CY 2024 PFS final rule (88 FR 79110), we finalized our proposal to establish Medicare CQMs and new benchmarks for scoring Shared Savings Program ACOs on the Medicare CQMs under MIPS in alignment with MIPS benchmarking policies. Because historical Medicare CQM data would not be available, we finalized that for PYs 2024 and 2025, we would score Medicare CQMs using performance period benchmarks. We also finalized that, for PY 2026 and subsequent PYs, when baseline period data became available to establish historical benchmarks in a manner that is consistent with the MIPS benchmarking policies at § 414.1380(b)(1)(ii), we would score Medicare CQMs using historical benchmarks.

As stated in the CY 2024 PFS final rule (88 FR 79109 and 79110), a few commenters expressed concern about Shared Savings Program ACOs being compared only to other Shared Savings Program ACOs that report Medicare CQMs. As part of their concern, they referenced that Medicare CQMs would be available only to Shared Savings Program ACOs. One commenter stated their preference to have their quality performance compared to all other participants on these measures, while another commenter stated that CMS should stop measuring Shared Savings Program ACOs against each other and instead measure Shared Savings Program ACOs on a national standard so that all ACOs can pass and do not lose out on savings due to arbitrary quality decile cut points. In our response to these comments, we stated that given that benchmarks are specific to each collection type and that since we proposed to establish

Medicare CQMs as a new collection type for only Shared Savings Program ACOs, only Shared Savings Program ACO data will be available to benchmark Medicare CQMs. For these reasons, we stated that it was appropriate to establish benchmarks for Medicare CQMs that were consistent with MIPS benchmarking policies (88 FR 79110). We also stated that Shared Savings Program ACOs that prefer to be compared to clinicians at large could do so by reporting eCQMs or MIPS CQMs, for which CMS calculates a benchmark using data reported by MIPS eligible clinicians reporting under the chosen collection type.

In the CY 2025 PFS final rule (89 FR 98117), we stated that in PY 2022, Shared Savings Program ACOs had a higher average performance on quality measures they were required to report to share in savings compared to other similarly sized clinician groups not in the Shared Savings Program. This included statistically significant higher performance for quality measures related to diabetes and blood pressure control; breast cancer and colorectal cancer screening; tobacco screening and smoking cessation; and depression screening and follow-up. We further stated that in shifting to Medicare CQMs, Shared Savings Program ACOs' quality performance would be benchmarked against other Shared Savings Program ACOs only reporting Medicare CQMs. We explained that since Shared Savings Program ACOs are high performers relative to comparably sized MIPS groups, benchmarking Medicare CQMs using only Shared Savings Program ACO data would lower some Shared Savings Program ACOs' MIPS measure achievement points on those measures. In other words, high-performing Shared Savings Program ACOs could earn lower measure achievement points relative to comparable MIPS groups because the Medicare CQM benchmarking pool is comprised of higher-than-average performance data. This would, in effect, create a "tournament approach" to scoring Medicare CQMs wherein Shared Savings Program ACOs must compete with other Shared Savings Program ACOs to earn measure achievement points.

In the CY 2025 PFS final rule, we finalized our proposal to add § 414.1380(b)(1)(ii)(F) to state that beginning in the CY 2025 performance period/2027 MIPS payment year, measures of

the Medicare CQMs collection type would be scored using flat benchmarks for their first 2 performance periods in MIPS (89 FR 98120). We further stated that the use of flat benchmarks would allow Shared Savings Program ACOs with high scores to earn maximum or near maximum achievement points while allowing room for quality improvement and rewarding that improvement in subsequent years (89 FR 98118). Use of flat benchmarks also helps to ensure that Shared Savings Program ACOs with high quality performance on a measure are not penalized as low performers (89 FR 98118).

As stated in the CY 2025 PFS final rule, many commenters supported the proposal to score Shared Savings Program ACOs reporting Medicare CQMs using flat benchmarks (89 FR 98119). One commenter stated that it will be a difficult transition for ACOs to progress from the CMS Web Interface attestation method to CQM/eCQM reporting and that Medicare CQM flat benchmarking will remove uncertainty from Shared Savings Program ACO attestation to Medicare CQMs as they will no longer have to rely on benchmarking based upon the PY (89 FR 98119). Additionally, many commenters recommended that flat benchmarks for Medicare CQM be made permanent rather than for 2 years and noted that flat benchmarks make Medicare CQM scoring more predictable (89 FR 98120). One commenter recommended that CMS consider extending the flat benchmark scoring policies for Medicare CQMs beyond each measure's first 2 performance periods and some commenters recommended that CMS retroactively apply the flat benchmark policy for the 2024 performance period (89 FR 98120).

In response to comments on the proposals in the CY 2026 PFS final rule (90 FR 49812) related to removing the population and income adjustment applied to a Shared Savings Program ACO's quality score beginning in PY 2025, one commenter stated that flat benchmarks are temporary and are not a lasting offset to the unique challenges faced by Shared Savings Program ACOs that serve high Area Deprivation Index (ADI), Medicare Part D Low Income Subsidy (LIS), and dual eligible populations. We stated that should we consider extending flat

benchmarks for Medicare CQMs, we would do so through notice and comment rulemaking (90 FR 49813).

(2) Proposed Revisions

Through responses to the RFI on deregulation and other forums, Shared Savings Program ACOs and other interested parties expressed support for policies that promote continuity while Shared Savings Program ACOs transition to digital quality measurement. In response to ACOs' concerns and to support Shared Savings Program ACOs in the transition to dQM reporting, for PY 2027 and subsequent years, in section IV.B.1.c.(1) of this proposed rule, we are proposing that all measures of the Medicare CQMs collection type would be scored using flat benchmarks. We are also proposing that for PY 2026, the following measures reported via the Medicare CQMs collection type for PY 2026 are scored using flat benchmarks instead of using historical benchmarks as finalized in the CY 2025 PFS final rule (89 FR 98120): Diabetes: Glycemic Status Assessment Greater Than 9% (Quality ID: 001), Preventive Care and Screening: Screening for Depression and Follow-up Plan (Quality ID: 134), and Controlling High Blood Pressure (Quality ID: 236). These three Medicare CQMs, under the policy finalized in the CY 2025 PFS final rule (89 FR 98120), would have historical benchmarks for PY 2026, consistent with MIPS benchmarking policies at § 414.1380(b)(1)(ii), because these measures would be in their third performance period in MIPS. We propose that Quality IDs: 001, 134, and 236, if reported via the Medicare CQMs collection type for PY 2026 (and subsequent years), would be scored using flat benchmarks. As discussed more fully later in this section, failure to apply this change retroactively would be contrary to the public interest. We note that Breast Cancer Screening (Quality ID: 112) and Colorectal Cancer Screening (Quality ID: 113) reported via the Medicare CQMs collection type would be scored using flat benchmarks for PY 2026 under the policy finalized in the CY 2025 PFS final rule (89 FR 98120), which is consistent with CMS' intent to score all measures reported via Medicare CQMs collection type using flat benchmarks.

In response to commenters who requested that we make Medicare CQMs a permanent collection type in the CY 2025 PFS final rule (89 FR 98108), we stated that from the inception of the Medicare CQMs collection type beginning in PY 2024, that we intended for the Medicare CQMs collection type to serve as a transition collection type to help ACOs build the infrastructure, skills, knowledge, and expertise necessary to report all payer/all patient measures (88 FR 79097 and 79098). In addition, as we stated in the CY 2025 PFS proposed rule, we believed that our policy to establish the APP Plus quality measure set to align with the Adult Universal Foundation measure set should also aim to prioritize the eCQMs collection type and the use of the Medicare CQMs collection type is a transition step on our building-block approach for ACOs' to adopt digital quality measurement (89 FR 61838). We noted in the CY 2025 PFS final rule that the sunsetting of Medicare CQMs would take place no sooner than 5 years from the time the rule was written, when we anticipated there would be widespread uptake of FHIR API technology (89 FR 98108). While FHIR technology is employed in other components of digital health information, we noted that we would assess the uptake of FHIR API technology for quality reporting in alignment with the CMS Digital Quality Measurement Strategic Roadmap, specifically, Domain 3: Optimize Data Aggregation. In particular, we would assess whether Shared Savings Program ACOs broadly have developed capabilities to efficiently leverage FHIR API technology to aggregate quality reporting data and patient-centered measurement and are reporting eCQMs.

As of PY 2026, FHIR-based reporting of quality measures to CMS is not yet available to Shared Savings Program ACOs. As discussed in section IV.A.4.c. of this proposed rule, we intend to introduce a 2-year transition period to FHIR-based reporting beginning with PY 2028. During the transition period, existing quality reporting options for Shared Savings Program ACOs (that is, eCQMs, MIPS CQMs, Medicare CQMs, and the proposed Medicare eCQMs) would continue to be available while FHIR-based dQM options are introduced for selected measures (that is, the 5 eCQMs and the proposed Medicare eCQMs in the APP Plus quality

measure set as proposed in section IV.A.4.b.(2) of this proposed rule). Following this transition period, beginning with PY 2030, FHIR-based reporting would be required for those applicable measures that were available as FHIR-based dQM reporting options during the transition period. The timing of this transition would influence our proposals related to the collection types available to Shared Savings Program ACOs and the associated scoring policies. We anticipate sunsetting the Medicare CQMs collection type and the use of flat benchmarks to score Medicare CQMs beginning in PY 2030, when FHIR-based reporting becomes mandatory for all the eCQMs and proposed Medicare eCQMs in the APP Plus quality measure set. As discussed in section IV.A.4.c. of this proposed rule, we are requesting feedback on the phased timeline for FHIR-based reporting which starts with a 2-year transition period followed by required FHIR-based reporting for applicable measures.

We expect that policies associated with this timeline would be proposed through future rulemaking.

In response to commenters who requested that we extend or make permanent flat benchmarks for Medicare CQMs, we stated in the CY 2025 PFS final rule (89 FR 98120) that we believed that the baseline period data, which would be available to establish historical benchmarks is consistent with MIPS benchmarking policies at § 414.1380(b)(1)(ii). As we stated in the CY 2025 PFS proposed rule (89 FR 61860), the use of historical benchmarks, when data are available, allows Shared Savings Program ACOs to know benchmarks prior to start of the PY and create opportunities for improvement. Also, as discussed in the CY 2024 PFS final rule, since Medicare CQMs would be subject to MIPS scoring policies, the application of MIPS benchmarking policies to Medicare CQMs is both logical and necessary for implementation of the new collection type (88 FR 79180). We believe it is no longer logical to apply this benchmark methodology to Medicare CQMs due to Shared Savings Program ACOs' concerns that quality-related changes are disruptive to the transition to digital quality measurement as well

as due to the sunsetting of the population and income adjustment as finalized in the CY 2026 PFS final rule, each described in further detail later in this section.

In 2025, we conducted interviews with a sample of Shared Savings Program ACOs who reported Medicare CQMs for PY 2024, the first year of the Medicare CQMs collection type.[253] Interviewed Shared Savings Program ACOs reported continued challenges with the transition to digital quality measurement. Some Shared Savings Program ACOs shared that uncertainty regarding digital reporting standards have led them to restrict or pause adding new practices to their organization. These new restrictions limit practice access to the Shared Savings Program and beneficiary access to value-based care. To support the transition to digital quality measurement, Shared Savings Program ACOs and other interested parties that responded to the RFI on deregulation demonstrated support for policies that promote continuity and recommended against further alignment of Shared Savings Program quality reporting policies with MIPS. Given the challenges and concerns that Shared Savings Program ACOs have shared regarding navigating additional Shared Savings Program policy changes in a time of larger quality reporting transition, coupled with Shared Savings Program ACO patient data privacy concerns and lack of capability to report other measure collection types such as eCQMs, as discussed in section IV.B.1.c.(1) of this proposed rule, we propose to extend the use of flat benchmarks to score all Medicare CQMs for PY 2027 and subsequent PYs, and for Quality IDs 001, 134, and 236 for PY 2026. This proposal would continue to support Shared Savings Program ACOs that choose to report via that collection type during the transition to reporting and would be consistent with the goals of the deregulatory RFI (90 FR 15481 and 15482).

Under current policy, flat benchmarks for Medicare CQMs are only used in a measure's first two years in MIPS. Thus, the number of Medicare CQMs in the APP Plus quality measure set that will use flat benchmarks will decline over time. For PY 2025, all four Medicare CQMs (Quality IDs 001, 112, 134, and 236) in the APP Plus quality measure set were scored using flat

[253] Findings are based on internal analysis of interviews with ACOs that reported Medicare CQMs for PY 2024.

benchmarks; however, this number decreased to two (Quality IDs 112 and 113) of five Medicare CQMs for PY 2026.

In the CY 2026 PFS final rule (90 FR 49807), we stated that we conducted an internal analysis of the PY 2024 Shared Savings Program ACO quality results to better understand the potential impact of the proposed removal of the population and income adjustment on 13 ACOs that earned the population and income adjustment bonus points and reported only Medicare CQMs. Specifically, we simulated the application of flat benchmarks for Medicare CQMs (as described at § 414.1380(b)(1)(ii)(F)), which was in effect starting in PY 2025. Had flat benchmarks been applied to the three Medicare CQMs in the APP quality measure set in PY 2024, the average MIPS quality performance category score earned by these 13 Shared Savings Program ACOs would have been on average 14 percentage points higher compared to an average increase of 4 percentage points that these Shared Savings Program ACOs earned from the population and income adjustment in PY 2024, a difference of 10 percentage points. This would thus increase the likelihood that these Shared Savings Program ACOs would meet the quality performance standard by achieving a quality score that is equivalent to or higher than the 40th percentile across all MIPS quality performance category scores, excluding entities/providers eligible for facility-based scoring or the alternative quality performance standard. We also stated that, while we anticipate that Shared Savings Program ACOs that choose to report Medicare CQMs would not be eligible for the eCQM/MIPS CQM reporting incentive or the Complex Organization Adjustment, these Shared Savings Program ACOs would likely sufficiently benefit from our policy to score Medicare CQMs using flat benchmarks as described at § 414.1380(b)(1)(ii)(F). Specifically, we anticipated that these Shared Savings Program ACOs would receive a positive scoring impact under flat benchmarks for Medicare CQMs, that would be greater than the current positive scoring impact these Shared Savings Program ACOs received under the population and income adjustment. This analysis further reflected the substantial impact of flat benchmarks on Shared Savings Program ACOs'

quality scores. Since the population and income adjustment is no longer applicable beginning in PY 2026, as finalized in the CY 2026 PFS final rule (90 FR 49815), using flat benchmarks to score Quality IDs 001, 134, and 236 if reported via the Medicare CQMs collection type for PY 2026, and scoring all Medicare CQMs using flat benchmarks in PY 2027 and subsequent PYs, would further support Shared Savings Program ACOs that will no longer have access to the population and income adjustment and help ensure that Shared Savings Program ACOs with high quality performance on a measure are not penalized as low performers. Additionally, Shared Savings Program ACOs that report quality measures using the eCQMs or MIPS CQMs collection type may qualify for the collection type's respective reporting incentive or may be eligible to receive the Complex Organization Adjustment (if reporting using the eCQMs collection type). This proposed policy would also support Shared Savings Program ACOs that do not yet report or cannot report eCQMs or MIPS CQMs.

Section 1871(e)(1)(A) of the Act prohibits the Secretary from applying substantive changes in regulations retroactively before the effective date of the change except where the Secretary determines, as relevant here, that failure to apply the change retroactively would be contrary to the public interest. It is in the public interest to apply our proposed change to score Diabetes: Glycemic Status Assessment Greater Than 9% (Quality ID: 001), Preventive Care and Screening: Screening for Depression and Follow-up Plan (Quality ID: 134), and Controlling High Blood Pressure (Quality ID: 236) when reported via the Medicare CQMs collection type for PY 2026 using flat benchmarks. The evaluation of Shared Savings Program ACOs' PY 2026 quality performance, including the use of measure benchmarks to calculate quality scores, will occur in PY 2027. Retroactive application of flat benchmarks for Medicare CQMs for PY 2026 would enable the Shared Savings Program to better recognize the quality of care provided in PY 2026 and incentivize future improvements based on the evaluation of that care. We analyzed PY 2024 data on Shared Savings Program ACOs that reported all three Medicare CQMs in the APP quality measure set, which had performance-based benchmarks, and compared PY 2024

quality scores to simulated quality scores using flat benchmarks for the three Medicare CQMs. Flat benchmarks were estimated to increase average quality scores by 11 percentage points in this analysis.[254] Higher percentage points would increase the likelihood that these Shared Savings Program ACOs would meet the quality performance standard for sharing in savings at the maximum rate under its track by achieving a quality score that is equivalent to or higher than the 40th percentile across all MIPS quality performance category scores, excluding entities/providers eligible for facility-based scoring or the alternative quality performance standard to be eligible to share in savings at a lower rate that is scaled based on the ACO's quality performance. The quality performance standard helps hold Shared Savings Program ACOs accountable for the quality of care their providers furnish to their beneficiaries and further encourages ACOs to demonstrate consistently that they are providing high quality of care to their beneficiary populations year over year (90 FR 49836). This analysis also illustrated that the use of performance-based benchmarks could lead to Shared Savings Program ACOs forgoing shared savings that might otherwise have been available for reinvestment. Based on the Shared Savings Program ACO public reporting requirements § 425.308(b)(4)(ii), Shared Savings Program ACOs that generate shared savings must publicly report the total proportion of shared savings invested in infrastructure, redesigned care processes, and other resources required to support the triple aim of better health for populations, better care for individuals, and lower growth in expenditures, including the proportion distributed among Share Savings Program ACO participants. As such, the proposed change would afford the Shared Savings Program ACOs with increased shared savings the opportunity to devote greater resources to providing better quality of care to Medicare beneficiaries over time and improving care coordination that benefits the Medicare beneficiaries served by the Shared Savings Program ACOs.

Additionally, Shared Savings Program ACOs that participated in the interviews discussed earlier in this section also shared that some practices have closed due to financial challenges

[254] Percent is based on internal analysis of ACOs' quality performance scores for PY 2024.

associated with the transition to digital quality measurement. Furthermore, some Shared Savings Program ACOs have begun to remove practices that cannot meet digital reporting requirements from their organization.[255] For practices experiencing financial and organizational instability, the loss of shared savings would compound these challenges and may cause them to close or negatively affect their ability to provide continuity of care, coordination of care, preventive care initiatives, and quality improvement initiatives for Medicare beneficiaries they serve. As a result, beneficiaries may experience challenges with accessing care, ineffective utilization of services, fragmented care, or duplicative tests or services, and ACOs may be slower to adopt digital quality measurement as a result.

As discussed in section III.G.3.f.(2) of this proposed rule, our proposal to remove Initiation and Engagement of Substance Use Disorder Treatment (Quality ID: 305) and Adult Immunization Status (Quality ID: 493) from the APP Plus quality measure set beginning in PY 2027, would result in the APP Plus quality measure set to have five Medicare CQMs for PY 2027 and subsequent PYs. These are the same Medicare CQMs that are in the APP Plus quality measure set for PY 2026. Under the proposals described in this section and as described in section IV.B.1.c.(1), all Medicare CQMs in the APP Plus measure set (Quality IDs: 001, 112, 113, 134, and 236) would be scored using flat benchmarks for PY 2026 and subsequent PYs. The proposed APP Plus quality measure set for PY 2027 and subsequent PYs is displayed in Table B-G4 of this proposed rule. The APP Plus quality measure set for PY 2026 is displayed in Table 40 of the CY 2025 PFS final rule (89 FR 98129).

As discussed in the CY 2025 PFS final rule, a quality performance benchmark is the performance rate a Shared Savings Program ACO must achieve to earn the corresponding quality points for each measure (89 FR 98118). Flat benchmarks assign a performance rate range to each decile. In flat benchmarks for non-inverse measures, any performance rate at or above 90 percent is treated as the top decile; any performance rate between 80 percent and 89.99 percent would be

[255] Findings are based on internal analysis of interviews with ACOs that reported Medicare CQMs for PY 2024.

treated as the second highest decile, and so on. For inverse measures, this would be reversed—any performance rate at or below 10 percent would be treated as the top decile; any performance rate between 10.01 percent and 20 percent would be treated as the second highest decile, and so on. The number of measure achievement points received for each measure is determined based on where a Shared Savings Program ACO's performance rate is within the benchmark decile categories.

For non-inverse measures, better quality performance is indicated by a higher performance rate. For example, Controlling High Blood Pressure (Quality ID: 236) is a non-inverse measure that measures the percentage of patients 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mmHg) during the measurement period. Better quality performance on this measure is demonstrated by having a higher percentage of patients whose blood pressure was adequately controlled. Table B-G3 lists the flat benchmarks for a non-inverse Medicare CQM under our proposals discussed in this section of the proposed rule. For example, if a Shared Savings Program ACO reports a non-inverse Medicare CQM in PY 2026 or a subsequent PY and earns a performance rate of 55.25 percent, then the Shared Savings Program ACO would score in the 6th decile on that measure.

TABLE B-G3: FLAT BENCHMARKS FOR A NON-INVERSE MEDICARE CQM IN PY 2026 AND SUBSEQUENT PYs

Decile	Performance Rate Range
1	< 10.00
2	10.00 – 19.99
3	20.00 – 29.99
4	30.00 – 39.99
5	40.00 – 49.99
6	50.00 – 59.99
7	60.00 – 69.99
8	70.00 – 79.99
9	80.00 – 89.99
10	>= 90.00

For inverse measures, better quality performance is indicated by a lower performance rate. This is reflected in flat benchmark such that lower quality performance rates are found in higher deciles. For example, Diabetes: Glycemic Status Assessment Greater Than 9% (Quality ID: 001) is an inverse quality measure that measures the percentage of patients 18-75 years of age with diabetes who had a glycemic status assessment (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) greater than 9.0 percent during the measurement period. Better quality performance on this measure is demonstrated by having a lower percentage of patients whose glycemic status assessment was greater than 9.0 percent. Table B-G4 lists the flat benchmarks for an inverse Medicare CQM under our proposals discussed in this section of the proposed rule. For example, if a Shared Savings Program ACO reports an inverse Medicare CQM in PY 2026 or subsequent year and earns a performance rate of 12.25 percent, then the Shared Savings Program ACO would score in the 9th decile on that measure. Diabetes: Glycemic Status Assessment Greater Than 9% (Quality ID: 001) is the only inverse Medicare CQM in the APP Plus quality measure set.

TABLE B-G4: FLAT BENCHMARKS FOR AN INVERSE MEDICARE CQM IN PY 2026 AND SUBSEQUENT PYs

Decile	Performance Rate Range
1	99.00 – 90.01
2	90.00 – 80.01
3	80.00 – 70.01
4	70.00 – 60.01
5	60.00 – 50.01
6	50.00 – 40.01
7	40.00 – 30.01
8	30.00 – 20.01
9	20.00 – 10.01
10	<= 10.00

There are scoring scenarios in which Shared Savings Program ACOs would earn higher measure achievement points under flat benchmarks compared to those they would earn under performance period benchmarks. Most notable are scenarios in which Shared Savings Program ACOs have a tight distribution of performance rates on a measure. For example, a non-inverse measure for which a performance rate of 90.00 percent is in the 8th decile. In this example, a

Shared Savings Program ACO that reported a performance rate of 90.00 percent would be scored in the 8th decile when the hypothetical performance period benchmark is applied. Using the flat benchmarks described in Table B-G3 of this proposed rule, a Shared Savings Program ACO that reported a performance rate of 90.00 percent would be scored in the 10th decile, resulting in greater measure achievement points than under the hypothetical performance period benchmarks described in this example. For more details on the calculation of measure achievement points, we refer readers to the "APM Performance Pathway (APP) Toolkit" which is updated for each PY and posted in the QPP Resource Library.

As described in section IV.B.1.c.(1) of this proposed rule and in § 414.1380(b)(1)(ii)(F)(2), we are proposing that beginning with the CY 2026 performance period/2028 MIPS payment year, measures of the Medicare CQMs collection type would use flat benchmarks.

We seek public comment on our proposals to score Shared Savings Program ACOs reporting Medicare CQMs using flat benchmarks for PY 2027 and subsequent years and to retroactively apply the flat benchmarks for Quality IDs: 001, 134, and 236 when reported via the Medicare CQMs collection type for PY 2026.

d. Proposals to Address Shared Savings Program ACOs' Challenges with Meeting the MIPS Data Completeness Requirement

(1) Background

Requirements for data completeness are essential to ensure that data submitted on quality measures are sufficiently complete to accurately assess each Shared Savings Program ACO's quality performance. The data completeness requirement means that a Shared Savings Program ACO participant submitting measure data on a quality measure must submit data on at least a specific percentage of their patients that meet the measure's denominator criteria. Meeting the data completeness requirement ensures that the measure represents an appropriate percentage of the patient population applicable for a given quality measure. Robust data completeness

requirements ensure the most accurate assessment of the performance of Shared Savings Program ACO participants.

In the CY 2017 Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models (81 FR 77125), we established a data completeness threshold to ensure that data submitted on quality measures are complete enough to accurately assess each MIPS eligible clinician's quality performance. Additionally, in the CY 2020 PFS final rule (84 FR 62568, 62953), we added a requirement at § 414.1340 that quality data would not be considered true, complete, or accurate if such data are submitted selectively such that the data are unrepresentative of a MIPS eligible clinician or group's performance. In the CY 2024 PFS final rule, we finalized that we would maintain the data completeness criteria threshold of 75 percent (88 FR 79337). Specifically, as finalized, the data completeness criteria for the quality performance category (§ 414.1340) state that MIPS eligible clinicians, groups, virtual groups, subgroups, and APM Entities submitting quality measure data on QCDR measures, MIPS CQMs, or eCQMs must submit data on at least 75 percent of the MIPS eligible clinician, group, virtual group, subgroup, and APM Entity's patients that meet the measure's denominator criteria, regardless of payer for MIPS payment years 2026 through 2030. In the CY 2024 PFS final rule, for APM Entities, specifically Shared Savings Program ACOs, we likewise established the data completeness criteria threshold of at least 75 percent for the Medicare CQMs aligned with the data completeness criteria threshold established for the eCQMs and MIPS CQMs collection types (88 FR 79337).

In the CY 2021 PFS final rule, we finalized modifications to the Shared Savings Program quality reporting requirements and quality performance standard for PY 2021 and subsequent PYs (85 FR 84720 through 84743) requiring Shared Savings Program ACOs to report quality data via the APP codified at § 414.1367. In the CY 2025 PFS final rule, we finalized that for PYs beginning on or after January 1, 2025, Shared Savings Program ACOs must submit quality data

via the APP on the quality measures contained in the APP Plus quality measure set to satisfactorily report on behalf of the eligible clinicians who bill under the TIN of a Shared Savings Program ACO participant for purposes of the MIPS quality performance category of the Quality Payment Program (89 FR 98568).

For data completeness criteria pertaining to the quality performance category, we finalized in the CY 2025 PFS final rule that an APM Entity, specifically a Shared Savings Program ACO that meets reporting requirements under the APP, must meet the data completeness requirements established at § 414.1340(d)(1). Shared Savings Program ACOs reporting quality data on the APP Plus quality measure set meet the quality performance standard if they achieve a quality score that is equivalent to or higher than the 40th percentile across all MIPS quality performance category scores. If a Shared Savings Program ACO fails to meet data completeness on a measure in the APP Plus quality measure set, it will receive a 0/10 for the affected quality measure(s), resulting in a lower quality score used to determine eligibility for shared savings. For a Shared Savings Program ACO in the first PY of the ACO's first agreement period, the Shared Savings Program ACO must meet the MIPS data completeness requirement on all eCQMs/MIPS CQMs/Medicare CQMs in the APP Plus quality measure set and receive a MIPS quality performance category score. Shared Savings Program ACOs are eligible for the eCQM/MIPS CQM reporting incentive if they report all eCQMs/MIPS CQMs in the APP Plus quality measure set and meet data completeness requirements for all measures. Lastly, under the Complex Organization Adjustment, Shared Savings Program ACOs may receive one measure achievement point for each submitted eCQM that meets case minimum and data completeness requirements.

Shared Savings Program ACOs continue to express concerns related to the transition to dQM reporting including challenges with data aggregation, engagement of specialty practices, and patient matching. Shared Savings Program ACOs have shared with CMS that specialty electronic health record (EHR) systems are not designed to support the APP Plus quality measure

set and that certain specialties may not be able to collect the needed data elements for quality reporting. Shared Savings Program ACOs noted that patients that are not managed by the Shared Savings Program ACO or do not have a primary care relationship with the Shared Savings Program ACO present data aggregation and patient deduplication challenges because specialists may not have quality reporting capabilities for the measures in the APP Plus quality measure set, which may not be part of specialists' clinical workflows. These challenges complicate a Shared Savings Program ACO's ability to meet the data completeness requirement. We have also received feedback that the MIPS data completeness requirement is a deterrent to specialist participation in Shared Savings Program ACOs. In the CY 2025 PFS final rule, some commenters stated that small independent practices and specialty practices are often unable to participate or continue to participate in the Shared Savings Program due to the technical and financial burden associated with the adoption of new technologies needed to meet reporting requirements (89 FR 98105). Several commenters requested that we consider adding exceptions or exclusions for small practices and certain specialties and/or altering data completeness requirements to address ongoing challenges and allow for Shared Savings Program ACOs to be successful in reporting eCQMs, MIPS CQMs, and Medicare CQMs (89 FR 98105).

With the sunset of the CMS Web Interface beginning in PY 2025 as finalized in the CY 2022 PFS final rule (86 FR 65440), Shared Savings Program ACOs are now required to report MIPS CQMs, eCQMs and/or Medicare CQMs and have reported difficulties with meeting the MIPS data completeness requirement. Shared Savings Program quality reporting data in PYs 2023 and 2024 indicates that Shared Savings Program ACOs have been slow to report eCQMs.

Since the CY 2021 PFS final rule was issued, Shared Savings Program ACOs and other interested parties have continued to express concerns about requiring Shared Savings Program ACOs to report all payer/all patient eCQMs/MIPS CQMs due to the cost of purchasing and implementing a system-wide infrastructure to aggregate data from multiple ACO participant

taxpayer identification numbers (TINs) and varying electronic health record (EHR) systems (86 FR 65257). In the CY 2022 PFS final rule, commenters supported our acknowledgement of the complexity of the transition to all payer/all patient eCQMs/MIPS CQMs (86 FR 65259). In the CY 2023 PFS final rule, commenters expressed concerns regarding the requirement to report all payer/all patient eCQMs/MIPS CQMs beginning in PY 2025, such as issues related to meeting all payer data requirements, data completeness requirements, data aggregation and deduplication issues, and interoperability issues among different EHRs (87 FR 69837).

In light of these concerns, we proposed in the CY 2024 PFS proposed rule to establish the Medicare CQMs as a new collection type for Shared Savings Program ACOs to help ACOs build the infrastructure, skills, knowledge, and expertise necessary to aggregate patient data. We established the data completeness criteria threshold of at least 75 percent for the Medicare CQMs aligned with the data completeness criteria threshold established for eCQM and MIPS CQM collection types. We believed that the Medicare CQM collection type would address the concerns from ACOs regarding the capability of meeting the data completeness requirement for all payer data.

In the CY 2024 PFS final rule, many commenters also raised questions and concerns regarding how CMS will determine the appropriate Medicare CQM population for these measures (88 FR 79102). Some commenters noted that the proposed denominator eligibility criteria are similar to, but differ in timeline from, the current assignment methodology and this creates unnecessary complexity. Additionally, while the availability of the Medicare CQMs as a collection type assists with the transition from reporting eCQMs and/or MIPS CQMs to reporting dQMs, some commenters noted that reporting through the Medicare CQMs collection type will not inherently advance their capabilities to report on eCQMs. For instance, the commenters noted that the Medicare CQMs collection type does not address the adoption of CEHRT across Shared Savings Program ACO participants, processes to enable aggregation of quality measurement data across all Shared Savings Program ACO participants, the ability to assess data

completeness, efficiently calculate quality measures outcomes, and the generation of a QRDA-III file (87 FR 79103 and 79104). To address these concerns, in the CY 2026 PFS final rule, we revised the definition of a "beneficiary eligible for Medicare CQM" to align with our modifications to the stepwise assignment methodology and the approach to identifying the beneficiaries assignable to a Shared Savings Program ACO. We intended for the revised definition to reduce Shared Savings Program ACOs' burden in the patient matching necessary to report Medicare CQMs because the list of "beneficiaries eligible for Medicare CQMs" would have greater overlap with the list of beneficiaries that are assignable to a Shared Savings Program ACO.

The Shared Savings Program continues to hear from Shared Savings Program ACOs and other interested parties about the challenges with reporting on all payer/all patient measures and meeting data management requirements given their muti-practice/multi EHR structure, the challenges to aggregate data with the health IT infrastructure in use by Shared Savings Program ACOs and current state of interoperability (89 FR 98122).

Below we describe several proposals to address data completeness challenges for ACOs, in recognition of the heterogeneity in Shared Savings Program ACO composition, with many Shared Savings Program ACOs being made up of numerous TINs of varying specialties. These proposals are intended to support Shared Savings Program ACOs' success in meeting the MIPS data completeness requirement by allowing for flexibility on the universe of beneficiaries that the Shared Savings Program ACO would be required to report quality data on, while still requiring the Shared Savings Program ACOs to collect meaningful data on their quality performance (that is, allowing ACOs to exclude some clinicians from their quality reporting and/or alignment with the Shared Savings Program ACO's list of assigned beneficiaries).

(2) Proposal to Revise the Shared Savings Program Quality Reporting Requirements beginning in PY 2026

Current Shared Savings Program quality reporting requirements at § 425.508(c) require that, for PYs beginning on or after January 1, 2025, Shared Savings Program ACOs must submit quality data on the APP Plus quality measure set to satisfactorily report on behalf of the eligible clinicians who bill under the TIN of a Shared Savings Program ACO participant for purposes of the MIPS quality performance category. Shared Savings Program ACOs have raised concerns about meeting reporting requirements in situations where they are unable to obtain data from a Shared Savings Program ACO Participant TIN. This situation may occur due to unforeseen circumstances such as the retirement of a provider in a solo practice or a practice closure. Additionally, Shared Savings Program ACOs have noted that specialty EHRs are not designed to support the APP Plus quality measure set and that certain specialties (for example, ophthalmology) provide little or no usable data.

In light of the concerns raised by Shared Savings Program ACOs regarding challenges meeting the Shared Savings Program quality reporting requirements, we are proposing to revise the quality reporting requirements at § 425.508(c), to include that for PYs beginning on or after January 1, 2026, Shared Savings Program ACOs may exclude one or more Shared Savings Program ACO participant TINs from a Shared Savings Program ACO's submission of eCQM/MIPS CQM/Medicare CQM/Medicare eCQM (if finalized) data (as applicable) for each measure. As discussed in section III.G.3.d.(3) of this proposed rule, we are proposing to create the Medicare eCQMs collection type, which would be a new collection type for PY 2027 and subsequent PYs. We are proposing in § 425.508(c)(1)(i) through (iii) that a Shared Savings Program ACO may choose to exclude a Shared Savings Program ACO participant TIN from its submission of eCQM/MIPS CQM/Medicare CQM/Medicare eCQM data for each measure. Applicable exclusions may include: (i) unforeseen circumstance(s) that are outside of the control of the Shared Savings Program ACO such as the unexpected closure of a group or individual's

practice that bills under the ACO participant TIN (for example, closure of the group or individual's practice in the middle of the PY due to an unforeseen reason (such as the retirement of a provider) and the Shared Savings Program ACO is unable to access quality data for the closed practice); (ii) the ACO participant TIN has a CEHRT that is intended for specialty use and does not support the measure(s) included in the APP Plus quality measure set (for example, an ophthalmology practice may provide little to no usable data because it utilizes a specialty-focused EHR that does not collect the necessary data elements for reporting on the primary care-focused APP Plus quality measure set; in this instance, the ACO would be unable to aggregate the ACO participant TIN's data); and (iii) other circumstances as determined by CMS. We further propose in § 425.508(c)(2)(i) through (iii) that Shared Savings Program ACOs may not exclude a Shared Savings Program ACO participant TIN from the Shared Savings Program ACO's quality data submission for each measure based on the demographics or health status of the beneficiaries who had an encounter during the performance year with an ACO participant TIN or based on the estimated impact of the ACO participant TIN on the ACO's quality performance.

In addition, we are proposing in § 425.508(c)(3) that, after the exclusion of Shared Savings Program ACO participant TINs, the Shared Savings Program ACO's submission of eCQM/MIPS CQM/Medicare CQM/Medicare eCQM data (as applicable) for each measure must include Shared Savings Program ACO participant TINs that represent at least 95 percent of the beneficiaries assigned to the Shared Savings Program ACO prior to the application of the measure specifications. Since a Shared Savings Program ACO may encounter an unforeseen circumstance that may be specific to reporting a clinical quality measure(s), the Shared Savings Program ACO may exclude one or more Shared Savings Program ACO participant TINs from the quality data submitted for only the impacted measure(s) for the applicable PY. As such, a Shared Savings Program ACO would be required to meet the 95 percent requirement for each measure at the measure level. This means that the quality data submitted by the Shared Savings

Program ACO for each measure in the APP Plus quality measure set must meet this requirement independent of the other measures in the APP Plus quality measure set. We note that, due to each measure's inclusion and exclusion criteria as specified in the measure specification, a Shared Savings Program ACO's submission of eCQM/MIPS CQM/Medicare CQM/Medicare eCQM data for each measure may not include 95 percent of the beneficiaries assigned to the Shared Savings Program ACO. However, under our proposal, the data submitted for each measure must include ACO participant TINs that represent at least 95 percent of the beneficiaries assigned to the Shared Savings Program ACO prior to the application of the measure specifications. This 95 percent requirement would allow Shared Savings Program ACOs to exclude one or more Shared Savings Program ACO participant TINs from a measure submission based on applicable circumstances defined by CMS under the proposed regulation text at § 425.508(c)(1) and discussed later in this section, while ensuring CMS still receives sufficient data to assess Shared Savings Program ACO quality in the applicable PY and over time.

We note that our proposal to require that the Shared Savings Program ACO's submission of eCQM/MIPS CQM/Medicare CQM/Medicare eCQM data (as applicable) for each measure must include Shared Savings Program ACO participant TINs that represent at least 95 percent of the beneficiaries assigned to the Shared Savings Program ACO prior to the application of the measure specifications is different than the MIPS data completeness requirement for the MIPS quality performance category described at § 414.1340 (a) and (d) and proposed (e). Under our proposal, Shared Savings Program ACOs would still be required to meet the MIPS data completeness requirement (that is, the Shared Savings Program ACO must report on at least 75 percent of the APM Entity's applicable beneficiaries who meet the measure's denominator criteria for PY 2027) for each eCQM/MIPS CQM/Medicare CQM/Medicare eCQM the Shared Savings Program ACO submits data for. MIPS data completeness is calculated based on the quality data submitted by a Shared Savings Program ACO and is assessed at the Shared Savings Program ACO-level; whereas, our proposal to allow a Shared Savings Program ACO to exclude

one or more Shared Savings Program ACO participant TINs from a Shared Savings Program ACO's submission of eCQM/MIPS CQM/Medicare CQM/Medicare eCQM data (as applicable) for each measure would be applied by the Shared Savings Program ACO prior to its submission of quality data to MIPS. Under our proposal, a Shared Savings Program ACO would determine the denominator for a measure by applying the measure specifications using data from the participant TINs included in its quality data submission. MIPS data completeness would then be calculated based on that reported denominator.

To facilitate population-based activities related to improving health or reducing growth in health care costs, protocol development, case management, and care coordination under the existing § 425.702(c)(1)(ii) and to support Shared Savings Program ACOs in aggregating data for the Shared Savings Program ACO's submission of eCQM/MIPS CQM/Medicare CQM/Medicare eCQM data (as applicable) for each measure under the proposed § 425.508(c)(3), we would provide Shared Savings Program ACOs with a new aggregate report that would contain the data necessary to determine how many beneficiaries would be represented by the TINs the ACO plans to report on. Specifically, the report would be at the beneficiary-TIN level and contain the number of beneficiaries that will be assigned to the ACO and demonstrate how the assigned beneficiaries are matched to the TIN(s). This report would be provided in Quarter 3 and Quarter 4 of each applicable performance year beginning with PY 2026. This would allow the Shared Savings Program ACO to have access to the data that is necessary to determine if the ACO's submission of eCQM/MIPS CQM/Medicare CQM/Medicare eCQM data for each measure includes Shared Savings Program ACO participant TINs sufficient to represent at least 95 percent of the beneficiaries assigned to the Shared Savings Program ACO prior to the application of the measure specifications. This new aggregate report would be delivered to Shared Savings Program ACOs via the Data Hub in the Shared Savings Program ACO Management System (*https://acoms.cms.gov*). If this proposal is finalized, we would provide instructions to Shared Savings Program ACOs in future education and outreach materials on how

to use the new aggregate report to determine the Shared Savings Program ACO participant TINs that represent at least 95 percent of the beneficiaries assigned to the Shared Savings Program ACO prior to the application of the measure specifications as required by the proposed § 425.508(c)(3) for purposes of submission of eCQM/MIPS CQM/Medicare CQM/Medicare eCQM data. The Quarter 3 report would be intended to provide Shared Savings Program ACOs with a preview of the necessary data, while the Quarter 4 report would be the definitive source for ACOs to determine whether the Shared Savings Program ACO meets the proposed Shared Savings Program requirement that the data submitted for each measure must include Shared Savings Program ACO participant TINs that represent at least 95 percent of the beneficiaries assigned to the Shared Savings Program ACO prior to the application of the measure specifications. We note that if our proposal is finalized, we would begin to provide ACOs with this report for Quarter 3 of PY 2026. For PY 2026 and subsequent PYs, Shared Savings Program ACOs must use the new Quarter 4 aggregate report to make the determination under the proposed § 425.508(c)(3). If this proposal is not finalized, we would not share the new aggregate reports.

Since we cannot align a beneficiary to a Shared Savings Program ACO participant TIN without eligible primary care claims, an ACO should not count beneficiaries without eligible primary care claims during the performance year when calculating the 95 percent of beneficiaries needed to meet the requirement proposed at § 425.508(c)(3). Moreover, beneficiaries that do not have at least one eligible primary care encounter during the performance year would not be included on the list of beneficiaries shared with ACOs in Quarter 3 and Quarter 4 during that performance year as proposed earlier in this section. For example, if a beneficiary is voluntarily aligned to the ACO but did not have an eligible primary care claim with a Shared Savings Program ACO participant during the performance year, that beneficiary would not be included on the list of beneficiaries shared with that ACO in Quarter 3 and Quarter 4 of the applicable performance year and the ACO would not include that beneficiary when calculating the numerator used to

determine whether the ACO was compliant with the 95 percent requirement proposed at § 425.508(c)(3). For purposes of calculating the 95 percent requirement, the denominator would be the Shared Savings Program ACO's total number of assigned beneficiaries, inclusive of beneficiaries that did not have an eligible primary care claim during the reporting period with a Shared Savings Program ACO participant.

We note that, under the current definition of a "beneficiary eligible for Medicare CQMs" at § 425.20, beneficiaries eligible for Medicare CQMs for PY 2026 are closely aligned with the Shared Savings Program ACO's assignable population rather than the ACO's assigned population (as proposed in section III.G.3.d.(4) of this rule for PY 2027 and subsequent PYs). Shared Savings Program ACOs that choose to report Medicare CQMs for PY 2026 would have the option to exclude Shared Savings Program ACO participant TINs from their submission of Medicare CQM data provided that the remaining Shared Savings Program ACO participant TINs represent at least 95 percent of the beneficiaries assigned to the ACO prior to the application of the measure specifications.

In addition, in § 425.508(c)(4), we are proposing that we would retain the right to audit and validate eCQM/MIPS CQM/Medicare CQM/Medicare eCQM data for each measure reported by a Shared Savings Program ACO and may request documentation from the Shared Savings Program ACO related to the exclusion of Shared Savings Program ACO participant TINs from the Shared Savings Program ACO's quality data submission. We are also proposing that failure to report quality measure data accurately, completely, and timely may result in compliance actions as described in §§ 425.216 and 425.218.

Section 1871(e)(1)(A) of the Act prohibits the Secretary from applying substantive changes in regulations retroactively before the effective date of the change except where the Secretary determines, as relevant here, that failure to apply the change retroactively would be contrary to the public interest. It is in the public interest to apply our proposed changes to § 425.508 "Incorporating quality reporting requirements related to the Quality Payment Program

Beneficiary" beginning in PY 2026 because, absent the proposed changes, Shared Savings Program ACOs that generated savings while maintaining or improving quality of care may have difficulty meeting the quality reporting requirements at § 425.508(c). Based on the Shared Savings Program ACO public reporting requirements at § 425.308(b)(4)(ii), Shared Savings Program ACOs that generate shared savings must publicly report the total proportion of shared savings invested in infrastructure, redesigned care processes, and other resources required to support the triple aim of better health for populations, better care for individuals, and lower growth in expenditures, including the proportion distributed among Shared Savings Program ACO participants. If a Shared Savings Program ACO does not meet the quality reporting requirements, then that Shared Savings Program ACO would not be eligible to share in savings that could be used for quality improvement initiatives for the Medicare beneficiaries.

The evaluation of Shared Savings Program ACOs' PY 2026 quality performance, including evaluation of data completeness, occurs in 2027. As such, retroactive application of the proposed reporting requirement for PY 2026 would be in the public interest and would afford Shared Savings Program ACOs that earn shared savings the opportunity to devote greater resources to providing better quality of care to Medicare beneficiaries over time and improving care coordination that benefits the Medicare beneficiaries served by Shared Savings Program ACOs, in accordance with ACO public reporting requirements at § 425.308(b)(4)(ii).

Additionally, Shared Savings Program ACOs that participated in the interviews discussed in section III.G.3.c of this proposed rule have also shared that some practices have closed due to financial challenges associated with the transition to digital quality measurement and have begun to remove practices that cannot meet digital reporting requirements from their organization. Practices that do not meet the quality reporting requirements and, therefore, do not earn shared savings, could experience financial instability. For these practices, the loss of shared savings would compound these challenges and may cause them to close or may negatively affect their ability to provide continuity of care, coordination of care, preventive care initiatives, and quality

improvement initiatives for Medicare beneficiaries they serve. As a result, beneficiaries may experience challenges with accessing care, ineffective utilization of services, fragmented care, or duplicative tests or services, and ACOs may be slower to adopt digital quality measurement as a result. The proposed changes would allow Shared Savings Program ACOs to devote greater resources to improving care coordination so that they are better positioned to deliver the right care at the right time, all to the benefit of Medicare beneficiaries served by the Shared Savings Program ACO and Medicare Trust Funds.

We believe the proposed changes would have minimal impact on Shared Savings Program ACOs' existing processes because the Shared Savings Program ACO would continue to aggregate quality data and apply the measure specifications prior to the submission of quality data. Additionally, Shared Savings Program ACOs would benefit from the ability to meet the MIPS data completeness requirement, in the event they are unable to acquire data from a subset of their participant TINs, which may enable them to achieve a quality score equivalent to the 40th percentile MIPS quality performance category score to be eligible to earn maximum shared savings and, for ENHANCED track Shared Savings Program ACOs, avoid shared losses.

In alignment with the proposals described in this section, we are proposing to revise the regulation text at § 425.508 as follows:

- Under new paragraph (c)(1), we would specify that, for PYs beginning on or after January 1, 2026, ACOs may exclude one or more TINs of ACO participants from an ACO's submission of eCQM/MIPS CQM/Medicare CQM/Medicare eCQM data (as applicable) for each measure. We would specify that applicable exclusions may include:

++ Unforeseen circumstance(s) that are outside of the control of the ACO, such as the unexpected closure of a group or individual's practice that bills under the ACO participant TIN.

++ An ACO participant TIN has a CEHRT that is intended for specialty use and does not support the measure(s) included in the APP Plus quality measure set.

++ Other circumstances as determined by CMS.

● Under new paragraph (c)(2), we would specify that ACOs may not exclude an ACO participant TIN from the ACO's quality data submission for each measure based on the following:

++ The demographics status of the beneficiaries who had an encounter during the performance year with an ACO participant TIN.

++ The health status of the beneficiaries who had an encounter during the performance year with an ACO participant TIN.

++ The estimated impact of the ACO participant TIN on the ACO's quality performance.

● Under new paragraph (c)(3), we would specify that the ACO's submission of eCQM/MIPS CQM/Medicare CQM/Medicare eCQM data (as applicable) for each measure must include ACO participant TINs that represent at least 95 percent of the beneficiaries assigned to the ACO prior to the application of the measure specifications.

● Under new paragraph (c)(4), we would specify that CMS retains the right to audit and validate eCQM/MIPS CQM/Medicare CQM/Medicare eCQM data reported by an ACO and may request documentation from the ACO related to the exclusion of ACO participant TINs under paragraph § 425.508(c)(1). We would further note that failure to report quality measure data accurately, completely, and timely may result in compliance actions as described at §§ 425.216 and 425.218.

We are seeking public comments on our proposals to revise the Shared Savings Program quality reporting requirements at § 425.508 beginning in PY 2026. We are also seeking comment on other circumstances we should consider that would allow ACOs to exclude one or more TINs of ACO participants from their submission of eCQM/MIPS CQM/Medicare CQM/Medicare eCQM data for a measure.

(3) Proposal for Shared Savings Program ACOs to Report Using the Medicare eCQMs Collection Type

Shared Savings Program ACOs have expressed concerns regarding the difficulty for

multi-TIN Shared Savings Program ACOs to aggregate and deduplicate patient-level data. Additional challenges persist with integration across multiple EHRs, and these challenges can be an impediment for some Shared Savings Program ACOs. In light of the concerns raised by Shared Savings Program ACOs and other interested parties related to reporting quality measures using the eCQMs collection type and our commitment to supporting Shared Savings Program ACOs in the transition to dQM reporting, for PY 2027 and subsequent PYs, we are proposing in section IV.A.4.d.(1)(b) of this proposed rule to establish the Medicare eCQMs for Accountable Care Organizations Participating in the Medicare Shared Savings Program (Medicare eCQMs) as a new collection type for Shared Savings Program ACOs reporting on the Medicare eCQMs (reporting quality data on beneficiaries eligible for Medicare eCQMs as proposed to be defined at § 425.20) within the APP Plus quality measure set. A Medicare eCQM is essentially an eCQM that is part of the APP Plus quality measure set and reported by a Shared Savings Program ACO on only the Shared Savings Program ACO's assigned beneficiaries, instead of its all payer/all patient population. That is, the Medicare eCQMs will generally follow the eCQM measure specifications; however, they will be reported on a different population and use a different identifier to distinguish that the submission is for a Medicare eCQM rather than for an eCQM.

In the CY 2025 PFS final rule, we noted the numerous benefits to using eCQMs, including their use of electronic standards that reduce reporting burden, and expressed intent to fully transition to digital quality measurement in CMS quality reporting and value-based purchasing programs (89 FR 98106). We believe the addition of Medicare eCQMs would support our efforts to transition to dQMs by supporting Shared Savings Program ACOs that want to report eCQMs but are not able to operationally report on all patient/all payer data due to data aggregation challenges.

Medicare eCQMs would serve to address concerns which are discussed in section III.G.3.d.(1) of this proposed rule by defining a population of beneficiaries that exists within the all payer/all patient eCQM specifications and tethering that population to a Shared

Savings Program ACO's assigned beneficiary population. Shared Savings Program ACOs have expressed challenges with quality data reporting as their list of eligible beneficiaries has often contained beneficiaries for whom the Shared Savings Program ACO is unable to identify a primary care relationship. Specifically, Medicare eCQMs would address the concern raised by Shared Savings Program ACOs that for Shared Savings Program ACOs with a higher proportion of specialty practices and/or multiple EHRs, the broader all payer/all patient eligible population would capture beneficiaries with no primary care relationship to the Shared Savings Program ACO. We intend to allow Shared Savings Program ACOs to continue to report using the existing collection types to maintain stability of collection types during the transition to dQMs. If finalized, Medicare eCQMs would provide an additional optional collection type for reporting quality data for Shared Savings Program ACOs. Medicare eCQMs would provide ACOs the option to report electronically only on their assigned beneficiary population, easing the operational considerations as outlined in this section, and support those Shared Savings Program ACOs with the transition to dQMs. For these reasons, we believe that it is appropriate to establish Medicare eCQMs as a new collection type for Shared Savings Program ACOs only. We also anticipate that in the future, when FHIR-based reporting becomes mandatory, Shared Savings Program ACOs would be able to continue to use the FHIR-based digital specifications to report only on their assigned beneficiary population.

We encourage ACOs to evaluate all quality reporting options to determine which collection type is most appropriate based on the ACO's unique composition and technical infrastructure. In addition to our proposal to allow ACOs the option to report quality data using the Medicare eCQMs collection type, for PY 2027 and subsequent PYs, ACOs would have the option to report quality data using the all payer/all patient eCQMs/MIPS CQMs, and/or the Medicare CQMs collection types. Our long-term goal continues to be to support ACOs in the adoption of dQMs. We would monitor the reporting of quality data using the Medicare eCQMs collection type.

To facilitate the reporting of Medicare eCQMs, in section IV.A.4.d.(1)(b) of this proposed rule, we are proposing to amend the definition of ‘‘collection type’’ in § 414.1305 to include Medicare eCQMs as an available collection type in MIPS for ACOs that participate in the Shared Savings Program.

Additionally, we are proposing to establish data submission and data completeness criteria, in §§ 414.1335(a)(5) and 414.1340(e), respectively, pertaining to the Medicare eCQMs collection type for the MIPS quality performance category as discussed in sections IV.A.4.d.(1)(c)(v) and IV.A.4.d.(1)(d)(ii) of this proposed rule.

We are proposing to define a “beneficiary eligible for Medicare eCQMs” at § 425.20 as a beneficiary identified for purposes of reporting Medicare eCQMs for Shared Savings Program ACOs participating in the Medicare Shared Savings Program (Medicare eCQMs), who is a beneficiary that is assigned to the Shared Savings Program ACO under subpart E.

In section IV.A.4.d.(1)(d)(ii) of this proposed rule, we are proposing to revise § 414.1340(e) to establish the data completeness criteria threshold for the Medicare eCQMs collection type, in which Shared Savings Program ACOs that meet reporting requirements under the APP submitting quality measure data on Medicare eCQMs must submit data on at least 75 percent of the ACO’s applicable beneficiaries eligible for the Medicare eCQM, as proposed to be defined at § 425.20, who meet the measure’s denominator criteria for MIPS payment year 2029 and future MIPS payment years (PY 2027 and subsequent PYs).

To facilitate population-based activities related to improving health under the existing § 425.702(c)(1)(ii) and to aid Shared Savings Program ACOs in the process of patient matching and data aggregation necessary to report Medicare eCQMs, we would provide Shared Savings Program ACOs with a list of beneficiaries that are assigned to the Shared Savings Program ACO and thus are eligible for Medicare eCQM reporting within the Shared Savings Program ACO. We anticipate that the list of beneficiaries eligible for Medicare eCQMs would be shared with Shared Savings Program ACOs on a quarterly basis, beginning with Quarter 1 of PY 2027. We

anticipate that the list of beneficiaries eligible for Medicare eCQMs would be in the same format and delivery schedule as the list of beneficiaries eligible for Medicare CQMs that Shared Savings Program ACOs currently receive on a quarterly basis. The list of beneficiaries eligible for Medicare eCQMs would differ from the list of beneficiaries eligible for Medicare CQMs in that we would apply the eCQM specifications to generate the measure-specific indicators for the list of beneficiaries eligible for Medicare eCQMs (unlike the list of beneficiaries eligible for Medicare CQMs which uses the Medicare CQM specifications to generate the measure-specific indicators). This new report would be delivered to Shared Savings Program ACOs via the Data Hub in the Shared Savings Program ACO Management System (*https://acoms.cms.gov*), but would not be included in the Shared Savings Program ACO's Quarterly Reports Package. The Quarter 4 list would include all beneficiaries eligible for Medicare eCQMs based on available claims data for encounters with dates of service from January 1 through December 31 and may be used as the final list for quality reporting. Like eCQMs, Medicare eCQMs would be reported end-to-end electronically. As such, we recognize that Shared Savings Program ACOs may have other technologically feasible means to identify beneficiaries eligible for Medicare eCQMs within the Shared Savings Program ACO or Shared Savings Program ACO participant TIN CEHRT. For this reason, we are not proposing to require that Shared Savings Program ACOs use the list of beneficiaries eligible for Medicare eCQMs to identify the universe of beneficiaries upon which the Shared Savings Program ACO would report Medicare eCQMs for an applicable PY; rather, the Quarter 4 list can be used as a resource to help Shared Savings Program ACOs identify beneficiaries eligible for Medicare eCQM reporting.

In section III.G.3.f.(2) of this proposed rule, we are proposing that there would be five eCQMs/MIPS CQMs/Medicare CQMs/Medicare eCQMs in the APP Plus quality measure set for Shared Savings Program ACOs for PY 2027 and subsequent PYs.

- Diabetes: Glycemic Status Assessment Greater Than 9% (Quality ID: 001);
- Breast Cancer Screening (Quality ID: 112);

- Colorectal Cancer Screening (Quality ID: 113);
- Preventive Care and Screening: Screening for Depression and Follow-Up Plan (Quality ID: 134); and
- Controlling High Blood Pressure (Quality ID: 236).

ACOs would have the option to report the five Medicare eCQMs, or a combination of eCQMs/MIPS CQMs/Medicare CQMs/Medicare eCQMs, to meet the Shared Savings Program quality reporting requirement at § 425.510(b) and the quality performance standard at § 425.512(a)(5).

To operationalize the reporting of the Medicare eCQMs collection type, if finalized, specifically to distinguish between the submission of data for a Medicare eCQM from the submission of data for an eCQM to CMS, we will create unique identifiers that are associated with each Medicare eCQM. These identifiers must be included in the submission files when reporting Medicare eCQMs beginning in PY 2027. Additional information on reporting Medicare eCQMs, if finalized, will be provided after the release of the CY 2027 PFS final rule.

We are not proposing to add Medicare eCQMs to the eCQM/MIPS CQM reporting incentive described at § 425.512(a)(5)(i)(B)(2) for PY 2027 and subsequent PYs. The eCQM/MIPS CQM reporting incentive intends to provide an incentive to ACOs to report the all payer/all patient eCQMs/MIPS CQMs while allowing them time to gauge their performance on the all payer/all patient eCQMs/MIPS CQMs. We are also not proposing to add Medicare eCQMs to the Complex Organization Adjustment described at § 414.1380(b)(1)(vii)(C) for PY 2027 and subsequent PYs. We reiterate that the Complex Organization Adjustment intends to account for the organizational complexities Shared Savings Program ACOs face when reporting all payer/all patient eCQMs (89 FR 98116).

In section IV.B.1.c.(2) of this proposed rule and in the regulations at § 414.1380(b)(1)(ii)(G)(*1*), we are proposing that, beginning with the CY 2027 performance period/2029 MIPS payment year, measures of the Medicare eCQMs collection type use flat

benchmarks. As stated in the CY 2025 PFS final rule (89 FR 98118), the use of flat benchmarks may allow Shared Savings Program ACOs with high scores to earn maximum or near maximum measure achievement points while allowing room for quality improvement and rewarding that improvement in subsequent years. Use of flat benchmarks also helps to ensure that Shared Savings Program ACOs with high quality performance on a measure are not penalized as low performers.

As part of our proposals for Shared Savings Program ACOs to report the Medicare eCQMs collection type for PY 2027 and subsequent PYs, we propose to revise the regulation text at §§ 425.20 and 425.512 as follows:

Under a new paragraph at § 425.20, we would define a beneficiary eligible for Medicare eCQMs as a beneficiary identified for purposes of reporting Medicare eCQMs for Shared Savings Program ACOs participating in the Medicare Shared Savings Program (Medicare eCQMs), who is a beneficiary that is assigned to the Shared Savings Program ACO under subpart E of this part.

Under § 425.512(a)(2)(iv), we would incorporate Medicare eCQMs into the existing quality performance standard policies for new Shared Savings Program ACOs. Under paragraph (a)(5)(iii)(C), we would also incorporate Medicare eCQMs into the existing policies that describe when a Shared Savings Program ACO would not meet the quality performance standard or the alternative quality performance standard.

We are seeking public comments on our proposals for Shared Savings Program ACOs to report the Medicare eCQMs collection type for PY 2027 and subsequent PYs.

(4) Proposal to Revise the Definition of a "Beneficiary Eligible for Medicare CQMs"

In the CY 2026 PFS final rule (90 FR 49797 through 49803), we finalized the revisions to the definition of a "beneficiary eligible for Medicare CQMs" at § 425.20 effective January 1, 2025. Specifically, beginning with PY 2025 and subsequent PYs, we revised the definition to require, in (1)(ii)(B) of the definition, "at least one primary care service with a date

of service during the applicable performance year from a Shared Savings Program ACO professional who is a primary care physician or who has one of the specialty designations included in § 425.402(c), or who is a physician assistant, nurse practitioner, or clinical nurse specialist." We stated that the revised definition of a "beneficiary eligible for Medicare CQMs" would reduce Shared Savings Program ACOs' burden in the patient matching necessary to report Medicare CQMs because the list of "beneficiaries eligible for Medicare CQMs" would have greater overlap with the list of beneficiaries that are assignable to a Shared Savings Program ACO. We stated that we believed our revised definition of a "beneficiary eligible for Medicare CQMs" would substantially address Shared Savings Program ACOs' and interested parties' concerns by better aligning the definitions and clarifying which beneficiaries' data to use for quality data reporting through Medicare CQMs. In the CY 2026 PFS final rule, some commenters suggested that CMS require Medicare CQMs be reported for ''attributed'' beneficiaries only (90 FR 49800). In response, CMS noted that Medicare CQMs are designed to help Shared Savings Program ACOs address challenges with aggregating patient data required to report the all payer/all patient MIPS CQMs and eCQMs by defining a population of beneficiaries that is broader than the assigned population but exists within the all payer/all patient MIPS CQM specification.

Since the publication of the CY 2026 PFS final rule and implementation of the revised definition aligning with assignable beneficiaries, we have heard from Shared Savings Program ACOs and other interested parties that the current definition of a "beneficiary eligible for Medicare CQMs" continues to cause confusion regarding which beneficiaries to use for quality data reporting. Specifically, Shared Savings Program ACOs have inquired about the differences between the current list of beneficiaries eligible for Medicare CQMs (which is broader than an ACO's assigned population) and the Shared Savings Program ACO's assigned and assignable populations. As discussed in the CY 2026 final rule, an analysis using PY 2024 data noted an average 85 percent overlap between a Shared Savings Program ACO's list of beneficiaries

eligible for Medicare CQMs and the list of beneficiaries assignable to the Shared Savings Program ACO (90 FR 49799). Moreover, we have heard from Shared Savings Program ACOs that the current definition aligning with assignable beneficiaries continues to create burden in patient matching, data aggregation and quality reporting for Shared Savings Program ACOs that elect to report Medicare CQMs. Lastly, Shared Savings Program ACOs have expressed that the current definition of "beneficiaries eligible for Medicare CQMs" that aligns with assignable beneficiaries includes beneficiaries for whom the Shared Savings Program ACO does not readily have data.

Considering the concerns raised by Shared Savings Program ACOs and other interested parties with reporting Medicare CQMs, we propose to revise the definition of a "beneficiary eligible for Medicare CQMs" at § 425.20 for PY 2027 and subsequent PYs, to align with the population of beneficiaries assigned to the ACO.

We implemented Medicare CQMs in PY 2024 to help some Shared Savings Program ACOs build the infrastructure, skills, knowledge and expertise necessary to report all payer/all patient MIPS CQMs and eCQMs (88 FR 79098). The confusion that Shared Savings Program ACOs have expressed about the differences between the list of beneficiaries eligible for Medicare CQMs and a Shared Savings Program ACO's assigned populations have complicated the process for Shared Savings Program ACOs to meaningfully implement Medicare CQMs for this purpose. Our proposed revision would build upon the revisions finalized in the CY 2026 PFS final rule and further refine and align the definition of a "beneficiary eligible for Medicare CQMs" to correspond to a Shared Savings Program ACO's assigned beneficiary list to continue to address Shared Savings Program ACOs' challenges with patient data aggregation. The proposed change to the definition of a "beneficiary eligible for Medicare CQMs" for PY 2027 and subsequent PYs intends to better support these Shared Savings Program ACOs in the transition to digital quality measurement and to eliminate an unintended barrier that Shared Savings Program ACOs have experienced in reporting Medicare CQMs, which have persisted

after the revision of the definition in the CY 2026 PFS final rule to align with assignable beneficiaries.

The Shared Savings Program relies on primary care-based assignment, and the APP Plus quality measure set is primary care-based. Our proposals to use the Shared Savings Program ACO's assigned beneficiary population for the Medicare CQMs collection type beginning in PY 2027 would hold Shared Savings Program ACOs accountable for the quality of care for only the beneficiaries assigned to them and align with the voluntary risk they have undertaken to coordinate beneficiaries' care. Also, focusing on care provided by primary care providers would be a reasonable approach that addresses concerns with data aggregation and specialist participation. Similarly, we have heard from Shared Savings Program ACOs that the current definition of a "beneficiary eligible for Medicare CQMs" is a detriment to Shared Savings Program ACOs meeting the MIPS data completeness requirement described at § 414.1340. As such, the proposed change aims to support Shared Savings Program ACOs in meeting the MIPS data completeness requirement by tethering the universe of beneficiaries that a Shared Savings Program ACO is required to report on for Medicare CQMs to the universe of beneficiaries that have a primary care relationship with the Shared Savings Program ACO as demonstrated through the beneficiaries' assignment to the Shared Savings Program ACO. We anticipate that Shared Savings Program ACOs that choose to report Medicare CQMs would experience fewer barriers in aggregating the applicable numerator and denominator data for beneficiaries that are assigned to the Shared Savings Program ACO and, as a result, would be better positioned to meet the MIPS data completeness requirement described at § 414.1340.

In the CY 2024 PFS final rule, we finalized a new paragraph at § 425.702(c)(1)(iii) to share aggregate reports with Shared Savings Program ACOs with the aim of facilitating population-based activities related to the improvement of health through quality measurement using Medicare CQMs and to aid Shared Savings Program ACOs in the process of patient matching and data aggregation necessary to report Medicare CQMs (88 FR 79099). It was

necessary at that time to revise the regulation text at § 425.702 because the list of beneficiaries eligible for Medicare CQMs, as finalized for PY 2024, was broader than the universe of beneficiaries assigned to the Shared Savings Program ACO. As discussed in this section of the proposed rule, we are proposing to align the definition of a "beneficiary eligible for Medicare CQMs" with the universe of beneficiaries assigned to the Shared Savings Program ACO. The sharing of aggregate reports for beneficiaries assigned to the Shared Savings Program ACO is regulated at § 425.702(c)(1)(ii). As such, since the list of beneficiaries eligible for Medicare CQMs would align with the universe of beneficiaries assigned to the Shared Savings Program ACO under this proposal, it is appropriate to also propose to sunset the regulation at § 425.702(c)(1)(iii) beginning in PY 2027. If finalized, we would provide Shared Savings Program ACOs with a quarterly list of beneficiaries eligible for Medicare CQMs, starting with PY 2027, that aligns with an ACO's list of assigned beneficiaries under the existing regulation at § 425.702(c)(1)(ii).

As part of our proposal to revise the definition of a "beneficiary eligible for Medicare CQMs" for PY 2027 and subsequent PYs, we would revise and republish the definition of a "beneficiary eligible for Medicare CQMs" at § 425.20 to include the following:

We would note that a beneficiary *eligible for Medicare CQMs* means a beneficiary identified for purposes of reporting Medicare CQMs for ACOs participating in the Medicare Shared Savings Program (Medicare CQMs), who meets the following requirements (as applicable):

- For performance years 2024 through 2026, the beneficiary is either of the following:

++ A Medicare fee-for-service beneficiary (as defined at § 425.20) who -

-- Meets the criteria for a beneficiary to be assigned to an ACO described at § 425.401(a); and

-- For performance year 2024, 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 who has one

of the specialty designations included in § 425.402(c), or who is a physician assistant, nurse practitioner, or clinical nurse specialist.

- -- For performance years 2025 and 2026, had at least one primary care service with a date of service during the applicable performance year from an ACO professional who is a primary care physician or who has one of the specialty designations included in § 425.402(c), or who is a physician assistant, nurse practitioner, or clinical nurse specialist.

++ A Medicare fee-for-service beneficiary who is assigned to an ACO in accordance with § 425.402(e) because the beneficiary designated an ACO professional participating in an ACO as responsible for coordinating their overall care.

- For performance years 2027 and subsequent performance years, a beneficiary that is assigned to the ACO under subpart E of this part.

We would also revise the regulation text at § 425.702 to specify that paragraph (c)(1)(iii) applies for performance years 2024 through 2026. We are seeking public comments on our proposal to revise the definition of a "beneficiary Eligible for Medicare CQMs".

e. Proposal to Revise the Shared Savings Program Scoring Policy for Excluded APP Plus Measures and APP Plus Measures That Lack a Benchmark

(1) Background

In the CY 2024 PFS final rule (88 FR 79122 and 79123), we stated that given that the Shared Savings Program does not determine which quality measures are excluded and lack a benchmark and that Shared Savings Program ACOs do not have a choice of measures that they can report under the APP, we do not want to adversely impact shared savings determinations for events outside the Shared Savings Program ACOs' control, such as in the event a measure is excluded or does not have a benchmark. Therefore, we finalized a scoring policy for excluded APP measures and APP measures that lack a benchmark at § 425.512(a)(7). Specifically, we finalized that, to determine whether the Shared Savings Program ACO meets the quality performance standard required to share in savings at the maximum rate under its track (or

payment model within a track), for PY 2024 and subsequent PYs, if a Shared Savings Program ACO reports all of the required measures, meeting the data completeness requirement at § 414.1340 of this subchapter for each measure in the APP measure set and receiving a MIPS quality performance category score as described at § 414.1380(b)(1) of this subchapter, we will use the higher of the Shared Savings Program ACO's quality score or the equivalent of the 40th percentile MIPS quality performance category score across all MIPS quality performance category scores, excluding entities/providers eligible for facility-based scoring, for the relevant performance year when the Shared Savings Program ACO meets either of the following:

- The ACO's total available measure achievement points used to calculate the ACO's MIPS quality performance category score is reduced under § 414.1380(b)(1)(vii)(A) of this subchapter.
- At least one of the eCQMs/MIPS CQMs/Medicare CQMs does not have a benchmark as described at § 414.1380(b)(1)(i)(A) of this subchapter.

Shared Savings Program ACOs that qualify for this existing policy at § 425.512(a)(7) can meet the quality performance standard if one measure in the APP Plus quality measure set is excluded or lacks a benchmark, and the Shared Savings Program ACO will not be evaluated on their quality performance on the remaining quality measures reported by the Shared Savings Program ACO.

(2) Proposed Revisions

When our scoring policy for excluded APP measures and APP measures that lack a benchmark was finalized in the CY 2024 PFS final rule, there were six total measures in the APP quality measure set, and Shared Savings Program ACOs were required to report only three eCQMs/MIPS CQMs (in addition to administering the CAHPS for MIPS survey) for PY 2024 and subsequent PYs (88 FR 79113). In the CY 2025 PFS final rule, we finalized that, for PY 2025 and subsequent PYs, Shared Savings Program ACOs will be required to report the APP Plus quality measure set (89 FR 98105). Under our proposal in section III.G.3.f.(2) of this

proposed rule, we are proposing that for PY 2027 and subsequent PYs, Shared Savings Program ACOs would be required to report on eight measures in the APP Plus quality measure set: five eCQMs/MIPS CQMs/Medicare CQMs/Medicare eCQMs, the CAHPS for MIPS survey, and two administrative claims-based measures that would be calculated by CMS. When CMS established the policy in the CY 2024 PFS final rule, we noted that there were two eCQMs in the legacy APP quality measure set that were suppressed by MIPS in PY 2022 (88 FR 79122). Since these two eCQMs were excluded, the growth in the number of quality measures Shared Savings Program ACOs are required to report increases the likelihood that a Shared Savings Program ACO's quality score would be based on a broader range of quality performance metrics than it would have been in PY 2022. This reduces the impact of measure exclusion on a Shared Savings Program ACO's MIPS quality performance category score. Applying the existing scoring policy at § 425.512(a)(7) when a single measure is excluded from MIPS would allow a Shared Savings Program ACO to meet the quality performance standard without an evaluation of the Shared Savings Program ACO's quality performance on the remaining measures in the APP Plus quality measure set.

Section 1899(b)(3)(C) of the Act states that the Secretary shall establish quality performance standards to assess the quality of care furnished by Shared Savings Program ACOs and shall seek to improve the quality of care furnished by Shared Savings Program ACOs over time by specifying higher standards, new measures, or both for purposes of assessing such quality of care. We believe that revising the scoring policy at § 425.512(a)(7) such that it would only be applied when there are four or more excluded measures in PY 2027 would ensure that Shared Savings Program ACOs are fairly assessed on their quality performance in our determination of whether they meet the quality performance standard to be eligible to share in savings at the maximum rate available for the Shared Savings Program ACO's track and, for ACOs participating in the ENHANCED track, to avoid maximum shared losses. Specifically, we propose to revise the scoring policy at § 425.512(a)(7) for PY 2027 and subsequent PYs, such

that it would apply only if the Shared Savings Program ACO's MIPS quality performance category score is calculated on less than five measures for a given PY. In other words, if there are four or more measures in the APP Plus quality measure set that are excluded from MIPS under § 414.1380(b)(1)(vii)(A) in PY 2027 or a subsequent PY, then the proposed scoring policy at § 425.512(a)(7)(iii) would apply.

We believe that our proposed revisions to § 425.512(a)(7) would result in a more accurate assessment of Shared Savings Program ACOs' quality performance, as each measure in the five-measure minimum threshold would contribute a reasonable weight (20 percent) to the Shared Savings Program ACO's MIPS quality performance category score. However, if there are fewer than five measures available in a given PY, Shared Savings Program ACOs would not risk losing the ability to meet the quality performance standard to be eligible to earn maximum shared savings, and for Shared Savings Program ACOs in the ENHANCED track, avoid maximum shared losses, due to issues with the measures outside of their control.

As discussed later in this section, we are proposing that the current scoring policy at § 425.512(a)(7) would no longer apply when at least one of the required measures in the APP Plus quality set does not have a benchmark for PY 2027 and subsequent PYs. Excluded measures do not contribute to the calculation of a Shared Savings Program ACO's MIPS quality performance category score for that PY. In section III.G.3.f.(2) of this proposed rule, we are proposing that the APP Plus quality measure set would have eight measures in total for PY 2027 and subsequent PYs. Thus, we would calculate a Shared Savings Program ACO's MIPS quality performance category score if there are five or more measures in the APP Plus quality measure set that have not been excluded from MIPS. We note that this policy would only apply if a Shared Savings Program ACO's MIPS quality performance category score is impacted by measure exclusion under MIPS. We also clarify that the policy would not apply for other reasons based on which a measure may be unscored. Specifically, it would not apply if the Shared Savings Program ACO does not meet the MIPS case minimum requirement at § 414.1380 on any

measure in the APP Plus quality measure set. Our proposal would allow us to better evaluate Shared Savings Program ACOs' quality performance and appropriately determine shared savings eligibility based on quality of care.

Therefore, we propose that, for PY 2027 and subsequent PYs, if the Shared Savings Program ACO's MIPS quality performance category score is calculated on less than five measures due to measure exclusion under MIPS and the Shared Savings Program ACO meets the other quality reporting requirements as described in the proposed § 425.512(a)(7)(iii), then we would use the higher of the Shared Savings Program ACO's quality score or the equivalent of the 40th percentile MIPS Quality performance category score across all MIPS Quality performance category scores, excluding entities/providers eligible for facility-based scoring.

We provide two hypothetical examples of the application of this proposed policy for illustrative purposes. Hypothetical example 1: for PY 2027, a Shared Savings Program ACO reports three eCQMs (Quality IDs: 001, 112, and 236), one Medicare CQM (Quality ID: 134), and one MIPS CQM (Quality ID: 113) in the APP Plus quality measure set, meets the MIPS data completeness requirement at § 414.1340 on all of these five measures, and receives a MIPS quality performance category score. The Shared Savings Program ACO also administers the CAHPS for MIPS survey and has the two administrative claims-based measures in the APP Plus quality measure set calculated by CMS. Hypothetically, if Quality IDs 001, 112, 113, and 236 are excluded from MIPS under § 414.1380(b)(1)(vii)(A) for PY 2027, then the Shared Savings Program ACO's MIPS quality performance category score would be based on four measures: the two administrative claims-based measures, the CAHPS for MIPS survey, and Quality ID: 134. The proposed scoring policy at § 425.512(a)(7)(iii) would apply in this scenario since the Shared Savings Program ACO's MIPS quality performance category score would be based on less than five measures. Therefore, the Shared Savings Program ACO would receive the higher of the Shared Savings Program ACO's quality score or the equivalent of the 40th percentile MIPS Quality performance category score across all MIPS quality performance category scores. This

would allow the Shared Savings Program ACO to meet the quality performance standard and be eligible to share in savings at the maximum rate available for their track and, for ENHANCED track Shared Savings Program ACOs, to avoid maximum shared losses.

Hypothetical example 2: for PY 2027, a Shared Savings Program ACO reports all five eCQMs in the APP Plus quality measure set, meets the MIPS data completeness requirement at § 414.1340 on all five eCQMs (Quality IDs: 001, 112, 113, 134, and 236), administers the CAHPS for MIPS survey, receives a MIPS quality performance category score, and has the two administrative claims-based measures calculated by CMS. Under this scenario, the eCQM version of Quality ID: 001 was excluded from MIPS under § 414.1380(b)(1)(vii)(A). Our proposed scoring policy would not apply in this case since the Shared Savings Program ACO's MIPS quality performance category score would be based on more than five measures: the two administrative claims-based measures, the CAHPS for MIPS survey, and four eCQMs.

In the CY 2024 PFS final rule (88 FR 79123), we stated that given that the Shared Savings Program does not determine which quality measures do not have a benchmark and that Shared Savings Program ACOs do not have a choice of measures they can report under the APP, we do not want to adversely impact shared savings determinations for events outside the Shared Savings Program ACOs' control, such as in the event a measure does not have a benchmark. Therefore, we finalized at § 425.512(a)(7) to include eCQMs, MIPS CQMs, and Medicare CQMs within the APP measure set that do not have a benchmark as described at § 414.1380(b)(1)(i)(A). In the CY 2025 PFS final rule (89 FR 98120), we finalized that beginning in the CY 2025 performance period/2027 MIPS payment year, measures of the Medicare CQMs collection type would be scored using flat benchmarks for their first two performance periods in MIPS. Also, in sections III.G.3.c. and III.G.3.d.(3) of this proposed rule, we are proposing that Medicare CQMs and Medicare eCQMs would be scored using flat benchmarks for PY 2027 and subsequent PYs. The use of flat benchmarks to score Medicare CQMs and Medicare eCQMs would mitigate the risk that MIPS would not be able to

calculate benchmarks for these measures in the APP Plus quality measure set. Additionally, we note that none of the eCQMs, MIPS CQMs, or Medicare CQMs that Shared Savings Program ACOs have reported over the past four PYs lacked benchmarks. Therefore, we propose that the scoring policy at § 425.512(a)(7) would no longer apply when at least one of the required measures in the APP Plus quality set does not have a benchmark for PY 2027 and subsequent PYs.

We would revise the regulation text at § 425.512(a)(7) as follows:

- We are revising paragraph (a)(7)(ii) to specify that it applies for performance years 2025 and 2026.
- Under new paragraph (a)(7)(iii), we would specify that, for performance year 2027 and subsequent performance years, if an ACO reports all of the required measures in the APP Plus quality measure set, meeting the data completeness requirement at § 414.1340 for each measure in the APP Plus quality measure set, and receiving a MIPS Quality performance category score as described at § 414.1380(b)(1), for the relevant performance year, and the ACO meets the following-

++ The ACO's MIPS Quality performance category score is calculated on less than five measures; and

++ Any unscored measure(s) must meet all of the following-

-- The ACO's total available measure achievement points used to calculate the ACO's MIPS Quality performance category score are reduced under § 414.1380(b)(1)(vii)(A).

-- The ACO's total measure achievement points used to calculate the ACO's MIPS Quality performance category score are not reduced under § 414.1380(b)(1)(iii).

We are seeking public comments on our proposed revisions to the Shared Savings Program scoring policy at § 425.512(a)(7).

f. Proposal to Update the APP Plus Quality Measure Set

(1) Background

We finalized in the CY 2025 PFS final rule (89 FR 98104) that, for PY 2025 and subsequent PYs, Shared Savings Program ACOs will be required to report the APP Plus quality measure set. We also finalized that Shared Savings Program ACOs will be required to report and be scored on all applicable quality measures in the APP Plus quality measure set according to the phase-in schedule for incorporating measures into the APP Plus quality measure set (89 FR 98105). We also stated in the CY 2025 PFS final rule (89 FR 98116 and 98117) that the APP Plus quality measure set for Shared Savings Program ACOs will include 11 measures (eight eCQMs/Medicare CQMs, two administrative claims-based measures, and the CAHPS for MIPS Survey measure) beginning with PY 2028 or the PY that is one year after the eCQM specifications become available for the Screening for the Social Drivers of Health (Quality ID: 487) and Adult Immunization Status (Quality ID: 493) measures, whichever is later, and Shared Savings Program ACOs will be scored on the required 11 measures. The final APP Plus quality measure set for Shared Savings Program ACOs, for PY 2025 and subsequent PYs, was specified in Tables 39 through 42 of the CY 2025 PFS final rule (89 FR 98128 through 98132).

In the CY 2025 PFS final rule (89 FR 98130 through 98132), we finalized that Diabetes: Glycemic Status Assessment Greater Than 9% (Quality ID: 001), Preventive Care and Screening: Screening for Depression and Follow-up Plan (Quality ID: 134), and Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups (Quality ID: 479) would be incorporated into the APP Plus quality measure set for PY 2025. Additionally, we finalized that Initiation and Engagement of Substance Use Disorder Treatment (Quality ID: 305) will be incorporated into the APP Plus quality measure set for PY 2027 and Adult Immunization Status (Quality ID: 493) will be incorporated into the APP Plus quality

measure set beginning with PY 2028 or the PY that is 1 year after the eCQM specification becomes available for Quality ID: 493, whichever is later.

In the CY 2026 PFS final rule (90 FR 49818), we finalized the removal of Screening for Social Drivers of Health (Quality ID: 487) from the APP Plus quality measure set (90 FR 49817 and 50311). With the removal of Quality ID: 487, the APP Plus quality measure set for Shared Savings Program ACOs will include ten measures (seven eCQMs/Medicare CQMs, two administrative claims-based measures, and the CAHPS for MIPS Survey measure) beginning with PY 2028 or the PY that is 1 year after the eCQM specification becomes available for Adult Immunization Status (Quality ID: 493), whichever is later (90 FR 49817). We stated that Shared Savings Program ACOs will be scored on the required ten measures (90 FR 49817). The final APP Plus quality measure set for Shared Savings Program ACOs, for PY 2028 or the PY that is 1 year after the eCQM specification becomes available for Quality ID: 493, whichever is later, was specified in Table B-G5 of the CY 2026 PFS final rule (90 FR 49818).

Shared Savings Program ACOs expressed concerns with increasing the number of measures in the APP Plus quality measure set each year. Shared Savings Program ACOs have suggested maintaining a stable measure set as they transition to digital quality reporting. In response to the CY 2026 PFS Digital Quality Measurement RFI, many commenters recommended that CMS maintain the APP Plus quality measure set as finalized without adding new measures to preserve resources for the transition to digital quality measurement and to consider challenges Shared Savings Program ACOs face in data aggregations for eCQM/MIPS CQM/Medicare CQM reporting (90 FR 49855 and 49856).

(2) Proposed Revisions

As discussed in section IV.A.4.b.(2) and Table Group D, in Appendix 1, of this proposed rule, we are proposing to adopt measure specification changes to the following measures that are included in the APP Plus quality measure set:

- Diabetes: Glycemic Status Assessment Greater Than 9% (Quality ID: 001) (eCQMs collection type only)
- Preventive Care and Screening: Screening for Depression and Follow-up Plan (Quality ID: 134)
- Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups (Quality ID: 479)

With the proposed removal of Initiation and Engagement of Substance Use Disorder Treatment (Quality ID: 305) and Adult Immunization Status (Quality ID: 493) from the APP Plus quality measure set as described in section IV.A.4.b.(2) of this proposed rule, we propose that the APP Plus quality measure set for Shared Savings Program ACOs would include eight measures (five eCQMs/MIPS CQMs/Medicare CQMs/Medicare eCQMs, two administrative claims-based measures, and the CAHPS for MIPS Survey measure) beginning with PY 2027. Shared Savings Program ACOs would be scored on the required eight measures. We believe that these proposals would lessen the burden associated with implementing new quality measures as Shared Savings Program ACOs move toward digital quality measurement. The proposed APP Plus quality measure set for Shared Savings Program ACOs, for PY 2027 and subsequent PYs is specified in Table B-G5. This table also reflects the proposed creation of the new Medicare eCQMs collection type for Shared Savings Program ACOs reporting the APP Plus quality measure set for PY 2027 and subsequent PYs, as discussed in section III.G.3.d.(3) and Table Groups D and DD, in Appendix 1, of this proposed rule.

TABLE B-G5: MEASURES INCLUDED IN THE APP PLUS QUALITY MEASURE SET FOR SHARED SAVINGS PROGRAM ACOS FOR PY 2027 AND SUBSEQUENT PYs

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

^ Indicates this is an outcome measure for purposes of qualifying for the eCQM/MIPS CQM reporting incentive and the alternative quality performance standard.

g. Summary of Proposals

In Table B-G6 of this proposed rule, we summarize the quality reporting requirements and quality performance standard policies for PY 2027 and subsequent PYs, including our proposals in this proposed rule. This table also reflects the creation of the new Medicare eCQMs collection type and removal of Initiation and Engagement of Substance Use Disorder Treatment (Quality ID: 305) and Adult Immunization Status (Quality ID: 493) from the APP Plus quality measure set for Shared Savings Program ACOs, as discussed in sections III.G.3.d.(3) and III.G.3.f.(2), respectively, of this proposed rule. The quality reporting requirements and quality performance policies for PY 2026 were summarized in Table B-G6 of the CY 2026 PFS final rule (90 FR 49819 and 49820).

TABLE B-G6: APP PLUS QUALITY MEASURE SET REPORTING REQUIREMENTS AND QUALITY PERFORMANCE STANDARD POLICIES FOR SHARED SAVINGS PROGRAM ACOS FOR PY 2027 AND SUBSEQUENT PYS

	PY 2027 and Subsequent PYs
Shared Savings Program ACO Quality Reporting Requirements	ACOs are required to report **5** eCQMs/MIPS CQMs/Medicare CQMs/Medicare eCQMs in the APP Plus quality measure set and administer the CAHPS for MIPS survey (except if the ACO does not meet the minimum beneficiary sampling requirements specified at § 414.1380(b)(1)(vii)(B)). CMS will calculate 2 administrative claims-based measures.
Shared Savings Program ACO Quality Performance Standard and Alternative Quality Performance Standard*	**ACOs that report the APP Plus quality measure set can meet the quality performance standard used to determine eligibility for maximum shared savings and to avoid maximum shared losses (if applicable) via one of the three pathways:** **1**. ***For all ACOs:*** Achieve a quality score that is equivalent to or higher than the **40th** percentile across all MIPS quality performance category scores, excluding entities/providers eligible for facility-based scoring, or **2.** ***For ACOs that report the 5 eCQMs/MIPS CQMs in the APP Plus quality measure set and meet the MIPS data completeness requirement at § 414.1340 for all 5 eCQMs/MIPS CQMs:*** Meet the eCQM/MIPS CQM reporting incentive by achieving a quality performance score equivalent to or higher than the **10th** percentile of the performance benchmark on at least 1 of the 4 outcome measures in the APP Plus quality measure set and a quality performance score equivalent to or higher than the **40th** percentile of the performance benchmark on at least 1 of the remaining 7 measures in the APP Plus quality measure set. ***3. For ACOs in their first PY of their first agreement period under the Shared Savings Program***: Report the APP Plus quality measure set and meet the MIPS data completeness requirement at 414.1340 on the 5 eCQMs/MIPS CQMs/Medicare CQMs/Medicare eCQMs in the APP Plus quality measure set, administer the CAHPS for MIPS survey (except if the ACO does not meet the minimum beneficiary sampling requirements specified at § 414.1380(b)(1)(vii)(B)), and receive a MIPS quality performance category score. **Alternative quality performance standard used to determine shared savings using the sliding scale methodology:** ACOs that do not meet the quality performance standard based on the criteria above can meet the alternative quality performance by reporting quality data on the APP Plus quality measure set and achieving a quality performance score equivalent to or higher than the **10th** percentile of the performance benchmark on at least 1 of the 4 outcome measures in the APP Plus quality measure set will share in savings (if otherwise eligible) at a lower rate that is scaled by the ACO's quality score. If an ACO (1) does not report any of the 5 eCQMs /MIPS CQMs/Medicare CQMs/Medicare eCQMs in the APP Plus quality measure set and (2) does not administer a CAHPS for MIPS survey, unless the ACO does not meet the minimum beneficiary sampling requirements specified at § 414.1380(b)(1)(vii)(B), the ACO will not meet the quality performance standard or the alternative quality performance standard. This ACO will be ineligible for shared savings and will owe maximum shared losses, if applicable.

*The quality performance standard policies described in this table apply to ACOs that are not subject to the extreme and uncontrollable circumstances policies at § 425.512(c).

4. Shared Savings Program Certified Electronic Health Record Technology (CEHRT) Use Requirements

a. Background

Section 1899(b)(3)(D) of the Act authorizes the Secretary to incorporate reporting requirements and incentive payments from section 1848 of the Act into the Shared Savings

Program, such as requirements and incentive payments related to electronic prescribing and electronic health records. The statute also authorizes the Secretary to use alternative criteria for determining whether to make such incentive payments.

Section 1833(z)(2)(C)(iii)(II)(bb) of the Act (as amended by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)) generally requires Advanced Alternative Payment Models (Advanced APMs) to require the use of CEHRT. Under this authority, we have codified Advanced APM CEHRT use criteria at § 414.1415(a). We have incorporated requirements related to the adoption and use of CEHRT in the Shared Savings Program regulations. We have adopted a definition of CEHRT in § 425.20 that cross references the Quality Payment Program's definition of CEHRT (§ 414.1305).

For the Shared Savings Program, CMS updated the CEHRT definition in the CY 2024 PFS final rule (88 FR 79309). Under paragraph (3) of the CEHRT definition in § 414.1305, CEHRT currently means EHR technology (which could include multiple technologies) certified by the Office of the National Coordinator for Health Information Technology (ONC) under the ONC Health IT Certification Program as meeting the 2015 Edition Base EHR definition, or subsequent Base EHR definition (set forth at 45 CFR § 170.102), and a designated set of health IT certification criteria adopted or updated in 45 CFR § 170.315 that are determined applicable for the APM.

In the context of health IT, the secure exchange, access, and use of electronic health information supports better informed decision making and a more efficient health care system.[256] Interoperability (as defined at 45 CFR § 170.102) enables this secure exchange and access. To this end, CMS intends to utilize approaches based on the HL7® (Health Level 7) Fast Healthcare Interoperability Resources® (FHIR)[257] standard to support the exchange of quality information,

[256] CMS Interoperability – CMS – Center for Medicare & Medicaid Services found at *https://www.cms.gov/priorities/key-initiatives/burden-reduction/interoperability/cms-interoperability.*
[257] Health Level 7 (HL7) Fast Healthcare Interoperability Resources (FHIR) - ONC - Office of the National Coordinator for Health Information Technology found at *https://healthit.gov/interoperability/investments/fhir/.*

consistent with CMS' digital quality measurement initiatives, as described in the FHIR RFI in the CY 2026 PFS proposed rule (90 FR 32710 through 32715). FHIR is a widely used application program interface (API)-focused standard used to represent and exchange health information maintained by the standards development organization HL7.ONC adopts the FHIR standard (currently FHIR R4) as well as FHIR implementation guides for different API use cases in 45 CFR § 170.215, and incorporates these standards into certification criteria for health IT.

In the CY 2019 PFS final rule (83 FR 59982 through 59988), we adopted requirements related to ACOs' use of CEHRT, beginning with PY 2019, and in subsequent years. In that final rule, we revised the Shared Savings Program annual certification requirements at § 425.302(a)(3)(iii) to require ACOs to certify at the end of each PY that the percentage of eligible clinicians participating in the ACO who used CEHRT to document and communicate clinical care to their patients or other health care providers met or exceeded the applicable percentage specified in the requirements established in § 425.506(f) (83 FR 60092). Specifically, we codified that beginning with PY 2019, and in subsequent years, for ACOs in a track that did not meet the financial risk standard to be an Advanced APM (for example, ACOs participating under BASIC track Levels A through D), the ACO was required to certify that 50 percent of the ACO's eligible clinicians used CEHRT to document and communicate clinical care to their patients or other health care providers. For ACOs in a track that met the financial risk standard to be an Advanced APM (for example, ACOs participating under BASIC track Level E or the ENHANCED track), the ACO was required to certify that the percentage of eligible clinicians participating in the ACO that use CEHRT to document and communicate clinical care to their patients or other health care providers met or exceeded the threshold established under the Quality Payment Program at § 414.1415(a)(1). Under this requirement (§ 425.506(f)(2)), for PY 2019 through PY 2024, 75 percent of eligible clinicians were required to use CEHRT to document and communicate clinical care to their patients or health care providers (§ 1415(a)(1)(i)). In the same final rule, we updated our regulations at § 425.20 to incorporate

the definition of CEHRT at § 414.1305 that applies under the Quality Payment Program (83 FR 60092).

In the CY 2024 PFS proposed rule (88 FR 52435), we stated our belief that aligning Shared Savings Program CEHRT use requirements with Merit-Based Incentive Payment System (MIPS) Promoting Interoperability performance category requirements would reduce burden on ACOs, because they would no longer have to meet distinct Shared Savings Program attestation requirements and MIPS Promoting Interoperability requirements. We also referred back to our statements in the CY 2019 PFS rule where we conveyed our desire to continue to promote and encourage CEHRT use by ACOs and their ACO participants and ACO providers/suppliers, and our desire to better align with the goals of the Quality Payment Program and the criteria for participation in certain alternative payment models tested by the CMS Innovation Center. We expressed our belief that our proposal to end the CEHRT attestation requirements and align the Shared Savings Program with the MIPS Promoting Interoperability performance category requirements would allow ACOs to focus on a unified set of program requirements for the use of CEHRT and reduce the administrative burden of managing compliance with a different set of program requirements with the same aim (88 FR 52435).

In the CY 2024 PFS final rule (88 FR 79124 through 79132), we modified the Shared Savings Program CEHRT requirements to end the CEHRT attestation requirements and align the Shared Savings Program with MIPS' Promoting Interoperability performance category requirements. We modified § 425.302(a)(3)(iii) to make the Shared Savings Program Annual CEHRT Certification requirement applicable only for PYs 2019 through 2024. This effectively sunset the Shared Savings Program CEHRT requirement that ACOs certify that the percentage of eligible clinicians participating in the ACO that used CEHRT to document and communicate clinical care to their patients or other health care providers met or exceeded the applicable percentage specified at § 425.506(f). We also revised the CEHRT reporting policy at § 425.507(a) for PYs beginning on or after January 1, 2025, to require, unless otherwise

excluded, that ACO participants, ACO provider/suppliers, and ACO professionals who are MIPS eligible clinicians, Qualifying APM Participants (QP), or Partial QPs (each as defined at § 414.1305), regardless of track, must (88 FR 79131):

- Report the MIPS Promoting Interoperability performance category measures and requirements to MIPS according to 42 CFR part 414, subpart O at the individual, group, virtual group, or APM entity level; and
- Earn a MIPS performance category score for the MIPS Promoting Interoperability performance category at the individual, group, virtual group, or APM entity level.

In the CY 2024 PFS final rule, we also finalized § 425.507(b), under which ACO participants, ACO providers/suppliers, or ACO professionals are excluded from the requirements specified in § 425.507(a) based on applicable policies that exclude or exempt eligible clinicians from reporting the MIPS Promoting Interoperability performance category as set forth in 42 CFR part 414, subpart O. We included in that provision the qualifier that an ACO participant, ACO provider/supplier, or ACO professional cannot be excluded from the requirements specified at § 425.507(a) solely on the basis of being a QP or Partial QP (88 FR 79131). We finalized that applicable exclusions may apply to ACO participants, ACO providers/suppliers, or ACO professionals that meet the low volume threshold as set forth at § 414.1310(b)(1)(iii), are non-MIPS eligible clinicians [eligible clinician as defined at § 414.1305; who is not a MIPS eligible clinician as set forth in § 414.1310(b)(2)], or have a reweighted MIPS Promoting Interoperability performance category to zero percent of the final score in accordance with applicable policies set forth at § 414.1380(c)(2).

Lastly, in the CY 2024 PFS final rule, we updated public reporting requirements at § 425.308(b)(9) to reflect the MIPS Promoting Interoperability performance category measures and activities (88 FR 79132). We required ACOs to publicly report the number of MIPS eligible clinicians, QPs, and Partial QPs (each as defined at § 414.1305) participating in the ACO who

earned a MIPS Promoting Interoperability performance category score at the individual, group, virtual group, or APM entity level, as set forth in § 425.507. This includes:

- The number of ACO participants, ACO providers/suppliers, and ACO professionals that meet the requirements of § 425.507(a) and are not excluded under § 425.507(b) for the applicable PY; and
- The number of ACO participants, ACO providers/suppliers, and ACO professionals that are excluded under § 425.507(b) that voluntarily reported and received a MIPS Promoting Interoperability performance category score for the applicable PY.

For PY 2025, we exercised enforcement discretion for the Shared Savings Program CEHRT requirements and will not take compliance actions under §§ 425.216 or 425.218 for PY 2025 if an ACO does not meet the requirements of §§ 425.507 and 425.308(b)(9). There will also be no impact on the ACO's ability to earn or receive shared savings for PY 2025.[258]

In the Frequently Asked Questions document where we provided notice that we were exercising enforcement discretion for PY 2025, we also stated that we would release additional information regarding Shared Savings Program Promoting Interoperability requirements for PY 2026. We are now providing ACOs with notice that we will extend the enforcement discretion that applied for PY 2025 to PY 2026. We will not take compliance actions under §§ 425.216 or 425.218 for PY 2026 if an ACO does not meet the requirements of §§ 425.507 and 425.308(b)(9). There will also be no impact on the ACO's ability to earn or receive shared savings for PYs 2025 or 2026.

Shared Savings Program ACOs, professional associations, and vendors reporting quality on behalf of ACOs have expressed concern with the burden of the Shared Savings Program requirement that all Shared Savings Program ACO participants report all MIPS Promoting

[258] Please see the notice of enforcement discretion in the Shared Savings Program Requirement to Report Objectives and Measures for Merit-based Incentive Payment Systems (MIPS) Promoting Interoperability Performance Category FAQ (*https://www.cms.gov/files/document/frequently-asked-questions-shared-savings-program-requirement-report-objectives-measures-mips.pdf*)

Interoperability performance category measures and activities. Most Shared Savings Program ACOs (74 percent) are in tracks that qualify as Advanced APMs (BASIC level E and ENHANCED).[259] Qualifying APM participants in these ACOs are exempt from Promoting Interoperability performance category reporting for the purposes of MIPS under 42 CFR § 414.1310(b)(i). Therefore, they are only being required to report MIPS Promoting Interoperability performance category measures and activities by the Shared Savings Program. ACOs have expressed confusion about MIPS Promoting Interoperability performance category reporting requirements, exclusions, and exceptions. Specifically, ACOs have requested clarification about how to aggregate and report across their organizations, especially when their practices use different EHRs or when ACOs have some practices that qualify for applicable exclusions.

We also recognize that ACOs are often comprised of many ACO professionals who serve large patient populations and that such ACOs may need to aggregate data across multiple EHR systems. An internal CMS analysis described in the CY 2025 PFS final rule that analyzed PY 2022 data indicates that Shared Savings Program ACOs reported substantially higher numbers of denominator-eligible patients for certain eCQM measures than other MIPS reporters, including 33 times more denominator eligible patients for eCQM 001—Diabetes: HbA1c Poor Control (>9 percent), 53 times more denominator eligible patients for eCQM 134—Preventative Care and Screening: Screening for Depression and Follow-Up Plan, and 25 times more denominator eligible patients for eCQM 236—Controlling High Blood Pressure. CMS data analysis also showed that ACOs provide a high volume of services, particularly those related to preventative screening measures; for example, in PY 2022, one ACO reported on over 700,000 denominator eligible beneficiaries for a single eCQM (89 FR 98436). Additionally, ACOs and related interested parties have shared that relatively few ACOs use one EHR, while a greater

[259] See Shared Savings Program Fast Facts as of January 1, 2026 (*https://www.cms.gov/files/document/2026-shared-savings-program-fast-facts.pdf*).

share use two to ten.[260] These data underscore the operational scale and complexity associated with this reporting.

Thus, providing additional flexibility to ACOs would be helpful in light of the complex populations they serve, the high volume of data they process, and the necessity of aggregating data across multiple EHRs. Changes to simplify the Shared Savings Program requirement for ACOs to fulfill CEHRT use requirements would also be consistent with the Administration's interest, as expressed in the "Request for Information: Deregulation" (90 FR 15481 through 15482), in identifying proposals to rescind or replace regulations that burden American businesses. In response to that RFI, several commenters asked that CMS reduce burdensome requirements for ACOs to report MIPS Promoting Interoperability performance category measures and activities, including a few specific suggestions that we reverse the Shared Savings Program's MIPS Promoting Interoperability performance category reporting requirement due to the increased burden on ACOs without adding any value. Others suggested that we revert to an attestation requirement, revise the definition of CEHRT, re-evaluate numerator and denominator requirements for CEHRT use reporting, or recognize CMS Innovation Center model participation, use of FHIR, or participation in health information exchanges as evidence of interoperability without the need for additional reporting or attestation.

From commenters' responses to a CMS RFI on digital quality measurement included in the CY 2026 PFS proposed rule (90 FR 32710 through 32715), we learned that interested parties broadly supported CMS' efforts to move toward FHIR-based digital quality measurement. Commenters noted that the use of interoperable sources that are available at the point of care would ultimately increase efficiency, reduce administrative burden, and empower patients and providers to make informed care decisions. Many commenters also stated that significant technical and operational work remains to be completed before implementation of FHIR-based

---

[260] See *https://www.naacos.com/ecqms-for-acos-recommendations-from-the-naacos-digital-quality-measurement-task-force/*.

digital quality measurement, to ensure there is sufficient infrastructure to support the migration to and execution of FHIR. Several commenters described that the phased adoption, technical assistance, and incentives for use of EHR data would promote a successful transition to FHIR-based digital quality measurement. Some commenters opposed movement to FHIR-based digital quality measurement, with noted concerns including the ability of small practices to transition, potential performance issues with technology, need for clarity around exclusions, and difficulty with aggregating across large organizations.

b. Proposal to Simplify Shared Savings Program CEHRT Use Requirements

We believe that reduction in burden for reporting CEHRT use will free ACO resources to focus on meaningful advancement toward digital exchange of health information, including digital quality measurement. As noted above, commenters on the Request for Information: Deregulation asked that we recognize ACO use of FHIR technologies and that we simplify Shared Savings Program CEHRT use requirements. We believe that these suggestions would advance FHIR-based digital quality reporting by giving credit for incremental advances toward digital quality reporting.

In response to the concerns and suggestions detailed above and in line with CMS' priorities to reduce burden and promote FHIR-based digital quality reporting and exchange of health information, we are proposing to sunset, beginning with PY 2027, the requirements at § 425.507(a) for Shared Savings Program ACO participants, ACO provider/suppliers, and ACO professionals that are MIPS eligible clinicians, Qualifying APM Participants, or Partial Qualifying APM Participants to report all MIPS Promoting Interoperability performance category measures and requirements and to earn a performance category score for the MIPS Promoting Interoperability performance category at the individual, group, virtual group, or APM entity level. Accordingly, we also propose to sunset the associated exclusions that complement this requirement at § 425.507(b). We are proposing to replace the requirement in § 425.507(a)

with different options for ACOs to meet CEHRT use requirements for the Shared Savings Program, described in further detail below.

As Shared Savings Program ACOs cover 12.6 million beneficiaries, served by over 700,000 participating clinicians and facilities,[261] we believe that a shift to FHIR-based digital quality reporting and exchange of health information at this scale would meaningfully advance care coordination and quality improvement. We further believe reducing the burden of Shared Savings Program participation could lead to increased program participation from ACOs and ACO professionals, which would magnify the impact, moving even more clinicians toward meaningful use of EHR technology to improve care for beneficiaries.

To encourage widespread adoption of FHIR-based transmission of clinical data, enable bi-directional exchange of clinical data across practices within ACOs, and support the capture of robust clinical quality information, we propose, in § 425.507(c), that for PY 2027 and subsequent PYs, to meet the Shared Savings Program CEHRT use requirement, ACOs would be required to perform at least one of three allowable activities. The three allowable CEHRT use activities, from which ACOs would choose at least one, are described in further detail in this section. In summary, they are:

(1) Completely report at least one of the five ACO-reported measures in the APP Plus quality measure set through the eCQMs collection type or the proposed Medicare eCQMs collection type (proposed in section III.G.3.d.(3) of this proposed rule) using CEHRT; OR

(2) Attest to the ACO's use of FHIR capabilities to support reporting of at least one of the five ACO-reported measures in the APP Plus quality measure set using CEHRT. Section IV.A.4.b.(2) of this proposed rule contains measures in the APP Plus quality measure set that are reportable by ACOs in PY 2027; OR

[261] See Shared Savings Program Fast Facts as of January 1, 2026 (*https://www.cms.gov/files/document/2026-shared-savings-program-fast-facts.pdf*).

(3) Select and attest to one of the proposed Shared Savings Program CEHRT use metrics, which are based on a subset of MIPS Promoting Interoperability performance category measures, and which may be updated annually if there are changes.

We also propose to sunset existing public reporting requirements at § 425.308(b)(9) and propose to add a new section at § 425.308(b)(11), which would require ACOs to publicly report which of the allowable CEHRT use options proposed above they elected to perform to meet CEHRT use requirements for the Shared Savings Program for PY 2027 and subsequent PYs.

(1) Meeting Shared Savings Program CEHRT Use Requirement by Reporting at Least One ACO-Reported Measure Through the eCQMs or Medicare eCQMs Collection Types

As discussed earlier in this section, commenters have asked that CMS recognize efforts that ACOs are already undertaking to advance CEHRT use, without the need for additional reporting or attestation. Accordingly, we are proposing to recognize ACO reporting of eCQMs without additional reporting requirements, for the purpose of satisfying the Shared Savings Program CEHRT use requirements. Because reporting of eCQMs or the proposed Medicare eCQMs would require the use of CEHRT and submission of CEHRT IDs[262] to communicate care quality to CMS, we believe that an ACO's reporting of measures using the eCQM collection type or the proposed Medicare eCQM collection type (see section III.G.3.d.(3) of this proposed rule for discussion of the proposal to establish Medicare eCQM collection type) is a concrete example of ACO CEHRT use that supports improved patient care. Clinical quality measure reporting helps identify areas for potential care improvement, and use of CEHRT to report quality of care is a step toward bi-directional exchange of health information and digital quality measurement.

We propose, in § 425.507(c)(1), that one option ACOs could select to meet the Shared Savings Program CEHRT use requirement is using EHR technology that meets the requirements in paragraph (3) of the CEHRT definition at § 414.1305. ACOs would need to use EHR

[262] For more information, please find the MIPS Data Submission User Guide on the QPP Resource Library: https://qpp.cms.gov/resources/resource-library

technology that is also certified to certification criteria that support the recording, calculation, and reporting of clinical quality measures by being certified to the ONC Health IT Certification Program certification criteria at 45 CFR § 170.315(c)(1) (included in the Base EHR definition in 45 CFR § 170.102), (c)(2) and (c)(3) to completely report at least one measure in the APP Plus quality measure set, through the eCQMs or the proposed Medicare eCQMs collection type. Paragraph (3) of the CEHRT definition at § 414.1305 is the CEHRT definition applicable to Advanced APMs. The requirement that Shared Savings program ACOs use CEHRT that is certified to the ONC Health IT Certification Program certification criteria at 45 CFR § 170.315(c)(2) and (c)(3) would be consistent with CEHRT use requirements under MIPS, as specified in paragraph (2)(ii)(B) of the CEHRT use definition at § 414.1305, which includes a specific requirement for use of EHR technology certified been certified to the ONC health IT certification criteria that support the calculation and reporting of clinical quality measures at 45 CFR § 170.315(c)(2) and (c)(3).

To "completely report" as we use that phrase in the proposed regulatory text, for the purpose of using this option to satisfy Shared Savings Program CEHRT use requirements, would mean that the ACO meets the Shared Savings Program quality reporting requirements proposed at § 425.508(c)(1) to (c)(4) and as discussed in section III.G.3.d.(2) of this rule as well as the MIPS data completeness requirements at § 414.1340 for the measure submission. The measure must be completely reported as part of annual quality reporting. Under this proposal, ACOs that completely report at least one quality measure through the eCQMs or the proposed Medicare eCQMs collection types, as determined by MIPS, would not be required to complete an attestation to meet Shared Savings Program CEHRT use requirements. Please note that, in section III.G.3.d.(2) of this proposed rule, we are proposing changes to the Shared Savings Program quality reporting requirements at § 425.508, which may alter the universe of patients used to determine compliance with the MIPS data completeness requirements at § 414.1340 and would be applicable to the proposed changes for the Shared Savings Program CEHRT use

requirement. Under this Shared Savings Program CEHRT use requirement proposal, ACOs electing to meet the Shared Savings Program CEHRT use requirement by completely reporting at least one ACO-reported measure in the APP Plus quality measure set through the eCQMs or the proposed Medicare eCQMs collection type would be required to meet the proposed Shared Savings Program quality reporting requirement changes proposed in section III.G.3.d.(2) of this proposed rule, if finalized, along with the MIPS data completeness requirements at § 414.1340 for that eCQM or the proposed Medicare eCQM measure submission.

We understand that ACOs may still face challenges in aggregating data. As discussed more fully in section III.G.3.d. of this proposed rule, we believe that the proposed data completeness requirement changes would help to mitigate the issues facing ACOs in aggregating data for eCQM or proposed Medicare eCQM reporting. We also note that eCQM or proposed Medicare eCQM reporting is just one of three proposed ways an ACO could meet the Shared Savings Program CEHRT use requirement.

(2) Meeting Shared Savings Program CEHRT Use Requirements by Attesting to Using FHIR Capabilities in Certified Health IT to Support Reporting of At Least One of the Five ACO-Reported Measures in the APP Plus Measure Set

We are proposing, in § 425.507(c)(2), that another option ACOs could select for PY 2027 and subsequent PYs, to meet the Shared Savings Program CEHRT use requirement, is completely reporting at least one of the measures in the APP Plus quality measure set and meeting the data completeness requirement under § 414.1340.

The ACO must also attest that it used technology certified to ONC Certification Criteria for Health IT (45 CFR § 170.315) supporting FHIR-based exchange to meet paragraph (3) of the CEHRT definition at § 414.1305 to support measure data collection. Specifically, it must attest to the use of a Health IT Module (as defined in 45 CFR § 170.102) that has been certified to an unexpired criterion or criteria in 45 CFR § 170.315 to make information in the U.S. Core Data for Interoperability (USCDI) available through a FHIR-based API (currently USCDI version 3;

45 CFR § 170.213(b)). Data represented by the USCDI can be used to support meeting the data requirements for measures in the APP Plus quality measure set. By mapping data elements in USCDI to measure specifications, users could leverage this functionality in their CEHRT to obtain data needed to calculate measures in the APP plus measure set. For instance, an initial analysis found data requirements for several MIPS CQMs/Medicare CQMs identified in the APP Plus quality measure set could be met using the data in USCDI version 3 obtained via an API meeting the requirements of 45 CFR § 170.315(g)(10) in previous performance years.[263]

We note that eligible clinicians and APM entities already have the flexibility to use data obtained via Health IT Modules certified to certification criteria in 45 CFR § 170.315 to report MIPS CQMs and Medicare CQMs, as CMS does not specify how eligible clinicians and APM entities must collect data for MIPS CQMs and Medicare CQMs, and no further updates are needed to our quality reporting policies to permit use of this technology. Rather, our proposed policy aims to encourage Shared Savings Program ACOs to use this approach to obtain data for quality measure reporting. Using standardized data from FHIR APIs can support more seamless aggregation of data across different EHR systems used by ACO participants. To meet the Promoting Interoperability requirement for the Shared Savings Program at the APM entity level as presently required in § 425.507(a), ACOs are already required to demonstrate use of CEHRT through the MIPS requirement to use CEHRT at § 414.1375(b)(1). Specifically, current policy requires that ACOs use EHR technology that is certified to certification criteria in 45 CFR § 170.315(g)(10), as it is a part of the "Base EHR" definition at 45 CFR § 170.102. The Base EHR definition is included in paragraph (3) of the "Certified Electronic Health Record Technology (CEHRT)" definition at 42 CFR 414.1305 used by the Shared Savings Program. For the purpose of meeting this option, ACOs electing to attest would attest that it used data collected from a FHIR-based API to support data collection using a Health IT Module certified

[263] *See* "Advancing Digital Quality Reporting Using Regulated Endpoints" *https://leavittpartners.com/wp-content/uploads/2026/04/Advancing-Digital-Quality-Reporting-Using-Regulated-Endpoints.pdf.*

to an unexpired criterion or criteria in 45 CFR § 170.315 supporting standardized API access, to support reporting a measure in the APP Plus measure set.

We are proposing to require ACOs to attest because, for the MIPS CQMs or Medicare CQMs collection types we cannot ascertain (absent attestation) whether an ACO used FHIR technology to support collection of data used to report these measures. For the proposed CEHRT use activity option in § 425.507(c)(1), discussed above, we will be able to identify the ACOs that met that CEHRT use activity from quality reporting submission data; however, attestation would be required for an ACO electing to meet Shared Savings Program CEHRT use requirements by using standardized data from FHIR APIs to support collection of data for reporting at least one measure in the APP Plus measure set. We note that, while the option to meet Shared Savings Program CEHRT use requirements by attesting to use of a FHIR-based API to support complete reporting of at least one measure in the APP Plus measure set could conceivably be used for any available measure collection type, it would not be necessary for ACOs electing to report eCQMs or Medicare eCQMs collection types. This is because those ACOs electing to report via eCQMs or Medicare eCQMs collection types would receive automatic credit for reporting through those collection types, as CMS would be able to ascertain based on quality data submissions that ACOs completely reported a measure in the APP Plus measure set using the eCQM or Medicare CQM collection type, and that is one option that would satisfy the Shared Savings Program CEHRT use requirement. Accordingly, the discussion here focuses only on the MIPS CQMs and Medicare CQMs collection types. For ACOs electing to meet Shared Savings Program CEHRT use requirements by attesting to use of data collected from a FHIR-based API to support complete reporting using a Health IT module certified to an unexpired criterion or criteria that supports standardized API access, for at least one measure through the MIPS CQMs or Medicare CQMs collection types, the measure must be completely reported as part of annual quality reporting. We propose that ACOs would attest to meeting this requirement through ACO-MS, after the conclusion of annual quality reporting, which occurs in the first quarter of the year

following the PY. For example, we anticipate that the attestation would be available in ACO-MS in the second quarter of 2028, after the conclusion of quality reporting for PY 2027. This proposed option for meeting Shared Savings Program CEHRT use requirements through the use of standardized data from FHIR APIs to report MIPS CQMs or Medicare CQMs would serve to recognize efforts underway by ACOs taking an interim step in the transition to FHIR-based digital quality reporting.

CMS described a parallel goal to implement FHIR reporting for eCQMs in an RFI posted in the CY 2026 proposed rule (90 FR 32710 through 32715), and requests comment on a timeline for transitioning to FHIR-based digital quality measurement in section IV.A.4.c. of this proposed rule. In the RFI regarding the timeline to transition to FHIR-based reporting in this proposed rule, we indicated that following this transition period, FHIR-based reporting would be required for those applicable measures that were available as FHIR-based dQM reporting options during the transition period, beginning with the 2030 performance period. These Shared Savings Program CEHRT use proposals are aligned with our efforts to recognize ACO movement toward FHIR-based digital quality measurement and take into consideration comments received on the Request for Information: Deregulation, where a few commenters noted that leveraging FHIR technology supports multidisciplinary collaboration and efficient information sharing without additional attestations. While we disagree that use of FHIR technology alone obviates the needs for an attestation, since we are presently not able to discern whether an ACO has utilized a certified Health IT Module (for example, a 45 CFR § 170.315(g)(10)-certified Health IT Module) to obtain standardized data from a FHIR-based API to aggregate data for quality reporting without an attestation, we acknowledge the value in use of FHIR technology. In response to commenters' concerns about reporting burden, we believe that this attestation would represent a significantly reduced burden in comparison to the current requirement in § 425.507(a) that all ACO participants report all MIPS Promoting Interoperability performance category measures and activities. Another commenter responded that CMS should incorporate

FHIR-based capabilities as a fundamental requirement in the Shared Savings Program. We believe that an ACO's use of a Health IT Module certified to an unexpired criterion or criteria within 45 CFR § 170.315 to obtain standardized data from FHIR APIs to support collecting data is a concrete step toward interoperability that will enable both digital quality reporting and bi-directional exchange of health information.

Under this proposed option for meeting the Shared Savings Program CEHRT use requirement, ACOs choosing to attest that they used a Health IT Module certified to an unexpired criterion or criteria within 45 CFR § 170.315 to obtain standardized data from a FHIR API to support collection of data for reporting at least one measure in the APP Plus measure set would also need to have completely reported that measure, according to data completeness requirements detailed earlier in this section.

(3) Meeting Shared Savings Program CEHRT Use Requirements by Attesting to One of the Three ACO CEHRT Use Metrics

We are proposing, in § 425.507(c)(3), that another option ACOs could select to meet the Shared Savings Program CEHRT use requirement, is to attest to at least one of the Shared Savings Program CEHRT use metrics from the list of metrics established for the applicable performance year. We are proposing three Shared Savings Program ACO CEHRT use metrics for PY 2027, listed in Table B-G7. Like similar measures that are included in the MIPS Promoting Interoperability performance category, these three Shared Savings Program ACO CEHRT use metrics represent meaningful ACO use of CEHRT for improved patient care. We are proposing to allow ACOs to attest that the ACO meets one of these three metrics to satisfy the Shared Savings Program CEHRT use requirement. This proposal is responsive to public comments on the deregulatory RFI (90 FR 15481 to 15482). Responses to the RFI included several comments asking that CMS permit attestation for meaningful use of CEHRT and exchange of health information, to ease reporting burdens and encourage small practices to participate in the Shared Savings Program. One commenter also suggested CMS incentivize

organizations to utilize real-time data exchange. We believe that allowing ACOs to attest to the use of bi-directional exchange of health information as one of the three options would promote ACOs engaging in this valuable activity while representing a significantly reduced burden as compared to our current Shared Savings Program CEHRT requirement that ACOs report on all MIPS Promoting Interoperability performance category measures and activities.

We would update the list of allowable metrics through notice and comment rulemaking if there are any changes for future years.

TABLE B-G7: AVAILABLE METRICS FOR SHARED SAVINGS PROGRAM ACO CEHRT USE ATTESTATION

MIPS Promoting Interoperability Performance Category Objective	Shared Savings Program ACO CEHRT Use Metric and Description
A. Electronic Prescribing	ACO Electronic Prescribing: At least one permissible prescription was written by an ACO provider/supplier in each of the ACO's participating TINs (except any TIN that had fewer than 100 permissible prescriptions in the performance period) and the prescription was transmitted electronically using CEHRT.
B. Health Information Exchange	ACO Health Information Exchange Bi-Directional Exchange: At least one ACO provider/supplier from each of the ACO's participating TINs participated in HIE bi-directional exchange for at least one patient with an HIE that has the capability to enable secure, bi-directional exchange for all patients, without excluding exchange partners, using CEHRT.
C. Provider to Patient Exchange	ACO Provider to Patient Exchange: At least one ACO provider/supplier from each of the ACO's participant TINs provided at least one patient electronic access to their health information using CEHRT.

The ACO CEHRT use metrics we are proposing are based on the following parallel MIPS Promoting Interoperability performance category measures: Electronic Prescribing,[264] Health Information Exchange (HIE) Bi-Directional Exchange,[265] and Provide Patients Electronic Access to Their Health Information.[266] The parallel MIPS Promoting Interoperability performance category measures provide instructions on how MIPS eligible clinicians can report the measures, with instructions to aggregate across all MIPS eligible clinicians for group and APM-level reporting in each of the measure specification documents. We are not proposing,

---

[264] *https://qpp.cms.gov/docs/pi_specifications/Measure%20Specifications/2026-MIPS-Promoting-Interoperability-e-Prescribing-Measure.pdf*.

[265] *https://qpp.cms.gov/docs/pi_specifications/Measure%20Specifications/2026-MIPS-Promoting-Interoperability-HIE-Bi-Directional-Exchange-Measure.pdf*.

[266] *https://qpp.cms.gov/docs/pi_specifications/Measure%20Specifications/2026-MIPS-Promoting-Interoperability-Provide-Patients-E-Access-to-Their-Health-Info-Measure.pdf*.

however, that ACOs would be required to report Shared Savings Program ACO CEHRT use metrics for every ACO provider/supplier in the ACO, as is required under the MIPS measure specifications, because we understand that this level of information may be difficult or burdensome for ACOs to aggregate. To recognize the varying capacities for ACO participants to report on CEHRT use and for ACOs to report on CEHRT use for all of their ACO participants, we are proposing that ACOs would be allowed to attest "Yes" if at least one ACO provider/supplier in each of the ACO's participating TINs performed the action described in the Shared Savings Program ACO CEHRT use metric using EHR technology certified to the ONC Certification Criteria for Health IT (45 CFR § 170.315) necessary to meet paragraph (3) of the CEHRT definition at § 414.1305 to complete the action described in each metric.

As discussed earlier in this section, ACOs have faced challenges in reporting a high volume of participant data involving multiple EHRs for MIPS Promoting Interoperability measures and activities. An additional source of confusion is the requirement to report on behalf of all participants when an ACO reports at the APM entity level, including participants who would have been excluded or have received special status for reporting purposes when reporting at the individual or group level. Similarly, because QPs do not receive MIPS scores or payment adjustments, the requirement that QPs report the MIPS Promoting Interoperability performance category and earn a performance category score is a burden unique to Shared Savings Program Promoting Interoperability requirements. ACOs have also reported incidents of practices included on the ACO's Participant Agreement closing throughout the year, which requires the ACO to report on behalf of groups with whom contact may be difficult. Given this, we no longer believe it is reasonable to require them to report on every ACO provider/supplier in the ACO. We recognize and have been reminded by interested parties that participation in an ACO itself represents a commitment to coordinating care. ACOs in the Advanced APM tracks of the Shared Savings Program (BASIC track Level E and ENHANCED track), whose qualifying participants are exempt from MIPS, have taken on financial risk for providing coordinated, efficient care. We

believe that in addition to that undertaking, our proposal to allow ACOs to attest that one ACO provider/supplier from each of the ACO's participating TINs has completed the action required under one of the ACO CEHRT use metrics we are proposing would be sufficient to demonstrate CEHRT use. We note that providers and suppliers who are MIPS eligible clinicians and who participate in ACOs in Shared Savings Program tracks that do not meet the definition of an Advanced APM (BASIC track levels A-D) and those in Advanced APM tracks who are not QPs will still be required to report MIPS Promoting Interoperability performance category measures (unless they are otherwise excluded under MIPS) to earn a score for the Promoting Interoperability performance category.

In this section, we provide summary level information of the three proposed ACO CEHRT use metrics. These details generally align with the measure specifications for the respective MIPS Promoting Interoperability measures; however, they reflect ACO-level attestation. From these, ACOs would be allowed to select one metric to which the ACO would be able to attest "Yes," to meet Shared Savings Program ACO CEHRT use requirements. Following the discussion of the three proposed metrics, we describe proposed allowable exclusions from ACO attestation. For each of these proposed activities, to attest "Yes," the ACO's participant TINs must use EHR technology certified to the ONC Certification Criteria for Health IT (45 CFR § 170.315) necessary to meet paragraph (3) of the CEHRT definition at § 414.1305. We further describe the specific certified Health IT Modules that must be used to complete the action in the measure, consistent with information provided by the MIPS program for corresponding measures. If finalized, we would make public on our website more detailed information on each of these metrics.

(i) ACO Electronic Prescribing: An ACO could attest "Yes," if, during the PY, at least one permissible prescription was written by at least one ACO provider/supplier in each of the ACO's participant TINs, and the prescription was transmitted electronically using CEHRT. In addition to the allowable exclusions from Shared Savings Program CEHRT use attestation

discussed later in this section, ACOs choosing to attest to this metric would be permitted to exclude from their assessment any ACO participant TIN whose providers and suppliers wrote fewer than 100 total permissible prescriptions during the PY. This exclusion would align with a similar exclusion in the parallel MIPS Promoting Interoperability e-Prescribing measure, which provides an exclusion for any MIPS eligible clinician who writes fewer than 100 permissible prescriptions during the performance period. This would mean that an ACO could attest that it met this metric even if no electronic prescription was written by any provider or supplier in one of the ACO's ACO participant TINs, where all of the ACO's participants TINs were composed of providers and suppliers who wrote fewer than 100 total permissible prescriptions. Similar to the MIPS e-Prescribing measure, a prescription would be defined as the authorization by an ACO provider or supplier to a pharmacist to dispense a drug that the pharmacist wouldn't dispense to the patient without such authorization. A permissible prescription is a prescription, as described in the preceding sentence, including electronic prescription of controlled substances, where creation of an electronic prescription for the medication is feasible using CEHRT and where allowable by state and local law. An ACO electing to attest to this metric to meet the Shared Savings Program CEHRT use requirement would be required to attest that at least one ACO provider or supplier in each of its ACO participant TINs used CEHRT, including health IT certified to the "electronic prescribing" criterion in 45 CFR § 170.315(b)(3) to complete the actions of this Shared Savings Program CEHRT use metric.

(ii) ACO Health Information Exchange (HIE) Bi-Directional Exchange: An ACO could attest "Yes" if, during the PY, at least one ACO provider or supplier from each of the ACO's participant TINs has, for at least one patient seen by the provider or supplier used EHR technology certified to the ONC Certification Criteria for Health IT (45 CFR § 170.315) necessary to meet paragraph (3) of the CEHRT definition at § 414.1305 to support bi-directional exchange with an HIE that: enables secure, bi-directional exchange to occur for every patient encounter, transition or referral, and record stored or maintained in the provider or supplier's

EHR during the PY in accordance with applicable law and policy; and that the HIE is capable of exchanging information across a broad network of unaffiliated exchange partners including those using disparate EHRs and does not engage in exclusionary behavior when determining exchange partners. These elements of this Shared Savings Program ACO CEHRT use metric align with those in the parallel MIPS Promoting Interoperability measure. An ACO electing to attest to this metric to meet the Shared Savings Program CEHRT use requirement would not be required to attest that at least one ACO provider or supplier from each ACO participant TIN used CEHRT functionality to perform bi-directional exchange for every patient throughout the PY. Rather, attesting "yes" to the measure requires that at least one ACO provider or supplier from each of the ACO's participant TINs used CEHRT functionality to perform bi-directional exchange for at least one patient with an HIE that has the capability to enable secure, bi-directional exchange for all patients, without excluding exchange partners. We recognize that a provider/supplier may have different options with respect to the certified health IT that it uses to connect to an HIE. Health IT certified to criteria including, but not limited to, the "transitions of care" criterion in 45 CFR § 170.315(b)(1), the "Clinical information reconciliation and incorporation" criterion in 45 CFR § 170.315(b)(2), and the "Standardized API for patient and population services" 45 CFR § 170.315(g)(10), could be utilized to support bi-directional exchange through an HIE. An ACO attesting to this metric, for the purpose of meeting the Shared Savings Program CEHRT use requirement, would be required to attest that at least one ACO provider or supplier in each of its ACO participant TINs used CEHRT, including health IT certified to but not limited to the criteria previously discussed, to complete the actions of this Shared Savings Program CEHRT use metric.

We note that the MIPS Promoting Interoperability performance category includes a corresponding measure under the HIE objective entitled "Enabling Exchange Under TEFCA," which enables eligible clinicians to earn credit for the HIE Objective if they participate as a signatory to a Framework Agreement (as that term is defined by the Common Agreement for

Nationwide Health Information Interoperability) to enable secure, bi-directional exchange of information for every patient encounter, transition of care or referral, and record stored or maintained in the EHR during the performance period, using CEHRT. We note that, while we have not proposed to adapt this measure for the proposed ACO CEHRT use requirements, ACO providers or suppliers who are able to attest "Yes" to the "Enabling Exchange Under TEFCA" measure under the MIPS Promoting Interoperability performance category would meet the requirement to have used CEHRT to perform bi-directional exchange for at least one patient. Accordingly, an ACO choosing to attest to having met this metric could consider an ACO provider or supplier who could attest to the MIPS Promoting Interoperability measure, "Enabling Exchange Under TEFCA" for a particular performance year to count as having met the requirement for their ACO participant TIN when determining whether one ACO provider or supplier from each of its ACO participant TINs has met the requirement for the proposed ACO Health Information Exchange (HIE) Bi-Directional Exchange metric.

(iii) ACO Provider to Patient Exchange: An ACO could attest "Yes" to this metric if, during the PY, at least one ACO provider or supplier from each of the ACO's participant TINs has, for at least one patient seen by the ACO provider or supplier (or the patient-authorized representative): provided timely access to view online, download, and transmit his or her health information; and ensured the patient's health information is available for the patient (or the patient's personal representative) to access using any application of their choice that is configured to meet the technical specifications of the Application Programming Interface (API) in the clinician's CEHRT. Similar to the MIPS Promoting Interoperability performance category measure, "Provide Patients Electronic Access to Their Health Information," for the ACO to attest "Yes," the patient would need to be able to access this information on demand, such as through a patient portal or personal health record (PHR) or by other online electronic means.

As detailed in the measure specifications for the parallel MIPS measure, specific rights and privacy protections apply to the provision of protected health information (PHI) to

individuals. While a covered entity may be able to fully satisfy a patient's request to access the patient's information through view, download, or transmit functionality, the metric would not replace a covered entity's responsibilities to meet the right of access requirements under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule (45 CFR part 160 and subparts A and E of part 164) to provide an individual, upon request, with access to PHI in a designated record set. There may be patients who can't access their health information electronically because of a disability. In these cases, ACO providers or suppliers who are covered by civil rights laws are required to provide individuals with disabilities equal access to information and appropriate auxiliary aids and services as provided in the applicable statutes and regulations.

An ACO electing to attest to this metric to meet the Shared Savings Program CEHRT use requirement would be required to attest that at least one ACO provider or supplier in each of its ACO participant TINs used health IT certified to the "view, download, and transmit to 3rd party" criterion in 45 CFR § 170.315(e)(1) to provide view, download, or transmit capabilities to at least one patient. The ACO participant would also be required to use health IT certified to the "application access — patient selection" criterion in 45 CFR § 170.315(g)(7), the "application access — all data request" criterion in 45 CFR § 170.315(g)(9), and the "standardized API for patient and population services" criterion in § 170.315(g)(10) to support information access through an API to their patients. We note, however, as we discussed with respect to the MIPS Promoting Interoperability performance category in section IV.A.4.d.(4) of this proposed rule, ONC proposed to remove the criteria in 45 CFR § 170.315(g)(7) and (g)(9) as of January 1, 2027 in the HTI-5 Proposed Rule (90 FR 60998). If ONC finalizes these proposals, we would no longer require ACOs to use health IT certified to the removed criteria to meet the measure and rather, the ACO would be required to attest to having used health IT certified to the "view, download, and transmit to third party" criterion in 45 CFR § 170.315(e)(1) to provide view, download, or transmit capabilities to patients and to the "standardized API for patient and

population services" criterion in § 170.315(g)(10), to meet the requirements of this Shared Savings Program ACO CEHRT use metric. ACOs electing to attest to any one of the three ACO CEHRT use metrics, including this one, would also still be required to attest that their participating ACO providers and suppliers used EHR technology necessary to meet paragraph (3) of the CEHRT definition at § 414.1305, as described previously. Patient health information would need to be made available to the patient to view, download, or transmit within 4 business days of the information being available to the ACO provider or supplier for every time that information is generated. Also, in alignment with the MIPS Promoting Interoperability performance category measure, for "view, download, or transmit" functionality, the required content would be: an unexpired version of the USCDI adopted at 45 CFR § 170.213; Provider's name and office contact information; Laboratory test report(s); Diagnostic image report(s), and for API functionality, the required data set is the USCDI.

(iv) Allowable ACO exclusions from Shared Savings Program CEHRT use metrics: Based on feedback we received from the RFIs discussed earlier in this section and questions we have received from ACOs on the existing Shared Savings Program CEHRT use requirements that we are proposing to sunset and replace, we understand that ACOs may face difficulties in determining whether an ACO provider or supplier from each of its ACO participant TINs has performed the required action for a given proposed Shared Savings Program ACO CEHRT use metric. We, therefore, propose to allow certain exclusions for ACOs electing to meet the Shared Savings Program CEHRT use requirement by attesting to one of the available Shared Savings Program CEHRT use metrics. By "exclusion," we mean that an ACO would be able to attest to having performed the activity required by the metric, even if one or more of the ACO's participant TINs did not have at least one ACO provider/supplier that performed the activity, if that TIN or TINs meets one of the exclusions described below.

We propose that ACOs would be permitted to apply exclusions for similar circumstances as the exclusions and exceptions under MIPS, when ACOs choose to report one of the three

proposed Shared Savings Program ACO CEHRT use metrics for purposes of satisfying the Shared Savings Program CEHRT use requirement in PY 2027 and future years. We note under MIPS, special statuses result in automatic reweighting of the Promoting Interoperability performance category to zero. For hardship circumstances, MIPS eligible clinicians or groups may be required to submit a hardship exception application that is subject to CMS approval. However, for the purposes of the Shared Savings Program CEHRT use requirement, we propose that an ACO may exclude from their Shared Savings Program CEHRT attestation an ACO participant TIN that meets certain exclusion criteria outlined below without requesting approval from CMS. This means that the ACO may still attest to having performed the action required by the metric, without consideration of whether at least one ACO provider or supplier from a TIN meeting these criteria performed the required action, when at least one ACO provider or supplier in each of the ACO's other participant TINs (that are not permitted to be excluded) performed the required action. The criteria under which an ACO would be permitted to exclude an ACO participant TIN are that the ACO determines the TIN is comprised solely of ACO providers and/or suppliers who:

- Would meet the definition of "special status"; or
- Are facing hardship circumstances that would qualify for MIPS Promoting Interoperability hardship exception requests, had such requests been submitted by a MIPS eligible clinician.

For Shared Savings Program CEHRT use metric exception purposes, the following would be considered special statuses. The definitions of these special statuses would be similar to the MIPS definitions at § 414.1305 except that they would not be limited to MIPS ECs, for the purpose of Shared Savings Program CEHRT use metric exceptions. For Shared Savings Program CEHRT use metric exclusion purposes, ACOs would be permitted to exclude an ACO participant TIN if the ACO determines that the TIN is comprised solely of ACO providers and suppliers meeting the following special statuses:

● ASC-based- ACO providers or suppliers who furnish 75 percent or more of their covered professional services during the performance period in sites of service identified by the POS codes used in the HIPAA standard transaction[267] as an ambulatory surgical center setting based on claims.

● Facility-based- ACO providers or suppliers who:

++ Furnish 75 percent or more of their covered professional services in sites of service identified by the place of service codes used in the HIPAA standard transaction as an inpatient hospital, on-campus outpatient hospital, or emergency room setting based on claims for a 12-month segment beginning on October 1 of the calendar year 2 years prior to the applicable performance period and ending on September 30 of the calendar year preceding the performance period with a 30-day claims run out; and

++ Furnish at least 1 covered professional service in sites of service identified by the place of service codes used in the HIPAA standard transaction as an inpatient hospital, or emergency room setting; and

++ Can be assigned to a facility with a value-based purchasing score, determined under the methodology specified in § 414.1380(e)(5), for the applicable period.

● Hospital-based- ACO providers or suppliers who provide 75 percent or more of their covered professional services during the PY in sites of service identified by the POS codes used in the HIPAA standard transaction as an inpatient hospital, on-campus outpatient hospital, off campus outpatient hospital, or emergency room setting based on claims.

● Non-patient facing- ACO providers or suppliers who billed 100 or fewer patient-facing encounters (including Medicare telehealth services defined in section 1834(m) of the Act) during the performance year. A patient-facing encounter is an instance in which the provider or

[267] For more information on HIPAA transactions, please see the CMS HIPAA and Administrative Simplification webpage: https://www.cms.gov/priorities/key-initiatives/burden-reduction/administrative-simplification/hipaa

supplier bills for items and services furnished such as general office visits, outpatient visits, and procedure codes under the PFS, as specified by CMS.

- Located in a health professional shortage area (HPSA)- ACO providers and suppliers are located in areas as designated under section 332(a)(1)(A) of the Public Health Service Act
- Rural area- ACO providers or suppliers that are in a ZIP code designated as rural by the Federal Office of Rural Health Policy (FORHP), using the most recent FORHP Eligible ZIP Code file available as described in the definition of "Rural area" at § 414.1305.

As noted earlier in this section, the special status definition for the Shared Savings Program CEHRT use metric exclusions would be similar to the one used for MIPS eligible clinicians at § 414.1305. In contrast to the MIPS special status definition, however, small practices would not be considered a special status for the purpose of exclusion from ACO CEHRT use metric attestation because we believe that joining an ACO should be a way for small practices to receive assistance with care coordination and quality improvement efforts such as use of CEHRT.

The hardship circumstances that would qualify an ACO participant TIN for exclusion from Shared Savings Program CEHRT use metric attestation would parallel those described in § 414.1380(c)(2)(i)(C), except that neither the ACO nor the ACO provider or supplier would need to submit an application to CMS. An ACO could exclude, for purposes of determining whether the ACO can attest "yes" to a Shared Savings Program CEHRT use metric, ACO participant TINs comprised solely of providers or suppliers meeting any of the following conditions:

- The ACO providers or suppliers lacked sufficient internet access during the performance period, and insurmountable barriers prevented them from obtaining sufficient internet access.
- The ACO providers or suppliers were subject to extreme and uncontrollable circumstances that caused their CEHRT to be unavailable.

- The ACO providers or suppliers were located in an area affected by extreme and uncontrollable circumstances as identified by CMS.

- 50 percent or more of the ACO providers' or suppliers' outpatient encounters occurred in practice locations where they had no control over the availability of CEHRT.

- The ACO providers' or suppliers' CEHRT was decertified under the Office of the National Coordinator for Health IT (ONC) Health IT Certification Program) either during the PY, or decertified during the calendar year preceding the performance year and the ACO providers or suppliers made a good faith effort to adopt and implement another CEHRT in advance of the performance year.

We are proposing that an ACO may exclude ACO participant TINs composed entirely of ACO providers or suppliers who meet these criteria from their determination as to whether at least one ACO provider or supplier from each of its ACO participant TINs has completed the action required by the ACO CEHRT use metric and still attest that the metric is met, because ACO participant TINs comprised solely of MIPS eligible clinicians meeting the definition of "special status" under MIPS would be exempt from reporting MIPS Promoting interoperability and those facing circumstances that would qualify for a MIPS Promoting Interoperability hardship may be granted an exception under MIPS. We recognize providers and suppliers in Shared Savings Program ACO participant TINs would face the same challenges in these situations. We are proposing that ACOs be allowed to determine whether any of their ACO participant TINs meet the criteria without requesting an exception from CMS because those ACO providers or suppliers who are QPs in an ACO that is in an Advanced APM track are exempt from MIPS and therefore cannot request MIPS hardship exceptions. They also cannot qualify for automatic reweighting due to special status. We therefore believe it would be appropriate to allow ACOs to exclude such ACO participant TINs from the ACO's assessment of whether at least one ACO provider or supplier from each of the ACO's participant TINs met the requirement of the Shared Savings Program CEHRT use metric and still attest that the metric has

been met. For example, an ACO participant whose ACO providers or suppliers have fewer than 100 patient-facing encounters in a PY may not have engaged in e-Prescribing, exchange of health information, or provider to patient exchange of health information, so the ACO can make the determination to exclude the ACO participant for the purposes of attesting to one of the proposed metrics. In another example, an ACO may not be able to ascertain whether at least one ACO provider or supplier in an ACO participant TIN comprised of hospital-based physicians who are employed at a hospital that does not participate in the ACO, have participated in an HIE. This ACO participant and its suppliers would be exempt from MIPS Promoting Interoperability reporting, so we believe it would be appropriate to recognize and account for these situations under the Shared Savings Program.

ACOs would be required to maintain documentation of excluded ACO participant TINs, including evidence that the TINs met one of the criteria for exclusion from the ACO's attestation to Shared Savings Program CEHRT use metrics, in the event of a CMS audit. ACOs that fail to maintain adequate documentation may be subject to compliance actions, as discussed in further detail in the Compliance with Shared Savings Program CEHRT Use Requirements paragraph of this proposed rule.

(4) New Public Reporting Requirements

We are proposing to sunset the requirement at § 425.308(b)(9) that ACOs must publicly report the total number of ACO participants, ACO providers/suppliers, and ACO professionals that are MIPS eligible clinicians, QPs, or Partial QPs (each as defined at § 414.1305) that earn a MIPS performance category score for the MIPS Promoting Interoperability performance category beginning with PY 2027. We propose to revise § 425.308(b)(9) by sunsetting its applicability after PY 2026. We propose to replace this reporting requirement, beginning with PY 2027, with a new requirement in proposed § 425.308(b)(11) that ACOs must publicly report which of the allowable CEHRT use activities in proposed § 425.507(c) (as proposed in this section of this proposed rule) the ACO has selected to perform to meet CEHRT use requirements

for the Shared Savings Program. We believe that one important aspect of patient-centered care is patient engagement and transparency, which can be achieved by the public reporting of ACO quality and cost performance. Public reporting helps to hold ACOs accountable and may improve a beneficiary's ability to make informed health care choices as well as facilitate an ACO's ability to improve the quality and efficiency of its care.

(5) Compliance with Shared Savings Program CEHRT Use Requirements

We reserve the right to audit an ACO's compliance with the Shared Savings Program CEHRT use requirements proposed at § 425.507(c). Our audit, under § 425.314(a), could include, for example, requesting documentation from an ACO regarding its attestation to having used a Health IT Module certified to a criterion or criteria in 45 CFR § 170.315 to obtain standardized data from a FHIR-based API to support collection of measure data to completely report at least one measure in the APP Plus quality measure set, as proposed at § 425.507(c)(2), for ACOs electing that option to satisfy Shared Savings Program CEHRT use requirements. As further example, an audit could also include requesting documentation from an ACO regarding any ACO participant TINs excluded for purposes of the ACO attesting to any of the CEHRT use metrics, for ACOs electing the option proposed at § 425.507(c)(3) to report one of three allowable ACO Shared Savings Program CEHRT use metrics for the purpose of meeting Shared Savings Program CEHRT use requirements. As part of an audit, CMS may also require that ACOs produce the CMS EHR Certification IDs[268] for the EHRs used by ACOs to meet ACO CEHRT use requirements. For ACOs reporting via the eCQMs or Medicare eCQMs collection types, they would be required to produce this information at the time of submission when using that collection type, but for ACOs electing one of the other two Shared Savings Program CEHRT use options, the ACO would be required to maintain documentation of CMS EHR Certification IDs from the Certified Health IT Product List (CHPL). This would mean ACOs attesting they

[268] The Office of the National Coordinator of Technology (ONC) maintains a searchable database of Certified Electronic Health Record Technology (CEHRT) IDs at CHPL Search (https://chpl.healthit.gov/#/search).

used a Health IT Module certified to an unexpired criterion or criteria within 45 CFR § 170.315 to obtain standardized data from a FHIR-based API to support collection of data for reporting at least one measure in the APP Plus measure set would need to provide, on request, the CMS EHR Certification ID for the certified technology used. Similarly, for ACOs electing to attest to one of the three proposed ACO CEHRT use metrics, ACOs would need to provide, on request, the CMS EHR Certification ID for each of its participant TINs from which it attested at least one ACO provider or supplier utilized CEHRT to meet the requirements of the metric. ACOs are required under § 425.314(b)(1) to maintain and give CMS, DHHS, the Comptroller General, the Federal Government or their designees access to records sufficient to enable the audit, evaluation, investigation, and inspection of the ACO's compliance with program requirements. Furthermore, we propose that if ACOs fail to meet Shared Savings Program CEHRT use requirements, lack adequate documentation to demonstrate that TIN exclusions applied for an ACO's Shared Savings Program CEHRT use metric were appropriate, or fail to provide such adequate documentation upon request, we may apply compliance actions under §§ 425.216 or 425.218. Such actions could include providing a warning notice, requesting a corrective action plan from the ACO, or placing the ACO on a special monitoring plan.

(6) No Impact on Current Shared Savings Program Quality or MIPS Scoring Policies or Process

The proposed options for Shared Savings Program ACOs to meet the Shared Savings Program CEHRT use requirement will not change the existing scoring methodology for the MIPS Promoting Interoperability performance category. This means that, regardless of which of the three activities (or which option within their selected activity) ACOs choose to meet the Shared Savings Program CEHRT requirement, the MIPS Promoting Interoperability performance category reporting requirements for MIPS eligible clinicians participating in an ACO will remain unaffected. Additionally, an ACO performing any of the three the CEHRT use requirement activities will not impact an ACO's quality score for purposes of determining the quality performance standard. For example, an ACO may choose to report an eCQM to meet the

Shared Savings Program's ACO CEHRT use requirement; however, the eCQM will not necessarily be included in the MIPS quality performance category score as determined under § 414.1380. If an ACO reports multiple collection types for a given measure, including eCQMs, scoring is based on the highest scoring collection type which may not be eCQMs. Therefore, reporting the eCQM to meet the CEHRT use requirement may or may not contribute to the final quality performance score. In this example, even if the eCQM submission was not included in the ACO's MIPS quality performance category score as determined under § 414.1380, the ACO's complete reporting of the measure using the eCQMs collection type would satisfy the Shared Savings Program's CEHRT use requirement. Similarly, if an ACO uses FHIR technology to completely report a measure in the APP Plus measure set and attests to having done so, for the purpose of meeting the Shared Savings Program CEHRT use requirement, the requirement will be met, regardless of whether that measure submission is used to calculate the ACO's MIPS quality performance category score under § 414.1380. By extension, in this example, an ACO's quality score for the purposes of determining shared savings as calculated under § 425.512 would be unaffected. The ACO's MIPS quality performance category score is an aggregate of the highest measure-level scores submitted by the ACO. However, submissions that do not contribute to an ACO's final MIPS quality performance category score are still eligible for purposes of meeting the Shared Savings Program CEHRT use requirement.

(7) Proposed Regulatory Changes

We are proposing the following revisions to the regulatory text at § 425.308(b):

- Revising paragraph (b)(9) to remove the introductory phrase that made the subsequent requirements applicable to performance year 2025 and subsequent performance years, and limiting them to performance years 2025 and 2026

- Adding new paragraph (b)(11) to specify that for performance year 2027 and subsequent PYs, the ACO must publicly report the CEHRT use activity selected by the ACO for the purpose of meeting the ACO CEHRT use requirement at § 425.507(c).

We are proposing the following revisions to the regulation text at § 425.507:

- Revising paragraph (a) to remove the introductory phrase that made the paragraph applicable to performance years beginning on or after January 1, 2025 and adding in its place an introductory phrase that would limit its applicability to performance years 2025 and 2026
- Revising paragraph (b) by adding an introductory phrase that would limit its applicability to performance years 2025 and 2026,
- Adding new paragraph (c) to specify that, for PYs beginning on or after January 1, 2027, an ACO would be required to demonstrate the use of CEHRT as defined at § 425.20 in one of the following manners–

++ Use CEHRT (as defined in paragraph (3) of the CEHRT definition at § 414.1305) that also supports the calculation and reporting of clinical quality measures by being certified to the ONC health IT certification criteria at 45 CFR § 170.315(c)(2) and (c)(3) to completely report at least one of the measures in the APP Plus quality measure set using the eCQMs or Medicare eCQMs collection types and meets the data completeness requirement at § 414.1340 of this chapter for the applicable PY; or

++ Completely report at least one measure in the APP Plus quality measure set and meets the data completeness requirement at § 414.1340 of this chapter for the applicable performance year using EHR technology that meets paragraph (3) of the CEHRT definition at § 414.1305 and attests that it used data collected from an HL7® Fast Healthcare Interoperable Resources (FHIR®)-based API to support quality measurement using a Health IT module (as defined in 45 CFR § 170.102) that has been certified to an unexpired criterion or criteria in 45 CFR § 170.315 supporting standardized API access.

++ Attest to at least one of the Shared Savings Program CEHRT use metrics from the list of metrics established for the applicable PY.

We are requesting public comment on these proposed changes to the policy at §§ 425.308(b) and 425.507.

c. *Request for Information on Applying Electronic Prior Authorization Measures to Shared Savings Program* ACOs

In section IV.A.4.d.(4) of this proposed rule, we include proposals on the use of electronic prior authorization measures in the MIPS Promoting Interoperability performance category. Specifically, in that section of this proposed rule, for the MIPS Promoting Interoperability performance category, we are proposing to 1) change the Electronic Prior Authorization measure from a required measure to a bonus measure for the CY 2027 performance period/2029 MIPS payment year and a required measure beginning with the CY 2028 performance period/2030 MIPS payment year and 2) require a new measure, Electronic Prior Authorization for Prescription Drugs, that requires requesting prior authorization for at least one prescription drug electronically using CEHRT. This measure would be required for the MIPS Promoting Interoperability performance category beginning with the CY 2028 performance period/2030 MIPS payment year.

We are seeking feedback on the use of electronic prior authorization by ACOs that participate in the Shared Savings Program. Specifically, we are seeking comment on the following:

- Requiring the use of specific FHIR-enabled Health IT Modules within CEHRT to complete at least one prior authorization request and determination for at least one medical item or service during the performance period or allowing it to be an option for meeting Shared Savings Program CEHRT use requirements beginning with the CY 2028 performance year.
- Creating a new, ACO-specific electronic prior authorization measure to require use of specific FHIR-enabled health IT modules within CEHRT to complete at least one prior authorization request and determination for at least one prescription drug during the performance period, beginning with the CY 2028 performance year.
- Considerations CMS should take into account, in developing electronic prior authorization measures to apply to Shared Savings Program ACOs.

5. Financial Methodology

a. Overview

As explained in greater detail below and in the regulatory impact section, the Shared Savings Program has demonstrated a strong track record of generating savings for Medicare while achieving high quality care for beneficiaries assigned to ACOs. For example, the Shared Savings Program has had eight consecutive years of generating savings for Medicare relative to benchmarks, with over $12 billion in total savings and a trend of increasing savings year-over-year between 2017 and 2024. As described in the CY 2026 PFS final rule Regulatory Impact Analysis (90 FR 49975 through 49976) and in the regulatory impact section of this rule, the Shared Savings Program has maintained a net savings percentage on total FFS spending of 0.5 percent. At the same time, ACOs in the Shared Savings Program have demonstrated higher quality relative to other physician groups, indicating that the Shared Savings Program is achieving savings while improving quality of care. For example, in PY 2024, Shared Savings Program ACOs helped more patients improve markers of good health, such as controlled blood pressure, hemoglobin A1c control (an indicator for diabetes), and depression screening with a follow-up plan, compared to 2023.[269] In PY 2024, nearly all ACOs outperformed similar types of physician groups on quality measures. As described in further detail later in this proposed rule, based on an internal CMS analysis of 87 ACOs that participated continuously in the Shared Savings Program between 2014 and 2023, Shared Savings Program ACOs showed statistically significant and substantial improvement across 7 comparable CMS Web Interface quality measures used during that period where quality performance improved across a wide range of clinical practice areas including screening and preventive measures, control of health conditions such as hypertension and diabetes. ACOs have performed consistently better than comparable

[269] Medicare Shared Savings Program Performance Year 2024 Financial and Quality Results Fact Sheet, https://www.cms.gov/files/document/fact-sheet-ssp-py24-financial-quality-results.pdf

physician groups on the patient experience survey measure, Getting Timely Care, Appointments, and Information, for every year that the survey has been fielded since 2019.

Based on the experience of the Shared Savings Program and as part of our effort to align spending and value in OM, we are focused on developing policies that would grow the number of health care providers and beneficiaries in accountable care relationships and grow savings to the Medicare Trust Funds while improving the quality of care for beneficiaries. To achieve these goals, in this section of the proposed rule, we are proposing several complementary modifications to the benchmarking and financial methodology under the Shared Savings Program to encourage new and sustained participation by ACOs in the program. Specifically, we are proposing to: (1) increase the sharing rate under BASIC track Level E (section III.G.5.c.(1) of this proposed rule), (2) reduce the weight on the regional adjustment for ACOs in the ENHANCED track (section III.G.5.c.(2) of this proposed rule), (3) modify the prior savings adjustment to increase the scaling factor (section III.G.5.d. of this proposed rule), (4) risk adjust the 5 percent cap on upward adjustments to the historical benchmark (section III.G.5.e. of this proposed rule), (5) incentivize new participation through a growth adjustment (section III.G.5.f of this proposed rule), and (6) reform the Accountable Care Prospective Trend (ACPT) component of the benchmark update factor to address projection error and allow for greater consistency in the calculations across agreement periods (section III.G.5.g. of this proposed rule).

Across the financial methodology proposals described in sections III.G.5.c.(1) (proposal to increase the sharing rate under BASIC track Level E), III.G.5.c.(2) (proposal to reduce the weight on the regional adjustment for ENHANCED track ACOs), and III.G.5.d (proposal to modify the prior savings adjustment scaling factor), we describe our observations of recurring patterns, that ENHANCED track ACOs receive larger positive regional adjustments than BASIC track ACOs, which inflate benchmarks and increases the probability of generating gross savings independent of operational efficiencies. At the same time, as discussed in section III.G.5.c.(1),

BASIC track Level E ACOs generate higher net savings for the Trust Funds despite lower gross savings, as the 75 percent shared savings rate under the ENHANCED track requires disproportionately higher gross savings to achieve equivalent net outcomes for the Trust Funds. Combined analyses described in sections III.G.5.c.(2) and III.G.5.d further show that the interaction of regional adjustment weighting, prior savings scaling, and track-specific sharing rates may incentivize ACOs to progress into the ENHANCED track based on benchmark generosity rather than demonstrated capacity to reduce expenditures. Together, these overlapping findings support the proposed recalibration of incentives reflected in our proposals discussed in these sections—namely increasing the BASIC track Level E sharing rate, lowering the positive regional adjustment weight applied to ENHANCED track ACOs, and strengthening the prior savings adjustment methodology—to better align benchmark dynamics with underlying efficiency, reduce distortions driven by regional cost variation, and reinforce long-term net savings objectives for the Shared Savings Program.

b. Summary of Statutory and Regulatory Background on Adjusting the Historical Benchmark

Section 1899(d)(1)(B)(ii) of the Act addresses how ACO benchmarks are to be established, updated, and reset at the start of each agreement period under the Shared Savings Program. This provision specifies that the Secretary shall estimate a benchmark for each agreement period for each ACO using the most recent available 3 years of per beneficiary expenditures for Parts A and B services for OM beneficiaries assigned to the ACO. The benchmark shall be reset at the start of each agreement period. Section 1899(d)(1)(B)(ii) of the Act also provides the Secretary with discretion to adjust the historical benchmark by "such other factors as the Secretary determines appropriate." Under this authority, over time we have adopted a variety of methods to adjust the historical benchmark to meet certain policy goals.

Benchmarking policies applicable to all ACOs in agreement periods beginning on January 1, 2024, and in subsequent years, are specified at § 425.652. We refer readers to discussions of the benchmark calculations in earlier rulemaking for details on the development of

the current policies (see November 2011 final rule, 76 FR 67909 through 67927; June 2015 final rule, 80 FR 32785 through 32796; June 2016 final rule, 81 FR 37953 through 37991; December 2018 final rule, 83 FR 68005 through 68030; CY 2023 PFS final rule, 87 FR 69875 through 69928; CY 2024 PFS final rule, 88 FR 79174 through 79208; CY 2025 PFS final rule, 89 FR 98155 through 98203; and CY 2026 PFS final rule, 90 FR 49831 through 49835).

In the CY 2023 PFS final rule, we adopted policies to modify the regional adjustment under § 425.656 (87 FR 69915 through 69923) and to reinstate a prior savings adjustment under § 425.658 (87 FR 69898 through 69915). The modifications to the regional adjustment were designed to limit the impact of negative regional adjustments on ACO historical benchmarks and further incentivize program participation among ACOs serving high-cost beneficiaries (87 FR 69916). We also reinstated the prior savings adjustment policy, such that a renewing or re-entering ACO may be eligible to receive an adjustment to its benchmark to account for savings generated in performance years that correspond to the benchmark years of its new agreement period (87 FR 69898 through 69915).

In the CY 2024 PFS final rule (88 FR 79185 through 79196), we modified the regional adjustment policy further to prevent any ACO from receiving an adjustment that would cause its benchmark to be lower than it would have been in the absence of a regional adjustment. We modified the prior savings adjustment policy further to account for the following: a change in savings earned by the ACO in a benchmark year due to compliance action taken to address avoidance of at-risk beneficiaries or a change in the amount of savings or losses for a benchmark year as a result of a reopening of a prior determination of ACO shared savings or shared losses and the issuance of a revised initial determination under § 425.315 (88 FR 79196 through 79200).

In the CY 2025 PFS final rule (89 FR 98155 through 98167), we finalized a health equity benchmark adjustment (HEBA) (revised to the “population adjustment” in the CY 2026 PFS final rule (90 FR 49831 through 49835)) that adjusts upward some ACOs' historical benchmarks

based on the number of beneficiaries the ACO serves who are dually eligible or enrolled in the Medicare Part D and receive the Low-Income Subsidy (LIS).

c. Proposed Changes to the Shared Savings Program Financial Methodology to Encourage Additional Savings in Two-sided Risk

(1) Proposal to Increase the Sharing Rate under Level E of the BASIC Track

(a) Background

As finalized in the December 2018 final rule (83 FR 67831 through 67841), for agreement periods beginning on July 1, 2019, and in subsequent years, eligible ACOs enter into an agreement period of not less than 5 years under one of two tracks of the Shared Savings Program, either the BASIC track (see §§ 425.600(a)(4) and 425.605) or the ENHANCED track (see §§ 425.600(a)(3) and 425.610).

As finalized in the December 2018 final rule (83 FR 67841 through 67857), the BASIC track includes a glide path from one-sided model Levels A and B to incrementally higher levels of performance-based risk under Levels C, D, and E. The ENHANCED track offers the highest level of risk and potential reward under the Shared Savings Program. Level E of the BASIC track and the ENHANCED track each qualify as an Advanced APM under the Quality Payment Program. In rulemaking following the December 2018 final rule, we modified the approach for determining an ACO's eligibility for participation options in the BASIC track and ENHANCED track, along with the number of performance years an ACO may remain under a one-sided model of the BASIC track's glide path.[270] In the following discussion, we provide select regulatory background on our establishment of the BASIC track's glide path, and relatedly the level of risk and potential reward under the glide path, as well as our considerations for ACOs' progression from participation in BASIC track Level E to the ENHANCED track.

---

[270] We refer readers to discussions in earlier rulemaking, including: December 2018 final rule (83 FR 67863 through 67922); May 8, 2020 COVID-19 IFC (85 FR 27575 and 27576) and CY 2021 PFS final rule (85 FR 84767 through 84769); Fiscal Year (FY) 2022 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) final rule (86 FR 45502 through 45506); CY 2023 PFS final rule (87 FR 69805 through 69821); and CY 2026 PFS final rule (90 FR 49760 through 49775).

With the December 2018 final rule (83 FR 67863 through 67922), we established an approach for determining an ACO's eligibility for participation options in the BASIC track and ENHANCED track, based on a combination of factors: ACO participants' Medicare FFS revenue (low revenue ACOs versus high revenue ACOs) and the experience of the ACO legal entity and its ACO participants with performance-based risk Medicare ACO initiatives. We finalized an approach under § 425.600(d) where ACOs eligible for the BASIC track's glide path that are inexperienced with performance-based risk Medicare ACO initiatives would have the flexibility to enter the glide path at any one of the five levels, with a limited exception under § 425.600(a)(4)(i)(B)(*1*) (see, for example, 83 FR 67904 through 67905). With the December 2018 final rule, we finalized provisions on the progression of ACOs along the BASIC track's glide path under § 425.600(a)(4)(i)(B), and finalized an approach to allow ACOs in the BASIC track's glide path to take on higher risk and potential reward within their current agreement period by more rapidly progressing along the glide path (see 83 FR 67844, and 67858 through 67859; and § 425.226(a)(2)). We also finalized that the BASIC track's highest Level of risk and potential reward (Level E) may be elected for any performance year by ACOs that enter the BASIC track's glide path, but it will be required no later than the ACO's fifth performance year of the glide path (83 FR 67844; 67850).[271]

To provide incentives for ACOs to move towards higher levels of performance-based risk, we limited the amount of potential shared savings under the one-sided model of the BASIC track (Levels A and B), while offering higher potential reward in relation to each level of higher risk as ACOs under the two-sided model levels of the BASIC track (Levels C, D and E) (see, for example, 83 FR 67848 and 67849). We explained in the December 2018 final rule that ACOs have reduced incentives to enter or remain in a one-sided model of the BASIC track's glide path

[271] In in the December 2018 Final Rule (83 FR 67844 through 67846) we also described advancing to Level E would be required for ACOs in their fourth performance year if they previously participated in Track 1, or new ACOs identified as re-entering ACOs because more than 50 percent of their ACO participants have recent prior experience in a Track 1 ACO.

if they are prepared to take on risk, and we anticipated that ACOs would seek to accept greater performance-based risk in exchange for the chance to earn greater reward (see 83 FR 67844).

In the December 2018 final rule, we stated that the approach to determining the maximum amount of shared losses under BASIC track Level E strikes a balance between (1) placing ACOs under a higher Level of risk to recognize the greater potential reward under this financial model and the additional tools and flexibilities available to BASIC track ACOs under performance-based risk and (2) establishing an approach to help ensure the maximum Level of risk under the BASIC track remains moderate (83 FR 67845). Further, this approach recognizes that eligible ACOs in Level E have the opportunity to earn the greatest share of savings under the BASIC track, and should therefore be accountable for a higher share of losses, particularly in light of their access to tools for care coordination and beneficiary engagement. We finalized higher maximum sharing rates for ACOs participating in two-sided levels of the BASIC track as a means of encouraging participation in the program and potentially providing greater resources to ACOs to support their transition to performance-based risk (87 FR 69951).

In the CY 2023 PFS final rule (87 FR 69819 through 69821), we removed the cap on the number of performance years an ACO was allowed to participate in BASIC track Level E, allowing ACOs to continue to participate in BASIC track Level E in future agreement periods and not requiring ACOs to advance to the ENHANCED track. We explained that, in our implementation of the Shared Savings Program, we intend to achieve larger programmatic goals by encouraging ACO participation and thereby promoting high quality, value-based care for OM beneficiaries (87 FR 69819). We continuously seek to balance creating sufficient incentives for participation in a voluntary program with ensuring that our policies achieve program goals to increase quality of care for Medicare beneficiaries and reduce expenditure growth to protect the Trust Funds. Accordingly, we discussed our belief that it would be in the best interest of the program and OM beneficiaries to permit eligible ACOs to continue participating under BASIC track Level E, rather than risk significant numbers of experienced, successful ACOs terminating

their participation in the program instead of progressing to the higher level of risk and potential reward under the ENHANCED track (87 FR 69819). Our experience as of the CY 2023 PFS final rule showed that ACOs in BASIC track Level E and ACOs in the ENHANCED track had similar performance results (we have since gained additional experience as discussed later in this section, that shows ACOs in BASIC track Level E produce greater net savings for CMS compared to ACOs in the ENHANCED track). We noted our belief that it is important to offer the option to remain in BASIC track Level E, to encourage ACOs that may be ready to take on the higher level of risk and potential reward under the ENHANCED track to progress to that participation option, secure in the knowledge that the more moderate level of risk and potential reward under BASIC track Level E would be available to the ACO in the future if the ACO concludes based on experience that that participation option is more appropriate for the ACO than the ENHANCED track (87 FR 69819).

We refer readers to the provisions of BASIC track under § 425.605, and the ENHANCED track under § 425.610, for policies on the calculation of shared savings and losses under each track/level (as applicable). With the CY 2026 PFS final rule (90 FR 49782 through 49783), we provided a summary of the level of risk and potential reward under Levels A through E of the BASIC track and ENHANCED track. In the following discussion we provide a consolidated summary.

In general, an ACO that meets or exceeds its minimum savings rate (MSR), and otherwise qualifies for a shared savings payment, shares in savings at a sharing rate specified by the ACO's participation track (and level, if applicable), not to exceed a performance payment limit (a percentage of the ACO's updated historical benchmark).[272,273] An ACO under a two-sided model that meets or exceeds its minimum loss rate (MLR) shares in losses at a shared loss

[272] We note that provisions of §§ 425.605(d)(1) and 425.610(d) refer to the applicable "final sharing rate", which we sometimes refer to as the "sharing rate" (for brevity), or alternatively the "shared savings rate". We consider these terms synonymous.

[273] There is a limited exception for eligible low revenue ACOs participating under the BASIC track, under which an ACO that does not meet the MSR requirement but meets other criteria may qualify for a shared savings payment, at a lower sharing rate, in accordance with § 425.605(h).

rate[274] specified by the ACO's participation track (and level, if applicable), not to exceed a loss recoupment limit (a percentage of the ACO's updated historical benchmark).

Under Levels A and B of the BASIC track (§ 425.605(d)(1)(i) and (ii)), ACOs may share in savings at a sharing rate of up to 40 percent, not to exceed 10 percent of the updated benchmark. Levels C, D, and E of the BASIC track (§ 425.605(d)(1)(iii), (iv) and (v)) each offer a sharing rate of up to 50 percent capped at 10 percent of the updated benchmark, with a fixed 30 percent loss sharing rate in each level's two-sided model. The loss recoupment limits increase across these levels. Under Level C (§ 425.605(d)(1)(iii)(D)), an ACO's shared losses may not exceed 2 percent of total Medicare Parts A and B FFS revenue of the ACO participants in the ACO capped at 1 percent of updated benchmark. Under Level D (§ 425.605(d)(1)(iv)(D)), an ACO's shared losses may not exceed 4 percent of total Medicare Parts A and B FFS revenue of the ACO participants in the ACO capped at 2 percent of updated benchmark. Under Level E (§ 425.605(d)(1)(v)(D)), an ACO's shared losses may not exceed 8 percent of total Medicare Parts A and B FFS revenue of the ACO participants in the ACO capped at 4 percent of updated benchmark. Under Level E, the loss recoupment limit is the percentage of revenue specified in the revenue-based nominal amount standard under the Quality Payment Program (QPP) (42 CFR § 414.1415(c)(3)(i)(A)) capped at 1 percentage point higher than the expenditure-based nominal risk amount (§ 414.1415(c)(3)(i)(B)). Under the ENHANCED track (§ 425.610), ACOs may share in savings at up to 75 percent (§ 425.610(d)), not to exceed 20 percent of the updated benchmark (§ 425.610(e)), and share in losses at a rate of 40 to 75 percent (§ 425.610(f)), capped at 15 percent of the updated benchmark (§ 425.610(g)). Since the establishment of the ENHANCED track (formerly named Track 3) with the June 2015 final rule (see 80 FR 32778 through 32779), and the BASIC track's glide path with the December 2018 final rule (as previously described in this section), we have not modified the maximum upside potential

[274] We note that the "shared loss rate" is also referred to as the "loss sharing rate".

reward with the final sharing rates or downside potential risk with the loss sharing rates under each track / level (as applicable).

(b) Proposed Revisions

In 2020, the first full performance year under the glide path, 13.5 percent of ACOs in the Medicare Shared Savings Program participated under BASIC track Level E. As ACOs became more experienced and progressed through the glide path, participation in BASIC track Level E experienced modest increases, which peaked in PY 2023 at 27.2 percent. As of PY 2026, participation in BASIC track Level E has decreased to 16 percent.

The disparity in sharing rates between the highest risk option under the BASIC track (BASIC track Level E) and the next highest risk option (ENHANCED track) has potentially disproportionately driven ACOs to take on the maximum risk allowed. For PY 2026, 58 percent of ACOs are participating in the ENHANCED track. This in part is likely a result of the 40 percent sharing rate in Levels A and B of the BASIC track and 50 percent sharing rate in Levels C, D, and E of the BASIC track, compared to the 75 percent sharing rate in the ENHANCED track. Based on current participation trends across the various risk tracks, we anticipate that the participation in BASIC track Level E may continue a downward trend as a percentage of total participation unless some action is taken. We believe that some ACOs cease longer term program participation in BASIC track Level E before they otherwise would because they transition to the ENHANCED track based on the incentives of the higher sharing rate, and this transition occurs before they're ready for the increased demands associated with the higher risk track. Decreased Shared Savings Program retention rates of ACOs that transition too quickly to the ENHANCED track, in combination with the decreased net savings rates associated with the ENHANCED track, ultimately result in decreased savings for the Medicare Trust Fund. Table B-G8 summarizes the distribution of ACO participation across the various risk tracks for PY 2022 through CY 2026.

TABLE B-G8: COUNT OF ACOS PARTICIPATING IN BASIC TRACK LEVELS AND ENHANCED TRACK FOR PYS 2022 THROUGH 2026

Performance Year	Total	BASIC Track			ENHANCED Track
		Levels A and B	Levels C and D	Level E	
PY 2022	483	199 (41%)	40 (8%)	98 (21%)	146 (30%)
PY 2023	456	151 (33%)	19 (4%)	125 (28%)	161 (35%)
PY 2024	480	159 (33%)	10 (2%)	104 (22%)	207 (43%)
PY 2025	476	137 (29%)	5 (1%)	81 (17%)	253 (53%)
PY 2026	511	121 (24%)	12 (2%)	82 (16%)	296 (58%)

While we still have the goal of ACOs transitioning to performance-based risk, we want to be conscious of long-term impacts to the Shared Savings Program related to participation, success, and growth. Participation in the ENHANCED track is a positive, but we believe that some ACOs may be taking on additional risk more quickly than they otherwise would because the ENHANCED track offers a 50 percent increase in savings compared to BASIC track Level E, while both tracks include two-sided risk. If ACOs progress to higher levels of risk before they are adequately prepared, they may take on too much risk with higher shared losses rates in the ENHANCED track, potentially resulting in program termination and a subsequent reduction in both program participation and care coordination for beneficiaries. We believe by reducing the savings percentage gap between BASIC track Level E and the ENHANCED track, we may increase participation in BASIC track Level E as well as the Shared Savings Program and increase long-term success of ACOs, particularly those with less experience, with unique patient or provider populations, and low revenue ACOs (which tend to be small, rural and physician-only ACOs).

Additionally, data analysis from the CMS Office of the Actuary of benchmark performance for cohorts of ACOs that participated in both PY 2022 and PY 2023 indicates that ACOs participating in the BASIC track generated 42 percent higher net savings for CMS as a percentage of their benchmark than ACOs transitioning to or continuing participation in the ENHANCED track, despite favorable regional adjustments likely inflating gross savings for ACOs under the ENHANCED track. Analysis of PY 2024 financial performance also indicates

net savings for the Trust Funds has remained higher on average for BASIC track ACOs. This also is largely due to the 50 percent differential in sharing rate currently present between BASIC track Level E and the ENHANCED track, which results in ENHANCED track ACOs needing to generate twice the gross savings to equal the same net savings for the Trust Funds as ACOs participating under BASIC track Level E. For example, if an ACO participated in BASIC track Level E and generated $2,000,000 in gross savings, and the ACO received the maximum sharing rate of 50 percent, the ACO would receive a $1,000,000 shared savings payment and net savings for the Trust Funds would be $1,000,000. If this same ACO participated in the ENHANCED track and generated $2,000,000 in gross savings, and the ACO received the maximum sharing rate of 75 percent, the ACO would receive a $1,500,000 shared savings payment and net savings for the Trust Funds would be $500,000. So, to generate the same net savings for the Trust Funds, the ENHANCED track ACO would need to have generated twice the gross savings, $4,000,000, to have generated $1,000,000 ($4,000,000 x 25 percent) net savings for the Trust Funds. For PY 2024, gross savings was higher for the ENHANCED track ACOs, but net savings as a percentage of gross savings and per capita net savings are higher for ACOs participating in BASIC track Level E, as shown in Table B-G9.

TABLE B-G9: PY 2024 GROSS AND NET SAVINGS FOR BASIC TRACK LEVEL E AND ENHANCED TRACK

Risk Track	Aggregate Gross Savings/Losses	Aggregate Net Savings/Losses	Per Capita Net Savings/Losses	Net Savings as a percent of Gross Savings
BASIC Track Level E	$1,114,104,073	$555,399,727	$286	50%
ENHANCED Track	$4,224,728,667	$1,129,061,411	$206	27%

As we seek to increase the percentage of Medicare beneficiaries in accountable care arrangements, we are balancing incentives and participation options to serve the dual purposes of sustaining participation by existing ACOs and increasing program growth, recognizing that ACOs vary in their composition of providers/suppliers, the needs of the populations they serve, and have varying degrees of efficiency relative to their region and experience with accountable care initiatives. We also reiterate our intention to achieve larger programmatic goals by

encouraging ACO participation and thereby promoting high quality, value-based care for OM beneficiaries. We continuously seek to balance creating sufficient incentives for participation in a voluntary program while ensuring that our policies achieve program goals to increase quality of care for Medicare beneficiaries and reduce expenditure growth to protect the Trust Funds.

Trends in recent performance years indicate ACOs participating in BASIC track Level E have roughly one-third fewer assigned beneficiaries and participating providers than ACOs participating in the ENHANCED track. Understanding that ACOs participating in BASIC track Level E face additional obstacles to success given their different compositions and experience, we believe that narrowing the gap in sharing rates between these two tracks will encourage long-term participation and growth in the Shared Savings Program by encouraging less experienced ACOs to only progress to the ENHANCED track when they're adequately prepared to do so.

Increasing the sharing rate for BASIC track Level E presents an opportunity to reverse the decreased participation in the BASIC track, increase net savings opportunities for the Trust Funds, and increase program participation. However, before considering whether to propose changes, we analyzed what change to the sharing rate was needed to ensure our goals were met without unintended consequences.

As we did when we established the BASIC track in the December 2018 final rule, we considered many sharing rates before arriving at our proposal. With the current sharing rate for BASIC track Level E set at 50 percent and ENHANCED track set at 75 percent, we analyzed alternative sharing rates for BASIC track Level E between 55 percent and 65 percent.

For the 104 ACOs entering an agreement period beginning on January 1, 2024 that participated in BASIC track Level E, we found that if all else is equal, the increase in shared savings payments under the alternative sharing rates we considered for BASIC track Level E ranged between 9.1 percent and 22.8 percent. After considering other policy changes proposed elsewhere in section III.G.5. of this proposed rule, such as the proposal to reduce the weight on regional adjustment for ACOs under the ENHANCED track and the proposal to modify the prior

savings adjustment to increase the scaling factor, we determined a 65 percent sharing rate was too high to maintain a sufficient gap in incentives between the two tracks and a 55 percent sharing rate was an inadequate incentive to achieve our goals of increasing participation in the program and increasing savings to the Trust Funds.

We believe that increasing the sharing rate to 60 percent for BASIC track Level E appropriately balances creating sufficient incentive to increase program participation and savings to the Trust Funds. We believe that there would still be sufficient benefits for ACOs to take on the higher risk and reward offered under the ENHANCED track, so that ACOs would continue to progress the ENHANCED track when they're ready to take on those higher levels of risk and reward.

We are proposing to increase the savings rate for BASIC track Level E from 50 percent to 60 percent for agreement periods beginning on or after January 1, 2027. The proposal to apply a modified sharing rate for agreement periods beginning on or after January 1, 2027 would ensure we maintain a consistent sharing rate for Level E throughout the duration of an ACO's an agreement period under the BASIC track, in accordance with § 425.212(a).[275] Closing the gap in the sharing rates between BASIC track Level E and the ENHANCED track would likely increase savings for the Trust Funds, while striking a better balance among incentivizing robust participation in the Shared Savings Program, incentivizing ACOs' move to two-sided risk, and offering a lower risk option than is offered under the ENHANCED track.

Analysis of the PY 2024 financial results indicates the average impact of increasing the sharing rate for BASIC track Level E from 50 percent to 60 percent was an increase in shared savings payments of $1,348,867 and a total increase of $110,607,059 in shared savings payments for the 104 ACOs that participated in BASIC track Level E. While the total shared savings payments for BASIC track Level E would increase under this proposal, we anticipate net savings

[275] In accordance with § 425.212(a), an ACO is subject to all regulatory changes that become effective during the agreement period, with the exception of the following program areas, unless required by statute: (1) eligibility requirements concerning the structure and governance of ACOs, and (2) calculation of the sharing rate.

to the Trust Funds to increase because of increased participation in the Shared Savings Program, higher retention of ACOs, and some ACOs opting to delay transition into the ENHANCED track.

Under our proposed approach, the current maximum 50 percent sharing rate under BASIC track Level E specified in § 425.605(d)(1)(v)(A)(*4*) (which is applicable for PYs beginning on or after January 1, 2024) would continue to apply to ACOs completing existing agreement periods in the BASIC track. Specifically, the maximum 50 percent sharing rate would apply in determining financial performance for a BASIC track ACO participating in an agreement period beginning on January 1, 2022, 2023, 2024, 2025, and 2026, that is participating in Level E for PY 2025 or any subsequent PY of the ACO's existing agreement period.

We propose to specify in a new paragraph (d)(1)(v)(A)(*5*) added to § 425.605 the sharing rate for BASIC track Level E, applicable for agreement periods beginning on or after January 1, 2027, for performance years beginning on or after January 1, 2027. Accordingly, this new paragraph would specify that an ACO that meets all the requirements for receiving shared savings payments under the BASIC track, Level E, receives a shared savings payment equal to a percentage of all the savings under the updated benchmark (up to the performance payment limit described in § 425.605(d)(1)(v)(B)). Except as provided in § 425.605(h) (which specifies an additional opportunity for an eligible low revenue BASIC track ACO to share in savings even if it does not meet the MSR requirement), the percentage would be as follows:

(1) 60 percent for an ACO that that meets the quality performance standard by meeting the criteria specified in § 425.512(a)(2) or (a)(5)(i).

(2) 60 percent multiplied by the ACO's quality score calculated according to § 425.512 for an ACO that meets the alternative quality performance standard by meeting the criteria specified in § 425.512(a)(5)(ii).

We also propose technical and conforming changes to other provisions of § 425.605. We propose to revise the heading text in the first sentence of § 425.605(d)(1)(v)(A)(*4*) introductory

text, to specify the provisions are applicable for ACOs in agreement periods beginning July 1, 2019, through January 1, 2026, for performance years beginning on or after January 1, 2024. For completeness and clarity, this proposed heading text would be inclusive of ACOs participating in agreement periods beginning on July 1, 2019 and January 1, 2020, which were previously reconciled for participation in BASIC track Level E for the performance year beginning on January 1, 2024. We note that agreement periods of 5 years and 6 months beginning on July 1, 2019, and 5-year agreement periods beginning on January 1, 2020, concluded on December 31, 2024. As we explained previously in this section of this proposed rule, the final sharing rate provisions specified under § 425.605(d)(1)(v)(A)(*4*) would continue to apply to ACOs participating in agreement periods beginning on January 1, 2022, 2023, 2024, 2025 and January 1, 2026, that would be reconciled for participation in BASIC track Level E for PY 2025 and any remaining PY of their agreement period. We also propose to amend § 425.605(h)(2), describing calculation of the sharing rate applied to a low revenue BASIC track ACO eligible for the expanded opportunity to share in savings if it does not meet the MSR, to revise the existing list of cross-references to include a reference to new paragraph § 425.605(d)(1)(v)(A)(*5*).

We also propose several technical corrections to the regulations in § 425.605. With the CY 2026 PFS final rule (see 90 FR 49816 through 49817, and 50018), we finalized amendments to phrasing in § 425.605, including in paragraphs (d)(1)(v)(A)(*3*)(*ii*) and (d)(1)(v)(A)(*4*)(*ii*) (describing the sharing rate applied under BASIC track Level E, by PY, for an ACO that meets the alternative quality performance standard). There were technical errors in the implementation of these finalized changes in the Code of Federal Regulations (CFR). We propose the following technical corrections:

- To revise § 425.605(d)(1)(v)(A)(*3*)(*ii*) to read, 50 percent multiplied by the ACO's quality score calculated according to § 425.512 for an ACO that meets the alternative quality performance standard by meeting the criteria specified in § 425.512(a)(4)(ii).

- To revise § 425.605(d)(1)(v)(A)(*4*)(*ii*) to read, 50 percent multiplied by the ACO's quality score calculated according to § 425.512 for an ACO that meets the alternative quality performance standard by meeting the criteria specified in § 425.512(a)(5)(ii).

We seek comment on the proposal to increase the sharing rate under BASIC track Level E from 50 percent to 60 percent, applicable for ACOs in agreement periods beginning on or after January 1, 2027, for performance years beginning on or after January 1, 2027, and the proposal to specify related provisions in the Shared Savings Program regulations under new § 425.605(d)(1)(v)(A)(*5*), as well as proposed technical and conforming changes to § 425.605(d)(1)(v)(A)(*4*) introductory text and § 425.605(h)(2). We also seek comment on our proposed technical corrections to § 425.605(d)(1)(v)(A)(*3*)(*ii*) and (d)(1)(v)(A)(*4*)(*ii*).

(2) Proposal to Reduce the Maximum Weight on the Regional Adjustment for ACOs under the ENHANCED Track

(a) Background

In the June 2016 final rule (81 FR 37962 through 37974), we introduced a regional adjustment to ACOs' historical benchmarks to increase participation in the Shared Savings Program and recognize efficiency of providers/suppliers in their regional service area. To implement the regional adjustment, we also established a methodology for defining regional Medicare spending. We defined an ACO's "regional service area" at § 425.20 as the counties in which its assigned beneficiaries reside and calculated regional costs using county-Level Medicare fee-for-service expenditures for assignable beneficiaries in those counties (81 FR 37958). These county expenditures were then aggregated to estimate average per-capita spending in the ACO's region, which served as the basis for the regional adjustment applied when benchmarks were rebased (81 FR 37957 and 37958).

In the June 2016 final rule (81 FR 37954 through 37991), we finalized a Shared Savings Program benchmark rebasing methodology to include a regional adjustment to the historical benchmark. More specifically, we finalized that the regional adjustment would be calculated as a

percentage of the difference between risk-adjusted average per capita expenditures in the ACO's regional service area and the ACO's rebased historical expenditures (81 FR 37966). We finalized that the regional adjustment would be applied for second or subsequent agreement periods, while benchmarks for an ACO's first agreement period would continue to be based solely on the ACO's historical spending and were not adjusted for regional expenditures (81 FR 37973).

To provide time for ACOs to anticipate and adapt to the regional adjustment being applied to historical benchmarks, we implemented a phased approach that gradually increased the weight applied to regional spending. The first time an ACO's benchmark was rebased using the regional adjustment, we applied 35 percent of the difference between regional spending and the ACO's rebased historical benchmark if the ACO's spending was below the regional average, and 25 percent if the ACO's spending was above the regional average. The second time the benchmark was rebased, CMS increased the weight to 70 percent for ACOs with spending below their regional average and 50 percent for those with spending above the regional average. Beginning with the third rebasing and in subsequent agreement periods, the adjustment was set at 70 percent of the difference between regional and ACO spending for all ACOs, unless CMS established a different weight through future rulemaking (81 FR 37971 through 37973).

In the 2016 final rule, we also finalized that if we adjust an ACO's benchmark during the term of the agreement period due to changes in participating providers/suppliers, the agency would reassess whether the ACO's spending was above or below the regional average to determine the appropriate adjustment percentage (81 FR 37964). Together, these provisions increased the role of regional spending in benchmark calculations while providing a transition period intended to limit abrupt benchmark reductions for higher-spending ACOs.

In the December 2018 final rule (83 FR 68018), we revised the methodology to address concerns that the 2016 regional adjustment could inadvertently inflate benchmarks for low-spending ACOs while discouraging participation by high-spending ACOs relative to their region. Under the revised rule, we also applied the regional adjustment starting with the first agreement

period. By design, the regional adjustment results in more generous benchmarks for ACOs that spend below their regions. In the December 2018 final rule (83 FR 68018), we noted that our initial experience with the regional adjustment found that 80 percent of ACOs that renewed for a second agreement period starting in 2017 received a positive adjustment. These ACOs saw their benchmarks increase by 1.8 percent, on average, when the adjustment was applied with the 35 percent weight, with several ACOs seeing increases of over 5 percent, and one over 7 percent. We also noted that for ACOs that renewed for a second agreement period starting in 2018, they showed a similar share of ACOs receiving a positive adjustment and one ACO seeing an adjustment of over 10 percent. We noted our concern that as the weight applied to the regional adjustment increases, benchmarks for the ACOs with the lowest spending relative to their region would become overly inflated to the point where they would need to do little to change their care practices to generate savings, which could reduce incentives for these ACOs to improve the efficiency of care provided to beneficiaries. To limit the influence of regional cost disparities, we reduced the maximum weight that could be applied to the regional adjustment in any agreement period from 70 percent to 50 percent. Additionally, we capped the total dollar impact of the regional adjustment at ±5 percent of national OM per capita expenditures for each beneficiary category (83 FR 68017 through 68024, and 42 CFR § 425.603).

In the CY 2023 PFS final rule (87 FR 69915 through 69923), we finalized additional policies to modify the regional adjustment to further support participation by high-cost or high-risk ACOs. We implemented a set of policies designed to mitigate the impact of negative regional adjustments on ACOs' benchmarks. First, we reduced the maximum negative adjustment from –5 percent to –1.5 percent of national OM per capita expenditures for Parts A and B services (based on benchmark year 3 for assignable beneficiaries). Second, we established an approach that gradually decreased the size of the negative regional adjustment for ACOs that have a higher proportion of dually eligible Medicare and Medicaid beneficiaries or a higher weighted-average prospective Hierarchical Condition Category (HCC) risk score (87 FR 69923).

In the CY 2023 PFS final rule (87 FR 69919), we expressed our belief that by reducing the impact of negative regional adjustments, these policies would incentivize ACOs that serve high-cost beneficiaries to join or continue to participate in the Shared Savings Program.

Most recently, in the CY 2024 PFS final rule (88 FR 79185 through 79196), we modified the regional adjustment policy further to prevent any ACO from receiving an adjustment that would cause its benchmark to be lower than it would have been in the absence of a regional adjustment.

As part of CMS's effort to align spending and value in OM, we are focused on developing policies that would accelerate accountable care service delivery across a spectrum of risk-bearing options. To achieve this vision, our proposed change to the regional adjustment is informed by strategic objectives focused on strengthening financial incentives for ACOs to participate in the Shared Savings Program and driving savings for ACOs and the Trust Funds.

(b) Proposed Revisions

For the reasons discussed in this section, we are proposing to reduce the maximum weight used in calculating the positive regional adjustment for lower-spending ACOs participating in agreement periods under the ENHANCED track from 50 percent to 35 percent, while leaving the weights for ACOs with a higher spending than the regional average unchanged.

Under the Shared Savings Program, an ACO's historical benchmark is adjusted to reflect differences between its own historical spending and average spending in its region—the regional adjustment. For ACOs with expenditures below their regional average, this adjustment is positive, increasing the ACO's benchmark and expanding savings opportunities available to the ACO. Analysis of PY 2024 financial reconciliation data indicates that ACOs in the ENHANCED track receive substantially larger positive regional adjustments on average than ACOs in BASIC track Level E ($304 versus $166 per beneficiary). Taken together with observed differences in

gross savings – where ENHANCED track ACOs achieve higher gross savings[276] per beneficiary than BASIC track Level E ACOs ($961 versus $714 in CY 2024) – this pattern suggests that more favorable benchmark adjustments may be contributing to the higher levels of observed gross savings for ENHANCED track ACOs. To assess whether the magnitude of the regional adjustment is associated with ACO performance, we calculated Pearson's correlations[277] between regional adjustment size and gross savings for ACOs reconciled in PY 2024.[278] Within the ENHANCED track, the larger regional adjustments are strongly associated with higher gross savings performance (r= 0.691, n=59), a relationship that is not observed among BASIC track Level E ACOs (r=0.09, n=17). The contrast between tracks raises the possibility that the scale of positive regional adjustments to the benchmark are partly driving performance rather than genuine efficiency gains. While this is a descriptive finding, it is consistent with our concern motivating the proposed reduction in the positive regional adjustment weight from 50 percent to 35 percent. Moreover, the average size of the adjustment has gone up –from $206 in PY 2020 to $344 in PY 2025, while the share of ACOs receiving a positive regional adjustment has remained mostly stable within a range between 70 and 86 percent over the same time period. This pattern suggests that, while the prevalence of regional adjustments has remained broadly unchanged, the financial impact of those adjustments has increased over time, amplifying the influence of regional adjustments on ACO benchmark calculations.

As discussed in the overview, there is limited evidence suggesting that the ENHANCED track is generating additional Trust Funds savings relative to the BASIC track. First, the size of the regional adjustment may be contributing to higher gross savings performance in the ENHANCED track, which causes us to question whether those savings reflect genuine cost

---

[276] Gross savings were calculated as the ACO's total savings amount divided by the total assigned beneficiary person years.

[277] Pearson's correlation coefficient is a statistical measure that summarizes the strength and direction of the linear relationship between two variables, taking values from −1 (perfect negative relationship) to +1 (perfect positive relationship), with 0 indicating no linear relationship.

[278] Internal analysis of financial performance according to track/level of participation of Medicare Shared Savings Program ACOs that participated in PY2024, including assessment of whether the magnitude of regional adjustment is associated with ACO performance.

reduction. Second, lower spending ACOs (defined as those with historical expenditures below their regional average) in the ENHANCED track currently benefit from both a higher shared savings rate and larger regional adjustments on average. Together, these advantages may incentivize selection into the ENHANCED track independent of an ACO's capacity to achieve genuine cost savings to Medicare. The proposed reduction in the positive regional adjustment weight for these ACOs, paired with an increase in the shared savings rate for BASIC track Level E, is designed to rebalance financial incentives across tracks and encourage ACOs to select their tracks based on their actual capacity to reduce costs rather than differences in financial advantages embedded in track design, thereby potentially improving Trust Funds net savings. Refer to the discussion in section III.G.5.a. and the data analysis described in section III.G.5.c.(1) for additional details.

We believe a 35 percent positive regional adjustment would maintain consistency with the current schedule of weights used to calculate the regional adjustment, a structure with which ACOs are already familiar. We also believe this approach would minimize complexity by maintaining a single weight for lower-spending ENHANCED track ACOs for all participation years. At the same time, it would preserve an appropriate balance between rewarding regional efficiencies demonstrated at the start of the agreement period and rewarding improvement relative to an ACO's past historical performance over time.

TABLE B-G10: PROPOSED PERCENTAGE WEIGHT APPLIED IN CALCULATING THE REGIONAL ADJUSTMENT

Agreement Period When ACO is Subject to Regional Adjustment	Weight Used to Calculate Regional Adjustment for BASIC Track ACOs that are Lower Spending Compared to Their Region	Weight Used to Calculate Regional Adjustment for ENHANCED Track ACOs that are Lower Spending Compared to Their Region	Weight Used to Calculate Regional Adjustment for ACOs that are Higher Spending Compared to Their Region
First	35%	35%	15%
Second	50%		25%
Third			35%
Fourth and subsequent			50%

NOTE: Refer to § 425.601(e)(2)(ii) and (f), and § 425.656(e) and (f). Refer to the December 2018 final rule (83 FR 67908–67909) Table 6 for examples of existing phase-in of regional adjustment weights based on agreement start date and applicant type.

We propose this change to be effective for agreement periods beginning on January 1, 2027, and in subsequent years. Reducing the weight used in calculating the regional adjustment applied to ACOs considering participation in the ENHANCED track would reduce the contribution of baseline regional efficiency on historical benchmark calculations. As a result, it would put a stronger emphasis on rewarding improvement in the provision of coordinated care and lowering costs rather than baseline efficiency at entry to the agreement period. The focus on improvement is accentuated when paired with the proposed higher prior savings adjustment weighting, discussed in section III.G.5.d. of this proposed rule. One goal of this proposal – reducing the regional adjustment weight – is to encourage ACOs to select a diverse cross-section of participants so that ACOs' success is driven by operational efficiencies and clinical performance rather than passive capture of ACO participants with pre-existing regional efficiencies. More modest regional adjustment amounts could also result in ACOs opting for participation in BASIC track Level E instead of the ENHANCED track, and therefore result in the Trust Funds retaining a greater share of savings while still offering ACOs a long-term incentive for creating savings because of the proposed higher prior savings adjustments in future agreement periods.

Under this proposal, the phase-in of weights used in the regional adjustment calculation for agreement periods beginning on January 1, 2027, and in subsequent years, as determined by an ACO's expenditures relative to their region, would change for ENHANCED track ACOs. We are not proposing to modify the negative regional adjustment weights, so the negative regional adjustment would remain unchanged. We propose that the maximum weight used to calculate the regional adjustment for ENHANCED track ACOs that are lower spending relative to their region would be set at 35 percent for all agreement periods, replacing the current phase-in schedule. The weights used for ACOs that are higher spending relative to their region, and for BASIC track ACOs that are lower spending would remain unchanged.

To assess the impact of the proposed policy change, we conducted a simulation[279] using PY 2024 historical benchmarks, in which the maximum positive regional adjustment weight was reduced from 50 percent to 35 percent for lower spending ACOs,[280] all other parameters, including the prior savings adjustment, were held constant. ACOs with an agreement start date prior to January 1, 2024 (n=53) experience larger percentage reductions in historical benchmarks (-0.87 percent) than ACOs with agreement start dates of January 1, 2024 (n=48, -0.69 percent). The difference reflects the benchmark methodology applicable to ACOs with agreement period start dates of January 1, 2024, under which ACOs are eligible for multiple upward adjustments and CMS applies the highest for which an ACO qualifies. In this simulation, ACOs that transition from receiving a regional adjustment to receiving the prior savings adjustment (because the regional adjustment has decreased to below the prior savings adjustment) experience smaller decreases in historical benchmarks than ACOs that remain subject to the regional adjustment. For lower spending ACOs, the prior savings adjustment can partially offset reductions to the benchmark when the weight of the regional adjustment is reduced. ACOs with agreement period start dates prior to January 1, 2024, do not have prior savings adjustments included in historical benchmark calculations, so they would be more impacted by our proposal to reduce the maximum weight of the regional adjustment.

Our proposal to reduce the maximum weight used in calculating the positive regional adjustment for ACOs participating in agreement periods under the ENHANCED track is consistent with our authority under section 1899(d)(1)(B)(ii) of the Act, which we have consistently relied on to make regional adjustments to the historical benchmark (81 FR 37962). Under this framework, ACO benchmarks are adjusted for beneficiary characteristics and other factors deemed appropriate by the Secretary, updated to reflect the projected absolute growth in

---

[279] Internal simulation analysis using PY2024 historical benchmarks, in which the positive regional adjustment weight was reduced from 50 percent to 35 percent for lower spending ACOs to assess the impact of the proposed policy change. This analysis did not stratify by agreement period; all ACOs with the same start date (before or after January 1, 2024) were treated as a single cohort.

[280] Defined as ACOs with historical expenditures below their regional service area average.

national per capita expenditures for the original Medicare fee-for-service program, and reset at the commencement of each agreement period.

We propose to amend § 425.656 to specify the phase-in of weights used in calculating the regional adjustment as applicable by agreement period start date. We propose to amend the introductory text of paragraph (e) of § 425.656 to specify the paragraph includes the phase-in of weights used in the regional adjustment calculation for agreement periods beginning on or after January 1, 2024 and before January 1, 2027. We propose to redesignate paragraph (f) of § 425.656 as paragraph (g). We propose to add a new paragraph (f) to specify the phase-in of weights used in the regional adjustment calculation for agreement periods beginning on January 1, 2027, and in subsequent years. Accordingly, we propose to specify the following under new proposed § 425.656(f)(1) through (4):

- Under new paragraph (f)(1) we would specify that the first time that an ACO's benchmark is adjusted based on the ACO's regional service area expenditures, we would calculate the regional adjustment as follows:

++ Using 35 percent of the difference between the average per capita amount of expenditures for the ACO's regional service area and the average per capita amount of the ACO's initial or rebased historical benchmark, if the ACO is determined to have lower spending than the ACO's regional service area.

++ Using 15 percent of the difference between the average per capita amount of expenditures for the ACO's regional service area and the average per capita amount of the ACO's initial or rebased historical benchmark, if the ACO is determined to have higher spending than the ACO's regional service area.

- Under new paragraph (f)(2) we would specify that the second time that an ACO's benchmark is adjusted based on the ACO's regional service area expenditures, we would calculate the regional adjustment as follows:

++ For an ACO participating under the BASIC track—

-- Using 50 percent of the difference between the average per capita amount of expenditures for the ACO's regional service area and the average per capita amount of the ACO's rebased historical benchmark if the ACO is determined to have lower spending than the ACO's regional service area; or

-- Using 25 percent of the difference between the average per capita amount of expenditures for the ACO's regional service area and the average per capita amount of the ACO's rebased historical benchmark if the ACO is determined to have higher spending than the ACO's regional service area.

++ For an ACO participating under the ENHANCED track—

-- Using 35 percent of the difference between the average per capita amount of expenditures for the ACO's regional service area and the average per capita amount of the ACO's rebased historical benchmark if the ACO is determined to have lower spending than the ACO's regional service area; or

-- Using 25 percent of the difference between the average per capita amount of expenditures for the ACO's regional service area and the average per capita amount of the ACO's rebased historical benchmark if the ACO is determined to have higher spending than the ACO's regional service area.

● Under new paragraph (f)(3) we would specify that the third time that an ACO's benchmark is adjusted based on the ACO's regional service area expenditures, we would calculate the regional adjustment as follows:

++ For an ACO participating under the BASIC track—

-- Using 50 percent of the difference between the average per capita amount of expenditures for the ACO's regional service area and the average per capita amount of the ACO's rebased historical benchmark if the ACO is determined to have lower spending than the ACO's regional service area; or

-- Using 35 percent of the difference between the average per capita amount of expenditures for the ACO's regional service area and the average per capita amount of the ACO's rebased historical benchmark if the ACO is determined to have higher spending than the ACO's regional service area.

++ For an ACO participating under the ENHANCED track —

-- Using 35 percent of the difference between the average per capita amount of expenditures for the ACO's regional service area and the average per capita amount of the ACO's rebased historical benchmark if the ACO is determined to have lower spending than the ACO's regional service area; or

-- Using 35 percent of the difference between the average per capita amount of expenditures for the ACO's regional service area and the average per capita amount of the ACO's rebased historical benchmark if the ACO is determined to have higher spending than the ACO's regional service area.

- Under new paragraph (f)(4) we would specify that the fourth or subsequent time that an ACO's benchmark is adjusted based on the ACO's regional service area expenditures, we would calculate the regional adjustment as follows:

++ For an ACO participating under the BASIC track, using 50 percent of the difference between the average per capita amount of expenditures for the ACO's regional service area and the average per capita amount of the ACO's rebased historical benchmark.

++ For an ACO participating under the ENHANCED track—

-- Using 35 percent of the difference between the average per capita amount of expenditures for the ACO's regional service area and the average per capita amount of the ACO's rebased historical benchmark if the ACO is determined to have lower spending than the ACO's regional service area; or

-- Using 50 percent of the difference between the average per capita amount of expenditures for the ACO's regional service area and the average per capita amount of the

ACO's rebased historical benchmark if the ACO is determined to have higher spending than the ACO's regional service area.

We propose to specify under new § 425.656(f)(5) the approach we would use to determine if an ACO has lower or higher spending compared to the ACO's regional service area, which would be identical to the existing approach for making this determination as specified under § 425.656(e)(5), except to include updated cross-references to provisions within the proposed new paragraphs (f)(1) through (4) rather than paragraphs (e)(1) through (3).

We also propose the following technical and conforming changes to the Shared Savings Program regulations, for completeness and clarity:

- In § 425.656(a), describing (generally) the purpose of the section on calculating the regional adjustment to the historical benchmark and the timing of applicability, we propose to revise the last sentence to denote the section "applies to regional adjustment calculations for agreement periods beginning on January 1, 2024, and in subsequent years, *except as specified otherwise*" (emphasis added to reflect revised text).

- In § 425.656(c)(2), describing percentage weight applied in the calculation of the regional adjustment, we propose to amend the existing cross-reference to § 425.656(e) to include cross-references to both § 425.656(e) and the proposed new § 425.656(f).

- Redesignating § 425.656(f) as § 425.656(g), and in redesignated § 425.656(g) introductory text, describing special rules for determining the weights used in the regional adjustment calculation for a re-entering ACO, we propose to replace the existing cross-references to § 425.656(b) through (e) with cross-references to § 425.656(b) through (f), to include proposed new § 425.656(f) in the cross-references.

- In § 425.600(f)(4)(ii), describing the program requirements that phase in over multiple agreement periods, and specifically the weight used in calculating the regional adjustment to the ACO's historical benchmark, we propose replacing the existing cross-references to §§ 425.601(f)

and 425.656(e), with cross-references §§ 425.601(f), § 425.656(e), and § 425.656(f), to include proposed new § 425.656(f) in the cross-references.

We seek comment on the proposal to reduce the maximum weight on the regional adjustment for lower-spending ACOs under the ENHANCED track to a weight of 35 percent for agreement periods beginning on January 1, 2027, and in subsequent years. Under this proposal, the weight for higher-spending ACOs, and for BASIC track ACOs that are lower spending would remain unchanged. We also seek comment on proposed technical and conforming changes to other provisions of § 425.656, and § 425.600.

d. Proposal to Increase the Prior Savings Adjustment by Increasing the Scaling Factor

(1) Background

Under section 1899(d)(1)(B)(ii) of the Act, an ACO's benchmark must be reset at the start of each agreement period. Section 1899(d)(1)(B)(ii) of the Act provides the Secretary with discretion to adjust the historical benchmark by "such other factors as the Secretary determines appropriate." Under this authority, as described in the June 2015 final rule (80 FR 32785 through 32791), we established a prior savings adjustment[281] that applied when establishing the benchmark for ACOs entering a second agreement period beginning on January 1, 2016, to account for the average per capita amount of savings generated during the ACO's prior agreement period (79 FR 72838). The prior savings adjustment was originally designed to adjust an ACO's benchmark for its second agreement period to account for the average per capita amount of savings generated by the ACO across the 3 performance years of its first agreement period. This average per capita amount also accounted for the ACO's quality performance in each performance year under its first agreement period. We limited the adjustment to the benchmark for the second agreement period to the average number of assigned beneficiaries in the prior agreement period (80 FR 32789).

[281] In the June 2015 final rule (80 FR 32788), we referred to this policy as accounting for shared savings payments when resetting the benchmark, after which we refer to it as the prior savings adjustment.

We removed the prior savings adjustment introduced as part of the June 2015 final rule and replaced it with the existing regional adjustment as part of the June 2016 final rule (81 FR 37954 through 37992). We reintroduced the prior savings adjustment as an ongoing component of the Shared Savings Program as part of the CY 2023 PFS final rule (87 FR 69898 through 69915).

In the CY 2023 PFS final rule, we established the methodology, codified at § 425.658 of the regulations, for the prior savings adjustment that applied in the establishment of benchmarks for renewing ACOs and re-entering ACOs entering an agreement period beginning on January 1, 2024, and in subsequent years. We describe the steps for calculating the prior savings adjustment in the CY 2023 PFS final rule (87 FR 69898). We finalized revisions to § 425.656 that specify how we express the regional adjustment as a single value and use this value in determining whether a regional adjustment or prior savings adjustment will be applied to the ACO's benchmark.

In the CY 2024 PFS final rule (88 FR 79185 through 79196), in response to concerns that negative regional adjustments may make it more difficult for ACOs to succeed in the Shared Savings Program financially, we finalized revisions to § 425.652 to specify that if the regional adjustment, when expressed as a single value, is negative then no regional adjustment will be applied to an ACO's historical benchmark. We also finalized revisions to § 425.658 to specify that we will calculate the per capita prior savings adjustment as the lesser of 50 percent of the prorated average per capita savings amount (computed as described in § 425.658(b)(3)(ii)) and the cap equal to 5 percent of national per capita OM expenditures for assignable beneficiaries for BY3, expressed as a single value.

In the CY 2024 PFS final rule we also finalized modifications to the approach to calculate and apply the regional adjustment, or the regional adjustment in combination with the prior savings adjustment, if applicable, for ACOs in agreement periods starting on January 1, 2024, or the regional adjustment, prior savings adjustment, or population adjustment,

if applicable, for ACOs in agreement periods starting on January 1, 2025, and in subsequent years. Specifically, we finalized revisions to § 425.652 that specify how we will determine and apply the adjustment to an ACO's benchmark depending on whether the ACO is eligible for a prior savings adjustment, whether the ACO is eligible for the population adjustment, and whether the ACO's regional adjustment, expressed as a single value, is positive or negative. An ACO will receive the most favorable of the adjustments, as applicable, with each adjustment capped at 5 percent of BY3 national assignable expenditures.

In the CY 2024 PFS proposed rule (88 FR 52494 through 52495), we requested information on potential changes to the 50 percent scaling factor used in determining the prior savings adjustment. Most commenters supported increasing the prior savings adjustment, with several commenters recommending using the maximum shared savings rate the ACO was eligible to receive during the benchmark years. For the full summary of comments, refer to the CY 2024 PFS final rule (88 FR 79228).

(2) Proposed Revisions

In the CY 2023 PFS final rule (87 FR 69910), we stated that we believed that a 50 percent scaling factor used to calculate the prior savings adjustment would be appropriate because it represents a middle ground between the maximum sharing rate of 75 percent under the ENHANCED track and the lower sharing rates available under the BASIC track. However, after further analysis of this policy and gaining additional years of experience with the current policy, we believe changing the prior savings adjustment scaling factor from 50 percent to 75 percent is warranted because the current methodology may not provide sufficiently strong or consistent incentives for ACOs to generate and sustain savings. We likewise believe the current methodology may not provide sufficient incentives for ACOs to continue participation in future agreement periods when the ACOs are compared against benchmarks that include their own previous success in reducing expenditures. As noted in the CY 2023 PFS final rule (87 FR 69909), in an analysis estimating how the prior savings adjustment may impact ACOs

participating in the Shared Savings Program if the prior savings adjustment would have been in place at that time, among 123 ACOs entering a new agreement period in PY 2020 and reconciled in one or more benchmark years, only 27 (22 percent) would have received a final adjustment that included prior savings. Among 153 ACOs entering a new agreement period in PY 2022 and reconciled in one or more benchmark years, only 43 (28.1 percent) would have received such an adjustment. These findings suggested that relatively few ACOs would benefit from the prior savings adjustment under the methodology that included the 50 percent scaling factor. Furthermore, after gaining initial experience with the prior savings adjustment applicable to agreement periods beginning on January 1, 2024, and in subsequent years, we have seen a relatively small number of ACOs receiving the prior savings adjustment with 82 (17 percent) of ACOs in CY 2025 receiving a prior savings adjustment and 18 (4 percent) of ACOs in PY 2024 receiving a prior savings adjustment.

In the CY 2023 PFS final rule (87 FR 69904), we also described scenarios in which ACOs with strong prior savings may not receive the prior savings adjustment. For example, as illustrated in Table 68 (87 FR 69907), pro-rating and scaling of prior savings using the 50 percent scaling factor can result in the final prior savings adjustment being smaller than the regional adjustment, even when the ACO's prior savings adjustment prior to applying the scaling factor exceeds the regional adjustment. This dynamic may weaken incentives for ACOs to generate and sustain savings over time.

We conducted a simulation limited to ACOs participating in the ENHANCED track with lower spending than their regional service area, because these ACOs would be directly impacted by the proposed change to the weight of the regional adjustment. The simulation applied both the proposed reduction of the regional adjustment weight from 50 percent to 35 percent and increasing the prior savings adjustment scaling factor from 50 percent to 75 percent. See section III.G.5.c.(2) for a description of the proposed change to the regional adjustment weight. The simulation was conducted on two cohorts: 37 ENHANCED track ACOs that began an

agreement period on January 1, 2024, and 107 ENHANCED track ACOs that began an agreement period on January 1, 2025. For both cohorts, we focused on PY1 of the agreement period; 2024 and 2025, respectively. Table B-G11 reports the results for five mutually exclusive groups of ACOs. **Group 1 (had regional adjustment and still would have it, no benchmark change due to 5 percent cap)** includes ACOs that remain at the existing 5 percent cap, leaving benchmarks unchanged, as the reduction in the regional adjustment weight did not decrease the regional adjustment below the 5 percent cap. **Group 2 (had regional adjustment, now would have prior savings adjustment)** consists of ACOs that currently receive a regional adjustment and for which the proposed increase in the prior savings adjustment scaling factor is large enough to either fully offset the reduced regional adjustment, resulting in benchmarks that do not decline and may increase, or to mitigate the effect of the reduced regional adjustment to some degree as the applicable adjustment to the benchmark would change as a result of the proposed policy changes. **Group 3 (had regional adjustment and still would have it, net benchmark decrease)** includes ACOs that receive the full proposed reduction to the weight of the regional adjustment and for which the prior savings adjustment, even at the proposed 75 percent scaling factor, remains smaller than the regional adjustment. For these ACOs, the final adjustment category would remain the regional adjustment both before and after the changes, resulting in a net decrease to the benchmark. **Group 4 (subject to the current 50 percent prior savings adjustment scaling factor)** includes ACOs for which the prior savings adjustment calculated under the current 50 percent scaling factor was already the applicable adjustment prior to the proposed policy change to the regional adjustment weight; because the prior savings adjustment remains the applicable adjustment, any benchmark change for these ACOs reflects the effect of the proposed increase in the prior savings adjustment scaling factor. **Group 5 (not subject to the proposed regional adjustment weight change)** includes ACOs that are not exposed to the regional adjustment weight adjustment—either because they are higher spending or already subject to the 35 percent positive weight—but that received the increased prior savings

adjustment (see footnote on Table B-G11). One ACO in the 2025 cohort had the population adjustment as their applicable adjustment and would continue to have it with any of the proposed changes.

TABLE B-G11: ESTIMATED BENCHMARK IMPACT OF PROPOSED REDUCTION IN REGIONAL ADJUSTMENT WEIGHT AND INCREASING PRIOR SAVINGS ADJUSTMENT

	ACOs beginning an Agreement Period on January 1, 2024			ACOs beginning an Agreement Period on January 1, 2025		
Group	**Number of ACOs (N=37)***	**Percent of ACOs (%)**	**Mean Change Per Capita Benchmark ($)**	**Number of ACOs (N=107) ***	**Percent of ACOs (%)**	**Mean Change Per Capita Benchmark ($)**
(1) Regional Adjustment retained (no benchmark change)	0	0.0%	$0.00	0	0.0%	$0.00
(2) Had regional adjustment would transition to prior savings adjustment	9	24.3%	$29.79	42	39.3%	$16.70
(3) Had regional adjustment and would continue to have it	21	56.8%	-$113.31	31	29.0%	-$85.36
(4) Subject to the current percent prior savings adjustment	7	18.9%	$105.98	33	30.8%	$110.30
(5) Not subject to the proposed regional weight change**	21	36.2% of total (n=58)	$15.98	24	18.3% of total (n=131)	$27.71

Table notes:
* Number of ACOs subject to the proposed policy changes.
** ACOs in this group are not subject to the regional adjustment weight reduction, but where applicable, the proposed 75 percent prior savings adjustment scaling factor was applied.

For ACOs that began an agreement period on January 1, 2025, the proposed policies would produce no meaningful net aggregate impact on benchmarks for ACOs in group 1. After applying the reduced regional adjustment weight, no ACO remains constrained by the 5 percent cap. Of the 107 ACOs, 42 (39.3 percent) fall in Group 2, with benchmarks increasing by a mean

of $16.70, 33 (30.8 percent) fall in Group 4, where the prior savings adjustment was already dominant, and 31 ACOs (29.0 percent) fall in Group 3 with benchmark decreases averaging $85.36 in magnitude. For the 2025 cohort, the increase in the scaling of the prior savings adjustment more than offsets the reduction in the weight of the regional adjustment in aggregate, producing a modest net benchmark increase concentrated among ACOs with proven savings records. The larger share of ACOs in this cohort for which the prior savings adjustment is the applicable adjustment (70.1 percent; Groups 2 and 4) reflects, in part, cohort-specific differences in benchmark composition and adjustment eligibility—specifically, a greater prevalence of ACOs with prior savings large enough that the prior savings adjustment exceeds the regional adjustment and therefore determines the final benchmark adjustment.

For ACOs that began an agreement period on January 1, 2024, the combined effect of the two proposed policies produces a net downward aggregate impact on benchmarks. No ACO in this cohort is constrained by the 5 percent cap, leaving most directly affected by the proposed regional adjustment weight reduction, with limited offset from the increase in the prior savings adjustment scaling factor. As a result, 21 ACOs (56.8 percent of those impacted) would experience benchmark decreases. A smaller share of ACOs hold the prior savings adjustment as their applicable adjustment (43.2 percent). Prior savings amounts are generally insufficient to exceed regional adjustments, and for these ACOs, the net effect of the two policies is a downward adjustment, consistent with the intended effect for ACOs whose benchmarks might have been inflated by the generous regional adjustment. As ACOs have additional incentives to focus on increasing savings in the future, prior savings amounts may continue to grow, resulting in different impacts than what are initially observed in these analyses.

We extended this analysis by re-running the simulation and incorporating the proposed risk adjustments to the 5 percent cap on positive regional adjustments and to the prior savings adjustment cap (Table B-G12) as outlined in section III.G.5.e. of this proposed rule.

TABLE B-G12: ESTIMATED IMPACT OF PROPOSED REGIONAL ADJUSTMENT WEIGHT REDUCTION, INCREASING PRIOR SAVINGS ADJUSTMENT, AND RISK-ADJUSTED CAPS ON ACO BENCHMARK ADJUSTMENTS

	ACOs beginning an Agreement Period on January 1, 2024			ACOs beginning an Agreement Period on January 1, 2025		
Group	**Number of ACOs (N=37)***	**Percent of ACOs (%)**	**Mean Change Per Capita Benchmark ($)**	**Number of ACOs (N=107)***	**Percent of ACOs (%)**	**Mean Change Per Capita Benchmark ($)**
(1) Regional Adjustment retained (no benchmark change)	0	0.0%	0.00	0	0.0%	0.00
(2) Had regional adjustment, would transition to prior savings adjustment	9	24.3%	13.97	41	38.3%	7.22
(3) Had regional adjustment and would continue to have it	21	56.8%	-115.91	32	29.9%	-93.72
(4) Subject to the current percent prior savings adjustment	7	18.9%	107.03	33	30.8%	121.36
(5) Subject to the population adjustment and would transition to regional adjustment	0	0	0	1	0.9	11.03

Table notes:
* Number of ACOs subject to the proposed policy changes.

Results in Table B-G12 under the proposed risk-adjusted 5 percent cap are largely consistent with those in Table B-G11. The distribution of ACOs across Groups 2 through 4 remains largely unchanged, and the reduction in the weight of the regional adjustment continues to be the primary driver of benchmark changes in both cohorts. The similar results between both analyses are a result of three factors. First, weighted mean risk scores in this sample are clustered near 1.0 (approximately 0.94 to 0.99 across enrollment statuses and cohorts), so risk-adjusting the caps changes their values only modestly (between 1 to 6 percent) and generally does not materially affect ACOs' effective regional or prior savings adjustments. Second, for most ACOs eligible for the prior savings adjustment, the scaling factor is the applicable constraint rather than

the cap; therefore, modifying a non-binding cap has little or no effect on the adjustment. Third, the reduction in the weight of the regional adjustment from 0.50 to 0.35 produces benchmark impacts substantially larger than those associated with risk-adjusting the caps, making it an important driver of changes to the benchmark under both analyses.

To strengthen incentives and mitigate impacts from ACOs' past performance on future agreement periods, we propose increasing the prior savings adjustment scaling factor, program-wide, from 50 percent to 75 percent, beginning with agreement periods starting January 1, 2027, and subsequent agreement periods. We have heard from interested parties that the prior savings adjustment scaling factor should be 100 percent to encourage further savings and address rebasing concerns. However, we believe that increasing the prior savings adjustment scaling factor above 75 percent would limit incentives for ACOs to continue to decrease spending in second and subsequent agreement periods, since they would be rewarded largely for previously demonstrated savings and would not be incentivized to continue to decrease costs (approaching 100 percent reward if the prior savings adjustment scaling factor is above 75 percent). Without a sufficient incentive level to decrease spending, this would jeopardize the ability of the Shared Savings Program to generate future savings to the Trust Funds. We believe that a prior savings adjustment scaling factor of 75 percent strikes the appropriate balance between encouraging long-term participation in the program and encouraging ACOs to save, while also supporting savings to the Trust Funds.

Table B-G13 shows simulated results of the proposal to increase the prior savings adjustment scaling factor to 75 percent while holding the weight on the regional adjustment constant. Table B-G13 is divided into several sections that correspond to the various criteria ACOs would be required to meet to receive the proposed prior savings adjustment. The first segment of the Table (rows [A] and [B]) identifies the total number of ACOs entering a new agreement period in the respective performance year (PY 2024 or PY 2025) and what proportion of all ACOs starting an agreement period in that performance year were reconciled in one or

more benchmark years. This is the first eligibility criterion ACOs must meet to receive the prior savings adjustment. The second segment of the Table (row [C]) identifies the proportion of ACOs, among those reconciled in one or more benchmark years, that had positive prorated average prior savings, which is the second criterion of the CMS methodology. All ACOs that do not receive a regional adjustment and have positive prorated average prior savings would receive some benefit from the prior savings adjustment. However, ACOs that receive a positive regional adjustment and have positive prorated average prior savings would only receive a benefit if the prior savings adjustment is greater than the positive regional adjustment the ACO otherwise would have received. The third section in Table B-G13 (row [D]) identifies the proportion of ACOs that were simulated to actually receive the prior savings adjustment among ACOs that were reconciled in one or more benchmark years. The fourth segment in Table B-G13 (row [E]) summarizes the positive impact of the prior savings adjustment relative to the regional adjustment the ACO would otherwise have received for ACOs that were simulated to receive the prior savings adjustment. This table demonstrates that more ACOs could receive the prior savings adjustment instead of the regional adjustment in later agreement periods when increasing the scaling factor for the prior savings adjustment to 75 percent.

TABLE B-G13: MODELED IMPACT OF 50 percent AND 75 percent PRIOR SAVINGS ADJUSTMENT SCALING FACTORS ON PY 2025 BENCHMARKS FOR 2024 AND 2025 STARTERS

	50% Prior Savings Adjustment Scaling Factor	75% Prior Savings Adjustment Scaling Factor
[A] ACOs Entering a New Agreement Period in 2024 or 2025	336	336
[B] ACOs Reconciled in One or More Benchmark Years	256	256
Percent of ACOs in [B] out of total in [A]	76%	76%
[C] ACOs with Positive Pro-rated Average Prior Savings Among ACOs Reconciled in One or More Benchmark Years	223	223
Percent of ACOs in [C] out of total in [B]	87%	87%
[D] ACOs Whose Final Adjustment Includes Adjustment for Prior Savings Among ACOs Reconciled in One of More Benchmark Years	82	137
Percent of ACOs in [D] out of total in [C]	37%	61%
[E1] Net Benefit to Benchmarks from Prior Savings Adjustment Relative to Regional Adjustment Otherwise Received ($) Under 50% Prior Savings Adjustment Scaling		

Factor (Calculated Among ACOs in [D] that began an agreement period on January 1, 2024)	
Minimum	$0.85
Average	$45.72
Maximum	$113.87
[E2] Net Benefit to Benchmarks from Prior Savings Adjustment Relative to Regional Adjustment Otherwise Received ($) Under 75% Prior Savings Adjustment Scaling Factor (Calculated Among ACOs in [D] that began an agreement period on January 1, 2025)	
Minimum	$0.52
Average	$62.01
Maximum	$157.53

In the CY 2023 PFS final rule (87 FR 69907), we explained our belief that incorporating an adjustment for prior savings — when more advantageous for ACOs than the regional adjustment — would help limit the negative ratchet effects of benchmark rebasing. Under the existing benchmarking methodology, savings an ACO achieves in one agreement period can reduce its rebased benchmark for a subsequent agreement period by lowering the historical spending that forms the basis for that benchmark. To illustrate the effect of the proposed scaling factor increase in reducing the impacts from rebasing: if an ACO reduces per capita expenditures by $1,000 relative to a $10,000 benchmark, its rebased benchmark would otherwise decrease to $9,000. Under the current 50 percent scaling factor, the prior savings adjustment restores $500, yielding a benchmark of $9,500. Under the proposed 75 percent scaling factor, $750 would be restored, resulting in a benchmark of $9,750 and a smaller effective downward adjustment of the benchmark.

The proposed increase to the prior savings adjustment scaling factor from 50 percent to 75 percent would provide additional relief from rebasing while continuing to incentivize ACOs to achieve further savings in future agreement periods. This change would shift a subset of ACOs from receiving the regional adjustment to receiving the prior savings adjustment, as the larger prior savings adjustment becomes more likely to exceed the regional adjustment. ACOs with higher regional or population adjustments would remain largely unaffected, while those with moderate to high levels of prior savings would particularly benefit.

Although MedPAC has previously urged CMS to use the prior savings adjustment to phase out the regional adjustment entirely,[282] we continue to disagree that a full phase-out is appropriate. We believe that the regional adjustment continues to provide valuable incentives, and that ACOs that are efficient relative to their regions should continue to receive a benchmark adjustment that recognizes that efficiency, consistent with our longstanding goal of reducing disincentives for high-performing ACOs that successfully lower spending. We are, however, also proposing to reduce the maximum weight applied to the regional adjustment for lower-spending ENHANCED track ACOs. Taken together, these proposals are intended to better balance incentives between regionally efficient ACOs and those that have demonstrated program success, through a history of earning shared savings, while further mitigating the ratcheting effects that may occur when prior savings are incorporated into future benchmarks (see section III.G.5.c.(2) of this proposed rule for details on the proposed regional adjustment changes).

We propose that this policy would apply for agreement periods beginning on January 1, 2027, and in subsequent years.

We propose to revise § 425.658(c), describing calculation of the per capita prior savings adjustment, to include proposed revised paragraph (c)(2), with the calculation methodology applicable for agreement periods beginning on January 1, 2027, and in subsequent years. Currently paragraph (c)(2) of § 425.658 is reserved. Under proposed § 425.658(c)(2), we would specify the use of a scaling factor of 75 percent (described in this section of this proposed rule), and a proposed risk adjusted 5 percent cap (described in section III.G.5.e.(2)(b) of this proposed rule) in determining the amount of the prior savings adjustment an ACO may receive (if eligible). Specifically, for agreement periods beginning on January 1, 2027, and in subsequent years, if an ACO is eligible for the prior savings adjustment as determined in § 425.658(b)(3), the prior savings adjustment would equal the lesser of the following: (i) 75 percent of the pro-

[282]Medicare Payment Advisory Commission (MedPAC) comment on the CY 2023 PFS proposed rule. *https://www.medpac.gov/wp-content/uploads/2022/09/09022022_Part_B_2023_CMS1770P_MedPAC_COMMENT_v2_SEC.pdf.*

rated average per capita amount computed in § 425.658(b)(3)(ii); or (ii) a single per capita value that would be the result of risk adjusting the 5 percent cap (the calculation of which is described in section III.G.5.e.(2)(b) of this proposed rule).

We also propose the following technical and conforming changes to other provisions of § 425.658, for completeness and clarity:

- In § 425.658(c)(1) introductory text, we propose to add a new first sentence to specify the existing provisions on calculation of the per capita prior savings adjustment apply for agreement periods beginning on or after January 1, 2024 and before January 1, 2027.
- In § 425.658(d), describing CMS' comparison of the per capita prior savings adjustment with the regional adjustment and the population adjustment, in determining which (if any) adjustment applies to an ACO's benchmark, we propose to amend the existing cross-reference to § 425.658(c)(1) to refer instead more generally to § 425.658(c).

We seek comment on our proposal to increase the prior savings adjustment scaling factor from 50 percent to 75 percent for agreement periods beginning on January 1, 2027, and in subsequent years, and the proposal to specify related provisions in the Shared Savings Program regulations in § 425.658(c)(2), as well as proposed technical and conforming changes to other provisions of § 425.658.

e. Proposal to Risk Adjust the 5 percent Cap on Upward Adjustments to the Historical Benchmark

(1) Background

For agreement periods beginning on January 1, 2025, and in subsequent years, in calculating the historical benchmark, CMS applies the highest of three upward adjustments for which the ACO is eligible: a positive regional adjustment, prior savings adjustment, or population adjustment, as described at § 425.652(a)(8)(ii)(B)(*1*). Each of these adjustments is subject to a cap of 5 percent of national per capita OM expenditures for the assignable beneficiary population, a limit first established in the CY 2018 PFS final rule (83 FR 68072).

In the June 2016 final rule (81 FR 37973), we introduced a regional adjustment to the ACO's historical benchmark. In the CY 2023 PFS final rule (87 FR 69915 through 69923), we finalized the application of a cap on the negative regional adjustment at negative 1.5 percent of national per capita expenditures for Parts A and B services and further modified the adjustment to limit its negative impact on ACO historical benchmarks. In the CY 2024 PFS final rule (88 FR 79185 through 79196), we further modified the regional adjustment to prevent any ACO from receiving an adjustment that would cause its benchmark to be lower than it would have been in the absence of a regional adjustment.

In the June 2015 final rule (80 FR 32785 through 32791), we established a prior savings adjustment to account for the average per capita amount of savings generated during an ACO's prior agreement period. We removed the adjustment in the June 2016 final rule (81 FR 37954 through 37992) and then reinstated it in the CY 2023 PFS final rule (87 FR 69898 through 69915), for renewing and re-entering ACOs beginning January 1, 2024. In the CY 2024 PFS final rule (88 FR 79196 through 79200), we modified the prior savings adjustment to account for changes in savings due to compliance actions or reopenings of prior determinations.

In the CY 2025 PFS final rule (89 FR 61887 through 61892), we introduced the health equity benchmark adjustment (HEBA), which adjusts upward an ACO's historical benchmark based on the number of dually eligible or Low-Income Subsidy (LIS)-enrolled beneficiaries served. With the CY 2026 PFS final rule (90 FR 49831 through 49834), we renamed the HEBA to the "population adjustment" to more accurately reflect the nature of the adjustment.

The positive regional adjustment, prior savings adjustment, and population adjustment are all capped at 5 percent of national per capita OM expenditures for the assignable beneficiary population. Further, the population adjustment calculation considers the difference between the 5 percent cap and the higher of regional adjustment, prior savings adjustment, or no adjustment (in the case where the regional adjustment is negative or the ACO is not eligible for the prior

savings adjustment)[283]. More generally, the 5 percent cap mitigates the potential risk of CMS paying ACOs shared savings payments that are the result of extreme or outlier positive adjustments to the benchmark.

(2) Proposal

ACOs serving medically complex populations with higher CMS-HCC risk scores (relative to the national assignable population) have expressed concern that the current 5 percent cap applied to the three upward adjustments to the historical benchmark (regional adjustment, prior savings adjustment, and population adjustment) is too restrictive. Specifically, when the cap is applied as a flat percentage without accounting for the degree to which the ACO serves a medically complex population, it imposes a hard ceiling that suppresses the historical benchmark. Rather than allowing the benchmark adjustments to reflect the actual higher costs required to care for these complex patients, the flat 5 percent cap limits the three upward adjustments. These ACOs have requested that the higher clinical complexity, higher CMS-HCC risk scores, and higher cost of providing care to their assigned beneficiary populations be considered when establishing a cap for adjustments to the historical benchmark. Risk adjusting the 5 percent caps accounts for the severity and case mix of each ACO's assigned beneficiary population, allowing a higher positive adjustment ceiling for ACOs serving medically complex populations while still fulfilling the cap's original purpose of safeguarding CMS against extreme or outlier positive benchmark adjustments. Beyond addressing ACO concerns, risk adjusting the 5 percent cap would encourage ACOs to enroll and manage higher acuity, higher cost beneficiaries, who stand to benefit most from coordinated care, by allowing the cap to scale upwards with the average CMS-HCC risk scores of their populations relative to the national average.

To better align benchmark adjustments with true clinical complexity and encourage participation among organizations engaged in providing high-needs care, we propose to risk

[283] 42 CFR 425.656; 42 CFR 425.658; 42 CFR 425.662.

adjust the 5 percent cap on each of the upward adjustments to the historical benchmark: the positive regional adjustment, the prior savings adjustment, and the population adjustment.

(a) Proposal to Risk Adjust the 5 percent Cap on Positive Regional Adjustments to the Historical Benchmark

We propose to risk adjust the 5 percent cap on positive adjustments to the national per capita dollar amount for each Medicare enrollment type (ESRD, Disabled, Aged/Dual, and Aged/non-dual), used to calculate the regional adjustment to the historical benchmark, according to the following steps:

- Step 1 – Identify the national per capita expenditure amount for the enrollment type for BY3.
- Step 2 – Identify the ACO's weighted average CMS-HCC risk score for the enrollment type for BY3.[284]
- Step 3 – By enrollment type, calculate the product of the amounts identified in Step 1 and Step 2.
- Step 4 – By enrollment type, calculate the cap for the enrollment type at 5 percent of the product derived in Step 3.
- Step 5 – Apply the risk-adjusted 5 percent cap calculated in Step 4 to the ACO's preliminary regional adjustment for the enrollment type. The preliminary regional adjustment refers to the regional adjustment amount for the enrollment type (that is, the per capita dollar amount) before any caps are applied.[285]

++ Step 5(i) – Identify the ACO's preliminary regional adjustment for the enrollment type.

---

[284] For more information on the calculation of the weighted average CMS-HCC risk score, we refer readers to section 3.2 of the Shared Savings and Losses, Assignment and Quality Performance Standard Methodology Specifications Version 14.

[285] For more information on the calculation of the preliminary regional adjustment for the enrollment type, we refer readers to section 4.1.2 step 5 of the Shared Savings and Losses, Assignment and Quality Performance Standard Methodology Specifications Version 14.

++ Step 5(ii) – Evaluate whether the value identified in Step 5(i) is greater than the risk-adjusted 5 percent cap determined in Step 4. If yes, set regional adjustment for the enrollment type at the risk-adjusted 5 percent cap calculated in Step 4. If no, set the regional adjustment for the enrollment type as the value identified in Step 5(i).

We illustrate how the proposed calculation methodology would be applied, considering the following hypothetical example in which positive adjustments are applied to the regional adjustment for all enrollment types for the ACO.

TABLE B-G14: HYPOTHETICAL EXAMPLE OF STEPS FOR RISK ADJUSTING THE 5 percent CAPS ON POSITIVE REGIONAL ADJUSTMENTS TO HISTORICAL BENCHMARKS

	Amount Under Current Policy (No Risk Adjustment Applied to 5 percent Caps)	Amount Under Proposed Policy (Risk Adjustment Applied to 5 percent Caps)
Step 1: Identify the national per capita expenditure amount for the enrollment type for BY3.		
ESRD	$121,092.11	$121,092.11
Disabled	$18,266.87	$18,266.87
Aged/dual	$30,290.30	$30,290.30
Aged/non-dual	$15,943.88	$15,943.88
Step 2: Identify the ACO's weighted average CMS-HCC mean risk score for the enrollment type for BY3.		
ESRD	NA	1.1022
Disabled	NA	0.9249
Aged/dual	NA	1.0648
Aged/non-dual	NA	1.0366
Step 3: By enrollment type, calculate the product of the amounts identified in Step 1 and Step 2.		
ESRD	NA	$133,467.72
Disabled	NA	$16,895.03
Aged/dual	NA	$32,253.11
Aged/non-dual	NA	$16,527.43
Step 4: By enrollment type, calculate the cap for the enrollment type as 5 percent of the product derived in Step 3. (Under current policy, the cap is calculated as 5 percent of the amount identified in Step 1.)		
ESRD	$6,054.61	$6,673.39
Disabled	$913.34	$844.75
Aged/dual	$1,514.51	$1,612.66
Aged/non-dual	$797.19	$826.37
Step 5: Apply the risk-adjusted 5 percent cap calculated in Step 4 to the ACO's preliminary regional adjustment for the enrollment type.		
Step 5(i) Identify the ACO's preliminary regional adjustment for the enrollment type.*		
ESRD	$376.91	$376.91
Disabled	$905.00	$905.00
Aged/dual	$3,036.48	$3,036.48
Aged/non-dual	$883.08	$883.08
Step 5(ii): Evaluate whether the value identified in Step 5(i) is greater than the risk-adjusted 5 percent cap determined in Step 4. If yes, set the regional adjustment for the enrollment type at the risk-adjusted 5 percent cap calculated in Step 4. If no, set the regional adjustment for the enrollment type as the value identified in Step 5(i).		
ESRD	$376.91	$376.91
Disabled	$905.00	$844.75
Aged/dual	$1,514.51	$1,612.66
Aged/non-dual	$797.19	$826.37

*For more information on the calculation of the preliminary regional adjustment for the enrollment type, we refer readers to section 4.1.2 step 5 of the Shared Savings and Losses, Assignment and Quality Performance Standard Methodology Specifications Version 14.[286]

[286] Refer to the Medicare Shared Savings Program, "Shared Savings and Losses, Assignment and Quality Performance Standard Methodology Specifications" (April 2026, Version #14), available at

An average CMS-HCC risk score of 1.000 indicates that the ACO's population risk aligns with the national assignable population average, while scores above 1.000 identify populations with higher-than-average risk and scores below 1.000 identify populations with lower-than-average risk. By risk-adjusting the 5 percent caps for each enrollment group, the caps would become tailored to each ACO's specific risk profile for BY3. In this hypothetical example, the caps for the ESRD, Aged/Dual, and Aged/Non-Dual groups increase to reflect elevated risk levels, while the cap for the Disabled group decreases to reflect a lower risk profile for that group. This hypothetical example illustrates how a single ACO may experience both increased and decreased 5 percent caps across enrollment types, depending on each enrollment type's average risk relative to the national assignable population. Notably, the proposed risk adjustment policy applies exclusively to the 5 percent caps on positive adjustments; caps for negative adjustments remain unchanged under the proposed policy.

We propose to revise and republish § 425.656(c)(3), to include the proposed approach to calculating the caps on regional adjustment amounts applicable for agreement periods beginning on January 1, 2027, and in subsequent years, as well as the existing calculation of the caps on the regional adjustment amounts that would apply for agreement periods beginning on or after January 1, 2024, and before January 1, 2027.

Under new § 425.656(c)(3)(ii), we propose to specify the approach to calculating the cap on regional adjustment amounts, applicable for agreement periods beginning on January 1, 2027, and in subsequent years. Accordingly, we propose to specify that CMS caps the per capita dollar amount for each Medicare enrollment type (ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, aged/non-dual eligible Medicare and Medicaid beneficiaries) calculated

---

https://www.cms.gov/files/document/medicare-shared-savings-program-shared-savings-losses-assignment-methodology-specifications-version.pdf-0 (herein for brevity "Shared Savings and Losses, Assignment and Quality Performance Standard Methodology Specifications Version 14").

under § 425.656(c)(2) at a dollar amount as described in the provisions that follow in subparagraphs (A) and (B), inclusive of the provisions included thereunder.

Under new § 425.656(c)(3)(ii)(A), we propose to specify that, for positive adjustments, the per capita dollar amount for a Medicare enrollment type would be capped at a dollar amount calculated as follows:

- As specified in proposed § 425.656(c)(3)(ii)(A)(*1*), we would calculate the product of the following: (i) the amount of national per capita expenditures for Parts A and B services under the OM fee-for-service program in BY3 for assignable beneficiaries in that enrollment type identified for the 12-month calendar year corresponding to BY3 using data from the CMS Office of the Actuary; and (ii) the ACO's weighted average risk score for the enrollment group for BY3.[287]

- As specified in proposed § 425.656(c)(3)(ii)(A)(*2*), we would calculate 5 percent of the enrollment type-specific product determined in § 425.656(c)(3)(ii)(A)(*1*).

Under new § 425.656(c)(3)(ii)(B), we propose to specify that, for negative adjustments, the per capita dollar amount for a Medicare enrollment type would be capped at a dollar amount equal to negative 1.5 percent of national per capita expenditures for Parts A and B services under the OM program in BY3 for assignable beneficiaries in that enrollment type identified for the 12-month calendar year corresponding to BY3 using data from the CMS Office of the Actuary.

The following list summarizes the proposed amendments to the structure and organization of § 425.656(c)(3) (as revised and republished):

- We propose to specify the existing provisions of § 425.656(c)(3), describing the caps on regional adjustment amounts based on a percentage of national per capita expenditures for the assignable beneficiary population for BY3, under new § 425.656(c)(3)(i). Accordingly, we propose to:

---

[287] For more information on the calculation of the weighted average risk score we refer readers to section 3.2 of the Shared Savings and Losses, Assignment and Quality Performance Standard Methodology Specifications Version 14.

++ Add a sentence at the start of the introductory text of new § 425.656(c)(3)(i) specifying the applicability of the calculation for agreement periods beginning on or after January 1, 2024, and before January 1, 2027.

++ Redesignate existing paragraphs (c)(3)(i) and (ii) of § 425.656 (specifying the cap on positive adjustments and negative adjustments, respectively) as paragraphs (c)(3)(i)(A) and (B).

- We propose to specify the proposed caps on regional adjustment amounts, applicable for agreement periods beginning on January 1, 2027, and in subsequent years, in new § 425.656(c)(3)(ii) (previously described in this section).

We seek comment on the proposal to risk adjust the 5 percent caps on positive regional adjustment amounts, applicable for agreement periods beginning on January 1, 2027, and in subsequent years, and related proposed changes to the Shared Savings Program regulations at § 425.656(c)(3) (as revised and republished).

(b) Proposal to Risk Adjust the 5 percent Cap on the Prior Savings Adjustment to the Historical Benchmark

We propose to risk adjust the 5 percent cap on national per capita dollar amount for each Medicare enrollment type (ESRD, Disabled, Aged/dual, and Aged/non-dual), used in determining the prior savings adjustment to the historical benchmark, according to the following steps:

- Step 1 – Identify the national per capita expenditure amount for the enrollment type for BY3.

- Step 2 – Identify the ACO's weighted average CMS-HCC risk score by enrollment type for BY3.

- Step 3 – By enrollment type, calculate the product of the amounts identified in Steps 1 and 2.

- Step 4 – By enrollment type, calculate 5 percent of the product derived in Step 3.

- Step 5 – Identify the proportion of the ACO's assigned beneficiaries within each enrollment type by dividing the number of assigned beneficiaries within each enrollment type by the total number of assigned beneficiaries.

- Step 6 – To calculate the final risk-adjusted 5 percent national expenditure value by enrollment type, multiply the risk-adjusted 5 percent amounts from Step 4 by the enrollment proportions from Step 5.

- Step 7 – Create a single prior savings cap value by summing the products from Step 6 across enrollment types.

- Step 8 – Multiply the prorated average per capita prior savings by the 75 percent scaling factor.[288]

- Step 9 – If the ACO is eligible for a prior savings adjustment, set the prior savings adjustment as the lesser of: the prior savings cap calculated in Step 7, and the weighted prorated average prior savings calculated in Step 8.

We illustrate how the proposed calculation methodology would be applied, considering the following hypothetical example in which the prior savings adjustment is applied for the ACO.

TABLE B-G15: HYPOTHETICAL EXAMPLE OF STEPS FOR RISK ADJUSTING THE 5 percent CAPS ON THE PRIOR SAVINGS ADJUSTMENT TO HISTORICAL BENCHMARKS

[288] For more information on the calculation of the prorated average per capita prior savings, we refer readers to step 6c of section 4.1.2 of the Shared Savings and Losses, Assignment and Quality Performance Standard Methodology Specifications Version 14.

	Amount Under Current Policy (No Risk Adjustment Applied to 5 percent Caps)	Amount Under Proposed Policy (Risk Adjustment Applied to 5 percent Caps)
Step 1: Identify the national per capita expenditure amount for the enrollment type for BY3.		
ESRD	$100,000.00	$100,000.00
Disabled	$12,000.00	$12,000.00
Aged/dual	$20,000.00	$20,000.00
Aged/non-dual	$12,000.00	$12,000.00
Step 2: Identify the ACO's weighted average CMS-HCC risk score by enrollment type for BY3.		
ESRD	NA	1.1022
Disabled	NA	0.9249
Aged/dual	NA	1.0648
Aged/non-dual	NA	1.0366
Step 3: By enrollment type, calculate the product of the amounts identified in Step 1 and Step 2.		
ESRD	NA	$110,222.22
Disabled	NA	$11,098.52
Aged/dual	NA	$21,296.18
Aged/non-dual	NA	$12,439.56
Step 4: By enrollment type, calculate 5 percent of the product derived in Step 3. (For the calculation under current policy, calculate 5 percent of the values identified in Step 1.)		
ESRD	$5,000.00	$5,511.11
Disabled	$600.00	$554.93
Aged/dual	$1,000.00	$1,064.81
Aged/non-dual	$600.00	$621.98
Step 5: Identify the proportion of the ACO's assigned beneficiaries within each enrollment type.		
ESRD	0.007	0.007
Disabled	0.052	0.052
Aged/dual	0.055	0.055
Aged/non-dual	0.886	0.886
Step 6: To calculate the final risk-adjusted 5 percent national expenditure value by enrollment type, multiply the risk-adjusted 5 percent amounts from Step 4 by the enrollment proportions from Step 5.		
ESRD	$35.00	$38.58
Disabled	$31.20	$28.86
Aged/dual	$55.00	$58.56
Aged/non-dual	$531.60	$551.07
Step 7: Create a single prior savings cap value by summing the products from Step 6 across enrollment types.		
Prior savings cap	$652.80	$677.07
Step 8: Multiply the prorated average per capita prior savings by the 75 percent scaling factor.*		
Prorated average per capita savings from BY1, BY2, and BY3	$900.00	$900.00
Proposed 75 percent scaling factor (Under current policy, use 50 percent scaling factor)	50%	75%
Weighted prorated average prior savings	$450.00	$675.00
Step 9: If the ACO is eligible for a prior savings adjustment, set the prior savings adjustment as the lesser of: [A] the prior savings cap calculated in Step 7, and [B] the weighted prorated average prior savings calculated in Step 8.		
Prior savings adjustment	$450.00	$675.00

* For more information on the calculation of the prorated average per capita prior savings, we refer readers to step 6c of section 4.1.2 of the Shared Savings and Losses, Assignment and Quality Performance Standard Methodology Specifications Version 14.

In this scenario, the ACO's prior savings adjustment would be higher under the proposed risk-adjusted caps than under current policy, driven by two key changes. First, the risk-adjusted prior savings cap in Step 7 is higher than the non-risk-adjusted cap, reflecting the ACO's higher-than-average risk profile and allowing the ACO to retain a larger share of its prior savings before

being capped. Second, the proposed increase to the prior savings adjustment scaling factor from 50 percent to 75 percent further raises the available adjustment amount. Together, these updates ensure that the prior savings adjustment reflects recent patient complexity.

As described in section III.G.5.d.(2) of this proposed rule, we are proposing to specify in revised § 425.658(c)(2) the methodology for calculating the per capita prior savings adjustment applicable for agreement periods beginning on January 1, 2027, and in subsequent years. Under proposed § 425.658(c)(2) (as revised), we would specify the use of a scaling factor of 75 percent (described in section III.G.5.d.(2) of this proposed rule), and the proposed risk adjusted 5 percent cap (described in this section of this proposed rule) in determining the amount of the prior savings adjustment an ACO may receive (if eligible). Specifically, for agreement periods beginning on January 1, 2027, and in subsequent years, if an ACO is eligible for the prior savings adjustment as determined in § 425.658(b)(3), the prior savings adjustment would equal the lesser of the following: (i) 75 percent of the pro-rated average per capita amount computed in § 425.658(b)(3)(ii); or (ii) a single per capita value that would be the result of risk adjusting the 5 percent cap.

With respect to risk adjusting the 5 percent cap, we propose to specify related provisions in revised § 425.658(c)(2)(ii). Specifically, we propose that, for agreement periods beginning on January 1, 2027, and in subsequent agreement periods, CMS calculates a single per capita value as follows:

Under § 425.658(c)(2)(ii)(A), we propose to specify that CMS would calculate the product of the following for each Medicare enrollment type (ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, aged/non-dual eligible Medicare and Medicaid beneficiaries)—

- The national per capita expenditures for Parts A and B services under the original OM FFS program in BY3 for assignable beneficiaries in that enrollment type identified for the 12-month calendar year corresponding to BY3 using data from the CMS Office of the Actuary; and

- The ACO's weighted average CMS-HCC risk score for that enrollment type for BY3.[289]

Under § 425.658(c)(2)(ii)(B), CMS would calculate 5 percent of each enrollment type-specific product determined in § 425.658(c)(2)(ii)(A). Under § 425.658(c)(2)(ii)(C), CMS would calculate the single per capita value as a person-year weighted average[290] by multiplying each of these enrollment type-specific values (determined in accordance with § 425.658(c)(2)(ii)(B)) by the proportion of the ACO's assigned beneficiaries within that particular enrollment type and then summing the results.

We also propose a technical and conforming change in § 425.672(c)(2)(iv), describing adjustment of calculation of national per capita OM expenditures for assignable beneficiaries for purposes of capping the prior savings adjustment (among other factors) for SAHS billing activity occurring in CY 2024 or subsequent calendar years. More specifically, in § 425.672(c)(2)(iv), we propose to amend the existing reference to § 425.658(c)(1)(ii), to refer instead to § 425.658(c)(1)(ii) and (c)(2)(ii) (as proposed).

We seek comment on the proposal to risk adjust the 5 percent cap used in calculating the value of the prior savings adjustment to the historical benchmark for agreement periods beginning on January 1, 2027, and in subsequent years. We also seek comment on the proposed calculation of the risk adjusted 5 percent cap as specified in proposed revisions to § 425.658, in paragraph (c)(2)(ii), as well as a proposed technical and conforming change to § 425.672(c)(2)(iv).

---

[289] For more information on the calculation of the weighted average CMS-HCC risk score we refer readers to section 3.2 of the Shared Savings and Losses, Assignment and Quality Performance Standard Methodology Specifications Version 14. *https://www.cms.gov/files/document/medicare-shared-savings-program-shared-savings-losses-assignment-methodology-specifications-version.pdf-0*.

[290] For more information on the calculation of the person-year weighted average we refer readers to section 3.2 of the Shared Savings and Losses, Assignment and Quality Performance Standard Methodology Specifications Version 14. *https://www.cms.gov/files/document/medicare-shared-savings-program-shared-savings-losses-assignment-methodology-specifications-version.pdf-0*.

(c) Proposal to Risk Adjust the 5 percent Cap on the Population Adjustment to the Historical Benchmark

We propose to risk adjust the 5 percent cap on national per capita expenditures for each Medicare enrollment type (ESRD, Disabled, Aged/dual, Aged/non-dual), used to calculate the population adjustment, according to the following steps:

- Step 1 – Identify the proportion of the ACO's assigned beneficiaries for the performance year who are enrolled in the Medicare Part D Low-Income Subsidy (LIS) or are dually eligible for Medicare and Medicaid. Under existing policy, which we do not propose to change, an ACO with a proportion less than 15 percent is ineligible to receive the population adjustment.

- Step 2 – Calculate risk-adjusted 5 percent of the national per capita expenditures for assignable beneficiaries as a single value by employing the following steps:

++ Step 2(i) - Identify the national per capita expenditures for assignable beneficiaries by enrollment type in BY3.

++ Step 2(ii) - Identify the ACO's weighted average CMS-HCC risk score by enrollment type for BY3.[291]

++ Step 2(iii) - By enrollment type, calculate the product of the amounts identified in Step 2(i) and Step 2(ii).

++ Step 2(iv) - By enrollment type, calculate the risk-adjusted, capped national per capita expenditures as 5 percent of the product derived in Step 2(iii).

++ Step 2(v) - Identify the proportion of the ACO's assigned beneficiaries within each enrollment type.

[291] For more information on the calculation of the weighted average CMS-HCC risk score, we refer readers to section 3.2 of the Shared Savings and Losses, Assignment and Quality Performance Standard Methodology Specifications Version 14.

++ Step 2(vi) - To calculate the final risk-adjusted 5 percent national expenditure by enrollment type, multiply the amount from step 2(iv) by the enrollment proportions from Step 2(v).

++ Step 2(vii) - Sum the values in Step 2(vi) to express the risk-adjusted 5 percent of the national per capita expenditures for assignable beneficiaries as a single value.

- Step 3 – Calculate population adjustment scaler by employing the following steps:

++ Step 3(i) - Identify the regional adjustment (expressed as a single value) and the prior savings adjustment.[292]

++ Step 3(ii) - Calculate the scaler as the difference between the values in Step 2(vii) and the higher of the regional adjustment and prior savings adjustment identified in Step 3(i).

- Step 4 – Calculate the population adjustment as the product of the values derived in Step 1 and Step 3(ii), for an ACO eligible for the population adjustment.

We illustrate how the proposed calculation methodology would be applied, considering the following hypothetical example in which the population adjustment is calculated for an ACO with generally higher risk beneficiaries than the national assignable population. Note that by proposing to risk adjust the caps for the regional adjustment and prior savings adjustment, this directly influences the population adjustment an ACO receives; the hypothetical example below (Table B-G16) assumes increased regional and prior savings adjustment amounts under the proposed policy.

TABLE B-G16: HYPOTHETICAL EXAMPLE OF STEPS FOR RISK ADJUSTING THE 5 percent CAPS ON THE POPULATION ADJUSTMENT TO HISTORICAL BENCHMARKS

	Amount Under Current Policy (No Risk Adjustment Applied to 5 percent Caps)	Amount Under Proposed Policy (Risk Adjustment Applied to 5 percent Caps)
Step 1: Identify the proportion of assigned beneficiaries with LIS or dual status.		
Proportion of LIS or dual beneficiaries for the performance year (if less than 15 percent, ACO is ineligible to receive population adjustment)	0.20	0.20
Step 2: Calculate risk-adjusted 5 percent of the national per capita expenditures for assignable beneficiaries as a single value		

[292] For more information on the calculation of the regional adjustment (expressed as a single value) and prior savings adjustment, we refer readers to sections 5 and 6 of the Shared Savings and Losses, Assignment and Quality Performance Standard Methodology Specifications Version 14.

	Amount Under Current Policy (No Risk Adjustment Applied to 5 percent Caps)	Amount Under Proposed Policy (Risk Adjustment Applied to 5 percent Caps)
Step 2(i): Identify the national per capita expenditures for assignable beneficiaries by enrollment type in BY3.		
ESRD	$100,000.00	$100,000.00
Disabled	$12,000.00	$12,000.00
Aged/dual	$20,000.00	$20,000.00
Aged/non-dual	$12,000.00	$12,000.00
Step 2(ii): Identify the ACO's weighted average CMS-HCC risk score by enrollment type for BY3.		
ESRD	NA	1.1022
Disabled	NA	0.9249
Aged/dual	NA	1.0648
Aged/non-dual	NA	1.0366
Step 2(iii): By enrollment type, calculate the product of the amounts identified in Step 2(i) and Step 2(ii).		
ESRD	$100,000.00	$110,222.22
Disabled	$12,000.00	$11,098.52
Aged/dual	$20,000.00	$21,296.18
Aged/non-dual	$12,000.00	$12,439.56
Step 2(iv): By enrollment type, calculate the risk-adjusted, capped national per capita values as 5 percent of the product derived in Step 2(iii).		
ESRD	$5,000.00	$5,511.11
Disabled	$600.00	$554.93
Aged/dual	$1,000.00	$1,064.81
Aged/non-dual	$600.00	$621.98
Step 2(v): Identify the proportion of the ACO's assigned beneficiaries within each enrollment type.		
ESRD	0.007	0.007
Disabled	0.052	0.052
Aged/dual	0.055	0.055
Aged/non-dual	0.886	0.886
Step 2(vi): To calculate the final risk-adjusted 5 percent national expenditure by enrollment type, multiply the amount from Step 2(iv) by the enrollment proportions from Step 2(v)		
ESRD	$35.00	$38.58
Disabled	$31.20	$28.86
Aged/dual	$55.00	$58.56
Aged/non-dual	$531.60	$551.07
Step 2(vii): Sum the values in Step 2(vi) to express the risk-adjusted 5 percent of the national per capita expenditures for assignable beneficiaries as a single value.		
Summed, capped BY3 national assignable expenditures.	$652.80	$677.07
Step 3: Calculate the population adjustment scaler.		
Step 3(i): Identify the regional adjustment (expressed as a single value) and the prior savings adjustment.		
Regional adjustment	$375.00	$400.00
Prior savings adjustment	$335.00	$350.00
Step 3(ii): Calculate the scaler as the difference between the values in Step 2(vii) and the higher of the regional adjustment or prior savings adjustment in Step 3(i).		
Population adjustment scaler	$277.80	$277.07
Step 4: Calculate the population adjustment as the product of the values derived in Step 1 and Step 3(ii).		
Population adjustment	$55.56	$55.41

Because the population adjustment scales based on the difference between 5 percent of risk-adjusted national assignable expenditures and the greater of the regional adjustment or prior savings adjustment, the proposed risk adjustments to the regional adjustment and prior savings adjustment caps would directly influence the final adjustment value an ACO receives.

For ACOs with higher-risk populations, the regional adjustment and prior savings adjustment will likely increase under the proposed policy, as expressed in the hypothetical example (Table B-G15). On the one hand, these increases reduce the available margin for the population adjustment by increasing the amount being subtracted from the scaler (for example, Steps 3(i) and 3(ii)). On the other hand, the risk-adjusted 5 percent cap for the population adjustment also increases for these ACOs with higher-risk populations, expanding the ceiling for the population adjustment amount (for example, Step 2(vii)). Consequently, the mechanisms of the proposed policy ensure that whichever adjustment an ACO ultimately receives is not limited by a flat 5 percent capped ceiling.

Based on an internal analysis simulating PY 2025 performance for 228 ACOs that entered new agreement periods beginning on January 1, 2025, risk adjusting the 5 percent cap on the regional adjustment, prior savings adjustment, and population adjustment would have the effect of increasing ACO benchmarks by an average of $2.98 (a 0.02 percent aggregate increase).[293] Among ACOs seeing a higher adjustment under this approach, benchmarks increased by an average of $84.18 (0.30 percent), while those ACOs with lower adjustments saw an average decrease of $27.66 (-0.22 percent). About half of ACOs (111 of 228, or 49 percent) had no change in their benchmark value under a risk-adjusted 5 percent cap for all three adjustments. While some ACOs (82 of 228, or 36 percent) had lower benchmarks under this approach, the magnitude of change for these ACOs was smaller than the gains made for ACOs that had an increase in their benchmarks (35 of 228, or 15 percent).

Among 91 ACOs receiving the regional adjustment as their adjustment category, these ACOs would have an average final adjustment that is $16.69 lower or 2.58 percent lower under the proposed policies compared to the current policy. Conversely, for the 8 ACOs that received

[293] Internal analysis simulating PY 2025 performance for 228 ACOs that entered new agreement periods beginning on January 1, 2025, applying the proposed policy to risk adjust the 5 percent caps on the regional adjustment, prior savings adjustment, and population adjustment. Simulation results were compared to PY 2025 performance on PY 2025 final historical benchmarks to determine the impact of the proposed policies.

the prior savings adjustment as their adjustment category, these ACOs would have an average final adjustment that is $142.21 higher or 14.42 percent higher, and 16 ACOs receiving the population adjustment would have an adjustment that is $69.10 higher or 12.61 percent higher. Additionally, 111 ACOs would see no change to their final adjustment under the proposed policy, 98 ACOs would have changes small enough that they ultimately would not impact benchmarks, and 2 ACOs changed the adjustment type received under the proposed policy (one with increased benchmarks and the other with decreased benchmarks as a result of the proposed policy and resultant change in adjustment type).

Ultimately, the simulation suggests that risk adjusting the caps will result in higher caps on positive adjustments for ACOs with above-average risk, which we believe may attract ACOs that serve more clinically complex populations with higher CMS-HCC risk scores or encourage existing ACOs to expand to include ACO providers/suppliers who serve such clinically complex populations.

We propose to revise and republish § 425.662(b)(2), to include the proposed approach to calculating the population adjustment applicable for agreement periods beginning on January 1, 2027, and in subsequent years, as well as the existing calculation of the population adjustment which would apply for agreement periods beginning on January 1, 2025, or January 1, 2026.

We propose to specify the existing provisions of § 425.662(b)(2), describing the calculation of the population adjustment, under new paragraph § 425.662(b)(2)(i). Accordingly, we propose to add a sentence at the start of the introductory text of new § 425.662(b)(2)(i) specifying the applicability of the calculation for agreement periods beginning on January 1, 2025, or January 1, 2026.

Under new § 425.662(b)(2)(ii), we propose to specify the calculation of the population adjustment scaler applicable for agreement periods beginning on January 1, 2027, and in subsequent years. We propose to calculate a scaler as the difference between:

§ 425.662(b)(2)(ii)(A), specifying a single per capita value that is the risk adjusted 5 percent cap, and § 425.662(b)(2)(ii)(B), specifying the highest among the regional adjustment (expressed as a single value), the per capita prior savings adjustment, or no adjustment (in the case where the regional adjustment is negative and the ACO is not eligible for the prior savings adjustment) (specified in new § 425.662(b)(2)(ii)(B)).

We propose the following provisions to state how we would calculate the single per capita value reflecting the risk adjusted 5 percent cap. Under § 425.662(b)(2)(ii)(A)(*1*), we propose to calculate the product of the following bulleted items for each Medicare enrollment type (ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, aged/non-dual eligible Medicare and Medicaid beneficiaries)—

- The national per capita expenditures for Parts A and B services under the original Medicare fee-for-service program in BY3 for assignable beneficiaries in that enrollment type identified for the 12-month calendar year corresponding to BY3 using data from the CMS Office of the Actuary;[294] and
- The ACO's weighted average CMS-HCC risk score for that enrollment type for BY3.[295]

Under proposed § 425.662(b)(2)(ii)(A)(*2*), CMS would calculate 5 percent of each enrollment type-specific product determined in § 425.662(b)(2)(ii)(A)(*1*). Under § 425.662(b)(2)(ii)(A)(*3*), CMS would calculate a single per capita value as a person-year weighted average[296] by multiplying each of these enrollment type-specific products (determined in accordance with § 425.662(b)(2)(ii)(A)(*2*)) by the proportion of the ACO's assigned beneficiaries within that particular enrollment type, then summing the results.

---

[294] We note that in the CY 2025 PFS final rule (89 FR 98158), we explained in detail how we calculate the national assignable expenditure amount used in this calculation, although the provision codified in § 425.662(b)(1) is more general.

[295] For more information on the calculation of the weighted average risk score we refer readers to section 3.2 of the Shared Savings and Losses, Assignment and Quality Performance Standard Methodology Specifications Version 14.

[296] For more information on the calculation of the person-year weighted average we refer readers to section 3.2 of the Shared Savings and Losses, Assignment and Quality Performance Standard Methodology Specifications Version 14.

We seek comment on the proposal to risk adjust the 5 percent cap used for calculating the population adjustment to the benchmark applicable for agreement periods beginning on January 1, 2027, and in subsequent years, and related proposed changes to the Shared Savings Program regulations at § 425.662(b)(2) (as revised and republished).

f. Proposal to Incentivize New Participation through a Growth Adjustment to the Historical Benchmark

(1) Background

(a) Background on Adjusting the Historical Benchmark

Section 1899(d)(1)(B)(ii) of the Act addresses how ACO benchmarks are to be established, updated, and reset at the start of each agreement period under the Shared Savings Program. This provision specifies that the Secretary shall estimate a benchmark for each agreement period for each ACO using the most recent available 3 years of per beneficiary expenditures for Parts A and B services for OM beneficiaries assigned to the ACO. The benchmark shall be reset at the start of each agreement period. Section 1899(d)(1)(B)(ii) of the Act also provides the Secretary with discretion to adjust the historical benchmark by "such other factors as the Secretary determines appropriate." Under this authority, over time we have adopted a variety of methods to adjust the historical benchmark to meet certain policy goals.

Relying on our authority under section 1899(d)(1)(B)(ii) of the Act, we codified benchmarking policies applicable to all ACOs in agreement periods beginning on January 1, 2024, and in subsequent years at § 425.652 (88 FR 79174 through 79208). We refer readers to discussions of the benchmark calculations in earlier rulemaking for details on the development of the current policies (November 2011 final rule, 76 FR 67909 through 67927; June 2015 final rule, 80 FR 32785 through 32796; June 2016 final rule, 81 FR 37953 through 37991; December 2018 final rule, 83 FR 68005 through 68030; CY 2023 PFS final rule, 87 FR 69875 through 69928; CY 2024 PFS final rule, 88 FR 79174 through 79208; CY 2025

PFS final rule, 89 FR 98155 through 98166; and CY 2026 PFS final rule, 90 FR 32690 through 32692).

In the CY 2023 PFS final rule, we adopted policies to modify the regional adjustment under § 425.656 (87 FR 69915 through 69923) and to reinstate a prior savings adjustment under § 425.658 (87 FR 69898 through 69915). The prior savings adjustment policy permits some renewing or re-entering ACOs to receive an adjustment to their benchmarks to account for savings generated in performance years that correspond to the benchmark years of their new agreement periods. The modifications to the regional adjustment limited the impact of negative regional adjustments on ACO historical benchmarks and further incentivized program participation among ACOs serving high-cost beneficiaries.

In the CY 2024 PFS final rule (88 FR 79185 through 79196), we modified the regional adjustment policy further to prevent any ACO from receiving an adjustment that would cause its benchmark to be lower than it would have been in the absence of a regional adjustment. In the CY 2024 PFS final rule (88 FR 79196 through 79200), we also modified the prior savings adjustment policy further to account for the following: a change in savings earned by the ACO in a benchmark year due to compliance action taken to address avoidance of at-risk beneficiaries; or a change in the amount of savings or losses for a benchmark year as a result of a reopening of a prior determination of ACO shared savings or shared losses and the issuance of a revised initial determination under § 425.315.

In the CY 2025 PFS final rule, we finalized provisions in §§ 425.652(a)(8) and 425.662 specifying the methodology for calculating the health equity benchmark adjustment (HEBA) to the historical benchmark, determining an ACO's eligibility for the adjustment, and the applicability of the adjustment (89 FR 61890 and 61891). In the CY 2025 PFS final rule, we noted the limitations of benchmarks based on historically observed spending, as they could be set too low if they are based on the spending of a population of underserved communities. The HEBA was finalized to provide additional financial resources to ACOs serving these

populations, and to encourage those ACOs to attract and retain beneficiaries from communities that have faced challenges related to accessing care (89 FR 61887). The adjustment is calculated based on the number of beneficiaries an ACO serves who are either enrolled in the Medicare Part D Low-Income Subsidy (LIS) program or are dually eligible for Medicare and Medicaid, offering a targeted mechanism to reflect the needs of higher-risk populations.

In the CY 2026 PFS final rule, we renamed the HEBA as the "population adjustment" for clarity under § 425.662 (90 FR 32683 through 32685). This finalized revision more accurately reflects the nature of the adjustment, which accounts for the proportion of the ACO's assigned beneficiaries who are enrolled in the Medicare Part D LIS program or dually eligible for Medicare and Medicaid.

(b) Methodology for Determining the Applicability of a Regional Adjustment, Prior Savings Adjustment, or Population Adjustment to the ACO's Historical Benchmark, for Agreement Periods Beginning on or After January 1, 2025

We calculate three adjustments to the historical benchmark under the benchmarking methodology for agreement periods beginning on January 1, 2025, and in subsequent years. These adjustments are a regional adjustment (§ 425.656), prior savings adjustment (§ 425.658), and the population adjustment (§ 425.662). We then determine whether to apply one of the three adjustments or no adjustment to the ACO's historical benchmark (§ 425.652(a)(8)(ii)).

The following is an overview of how, under this methodology, we currently calculate the adjustment to apply when establishing benchmarks for ACOs entering an agreement period beginning on January 1, 2025, and in subsequent years:

- *Step 1:* We calculate the capped regional adjustment expressed as a single dollar value as specified in § 425.656. We calculate the regional adjustment to the historical benchmark based on the ACO's regional service area expenditures, making separate calculations for the following populations of beneficiaries: ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, and aged/non-dual eligible Medicare and Medicaid beneficiaries.

++ Under § 425.656(c)(3), we cap the per capita dollar amount for each Medicare enrollment type at a dollar amount equal to a percentage of national per capita expenditures for Parts A and B services under the OM program in BY3 for assignable beneficiaries in that enrollment type identified for the 12-month calendar year corresponding to BY3 using data from the CMS Office of the Actuary.

-- Under § 425.656(c)(3)(i), for positive adjustments, the per capita dollar amount for a Medicare enrollment type is capped at 5 percent of the national per capita expenditure amount for the enrollment type for BY3.

-- Under § 425.656(c)(3)(ii), for negative adjustments, the per capita dollar amount for a Medicare enrollment type is capped at negative 1.5 percent of the national per capita expenditure amount for the enrollment type for BY3.

++ Under § 425.656(d)(1), we express the regional adjustment as a single value by taking a person year[297] weighted average of the Medicare enrollment type-specific regional adjustment values.

- *Step 2:* For eligible ACOs, we calculate the capped prior savings adjustment as specified in § 425.658. Under § 425.658(c)(1), we calculate an adjustment to the historical benchmark to account for savings an ACO generated in the 3 years prior to the start of the ACO's current agreement period for renewing or re-entering ACOs that were reconciled for one or more PYs in the Shared Savings Program during this period.

- *Step 3:* For eligible ACOs, we calculate the capped population adjustment as specified in § 425.662. Under § 425.662(b), we calculate an adjustment to the historical benchmark to offer a targeted mechanism to reflect the needs of higher-risk populations and account for ACOs

---

[297] To calculate person years: We sum the number of Shared Savings Program-eligible months (beneficiaries are only assigned a monthly enrollment status for months in which they are alive on 1st of the month, enrolled in both Parts A and B, and not enrolled in a Medicare Group Health Plan for the month) for each assigned beneficiary for each Medicare enrollment type; we then divide this number by 12 (the number of months in a calendar year). Refer to the Shared Savings and Losses, Assignment and Quality Performance Standard Methodology Specifications Version 14, Section 3.1 Calculating ACO-Assigned Beneficiary Expenditures.

with 15 percent or more assigned beneficiaries enrolled in LIS or dually eligible for Medicare and Medicaid during the PY.

- *Step 4:* We determine the final adjustment to the benchmark, as specified in § 425.652(a)(8)(ii). We compare the regional adjustment calculated in accordance with § 425.656, the prior savings adjustment calculated in accordance with § 425.658, and the population adjustment calculated in accordance with § 425.662.

++ Under § 425.652(a)(8)(ii), the ACO receives the highest of the positive adjustments for which it is eligible. The adjustments are calculated as described in § 425.656(c), § 425.658(c), or § 425.662(b), respectively, and applied separately to the following populations of beneficiaries: ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, and aged/non-dual eligible Medicare and Medicaid beneficiaries. If an ACO is not eligible to receive a prior savings adjustment under § 425.658(b)(3)(i) or the population adjustment under § 425.662(b)(3), and the regional adjustment, expressed as a single value as described in § 425.656(d), is negative or zero, the ACO does not receive an adjustment to its benchmark.

(c) Background on Incentivizing Growth in the Shared Savings Program

In recent years, we have repeatedly emphasized our interest in promoting growth in the Shared Savings Program through the policies we have established. In the CY 2024 PFS, we stated, “This rulemaking also seeks to further advance Medicare's overall value-based care strategy of growth […] through the Medicare Shared Savings Program” (88 FR 78819). We reiterated this aim in the CY 2025 PFS final rule (89 FR 97711) and CY 2026 PFS final rule (90 FR 49768). Many of the Shared Savings Program policies finalized through past rulemaking have either directly or indirectly focused on increasing ACO participants in the program and increasing the number of beneficiaries receiving care from ACOs. For example, in the CY 2024 PFS final rule (88 FR 79139 through 79163) we modified the step-wise beneficiary assignment methodology by adding a new third step that uses an expanded period of time to identify if a beneficiary has received at least one primary care service from an ACO professional. This

change, taken with all other changes in the CY 2024 PFS final rule, was designed to enhance program growth (88 FR 78819), making more than 331,000 additional beneficiaries eligible for assignment, and increasing overall participation in the Shared Savings Program. Based on an internal analysis of CY 2024 primary care services, nearly 300,000 active individual practitioners with specialties used in assignment and billing assignment eligible services had not participated in a Shared Savings Program ACO or CMS Innovation Center model initiative involving shared savings during the 6-year period from 2019 through 2024.

We have seen increasing participation in the Shared Savings Program since the start of the program in 2012, with 3 million beneficiaries assigned to Shared Savings Program ACOs in the program's first year and as of January 2026, over 12 million beneficiaries assigned to Shared Savings Program ACOs. We have observed that when participation in the program increases, we see increases in both quality improvements for beneficiaries and increased savings to the Trust Funds. The Shared Savings Program has had 8 consecutive years of generating savings for Medicare relative to benchmarks, with over $12 billion in total savings,[298] and with an upward trend in savings year over year.[299] Additionally, we have observed that Shared Savings Program ACOs have demonstrated improved quality performance over time and higher quality performance relative to other physician groups, suggesting that the Shared Savings Program is achieving savings while improving quality of care. Based on an internal CMS analysis of 87 Shared Savings Program ACOs that participated continuously in the Shared Savings Program between 2014 and 2023, Shared Savings Program ACOs showed statistically significant and substantial improvement across seven comparable CMS Web Interface quality measures used during that period, where quality performance improved across a wide range of clinical practice areas including screening and preventive measures and control of health conditions such as

[298] Additional information on past years Shared Savings Program Performance Year Finance and Quality Results is available at: https://data.cms.gov/medicare-shared-savings-program/performance-year-financial-and-quality-results

[299] The Regulatory Impact Analysis reviews evidence that aggregate savings measured by benchmarks have been supported by observation of lower (higher) per capita spending trends in markets with earlier (later) ACO adoption.

hypertension and diabetes. Please refer to Table B-G16 for details on the quality performance of these 87 Shared Savings Program ACOs. As discussed further in section III.G.3 of this proposed rule, Shared Savings Program ACOs have been transitioning to new quality measure collection types over the last several years and are now being assessed on the APP Plus quality measure set, that can pose limitations on comparing Shared Savings Program ACOs' most recent quality performance to their historical performance. Specifically, Shared Savings Program ACOs have transitioned from reporting on a sampling methodology (for example, web interface) to reporting on a broader patient population, which could impact comparisons on quality performance.

However, there is evidence that Shared Savings Program ACOs perform better than their MIPS counterparts under the new quality reporting collection types. In PY 2024, Shared Savings Program ACOs scored better than comparable MIPS groups on all three electronic clinical quality measures (eCQMs) in the APP Plus quality measure set, with the difference being statistically significant for two of those measures (Quality ID: 134 Preventive Care and Screening: Screening for Depression and Follow-Up Plan ($p < .001$) and Quality ID: 236 Controlling High Blood Pressure ($p < .01$) (90 FR 50002)). Shared Savings Program ACOs also performed better than comparable MIPS groups on two of the three MIPS CQMs in the APP Plus quality measure set and the difference was statistically significant for one measure (Quality ID: 236 Controlling High Blood Pressure ($p < .01$) (90 FR 50002)). Refer to Table B-G17 for an overview of Shared Savings Program ACOs' PY 2024 quality performance relative to comparable MIPS Groups. Informed by the historical performance of the Shared Savings Program on savings and quality improvement by health care providers and for beneficiaries assigned to a Shared Savings Program ACO, we are interested in identifying additional incentives to grow participation in the Shared Savings Program and expand the reach of cost savings and improved quality of care.

TABLE B-G17: QUALITY PERFORMANCE AMONG 87 ACOS WHO PARTICIPATED IN THE SHARED SAVINGS PROGRAM CONTINOUSLY FROM PY 2014 to 2013

Quality #	Measure Title (CMS Web Interface)	PY 2014 Mean	PY 2023 Mean	Difference
001	Diabetes: Glycemic Status Assessment Greater Than 9% (Inverse measure)**	20.47	9.21	–11.25*
110	Preventive Care and Screening: Influenza Immunization	58.66	71.64	+12.98*
112	Breast Cancer Screening	62.51	81.53	+19.03*
113	Colorectal Cancer Screening	56.74	78.53	+21.79*
134	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	37.34	82.06	+44.73*
238	Controlling High Blood Pressure	67.32	80.20	+12.88*
318	Falls: Screening for Future Fall Risk	46.80	91.43	+44.62*

*Indicates statistically significant differences between ACOs in PY 2014 and 2023 ($p < .05$). The Difference column represents the mean PY 2023 ACO performance rate minus the mean PY 2014 ACO performance rate.
** This is an inverse measure, and a lower number indicates better quality performance.
Long–participating ACOs N=87.

TABLE B-G18: PY 2024 QUALITY MEASURES THAT SHARED SAVINGS PROGRAM ACOs PERFORMED BETTER ON THAN COMPARABLE MIPS GROUPS

Quality #	Measure Title	Difference in Mean ACO and MIPS Group Performance Rates for PY 2024 (%)*
	eCQMs	
001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	-3.75**
134	Preventive Care and Screening: Screening for Depression and Follow-up Plan	9.11****
236	Controlling High Blood Pressure	3.39***
	MIPS CQMs	
001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	-7.63**
236	Controlling High Blood Pressure	8.59***
321	**CAHPS for MIPS**	0.08
CAHPS-1	Getting Timely Care, Appointments, and Information	2.47***
CAHPS-5	Health Promoting and Education	0.84
CAHPS-6	Shared Decision Makin	0.08
CAHPS-7	Health Status and Functional Status	0.11
CAHPS-11	Stewardship of Patient Resources	0.17
	Administrative Claims	
484	Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	-0.59**

*The numbers in this column represent the mean ACO performance rate minus the mean MIPS group performance rate for each measure.
**This is an inverse measure, and a lower number indicates better quality performance.
***Indicates statistically significant differences between ACOs and comparable MIPS groups ($p < 0.01$).
****Indicates statistically significant differences between ACOs and comparable MIPS groups ($p < 0.001$).

As described previously, we have observed substantial evidence that the Shared Savings Program both generates savings and improves quality of care for beneficiaries. We also have observed there are still health care providers and beneficiaries not yet in accountable care relationships, and there is additional potential to increase participation in the Shared Savings Program and thereby continue to grow savings to the Medicare Trust Funds while improving the quality of care for beneficiaries. Although the number of primary care practitioners participating in a Shared Savings Program ACO has steadily grown over time, a targeted incentive that encourages ACOs to recruit new practitioners and the beneficiaries they serve may help offset some of the initial investment costs associated with first time participation. As of PY 2024, there were 12.3 million beneficiaries that were eligible to be assigned to a Shared Savings Program ACO but were not assigned to an ACO. Approximately 11.1 million of these beneficiaries were

not part of any shared savings initiative in PY 2023 or PY 2024, 6.7 million of which were primarily served by one of the aforementioned 300,000 practitioners who had no shared savings experience during the 6-year period from 2019 through 2024. ACOs may seek to recruit these practitioners and in turn provide care for their beneficiary populations if a well-designed incentive could help reduce certain financial barriers to recruitment and initial participation.

(d) Background on Determining Risk Experience

In the December 2018 final rule (83 FR 67894 through 67899), we finalized the definitions of performance-based risk Medicare ACO initiative, and what it means for an ACO to be deemed experienced and inexperienced with performance-based risk Medicare ACO initiatives under § 425.20. Under paragraph (1) of the definition of "experienced with performance-based risk Medicare ACO initiatives," an ACO is considered experienced if the ACO (or a plurality of its ACO participants) has participated in a CMS initiative that requires an ACO to participate under a two-sided model (with shared savings and losses) such as Level E of the BASIC track and the ENHANCED track of the Shared Savings Program or other Innovation Center ACO models such as ACO REACH.[300] Under paragraph (2) of the definition, an ACO is also considered experienced if forty percent or more of the ACO's participants participated in a performance-based risk Medicare ACO initiative in any of the 5 most recent performance years. This means either the ACO itself (as a legal entity) has participated in such a program, or 40 percent or more of its participating provider groups (TINs) participated in such a program during any of the five performance years prior to the start of the ACO's agreement period. An ACO is considered inexperienced with performance-based risk Medicare ACO initiatives if its legal entity has never participated in a Medicare program with shared savings and shared losses and if less than 40 percent of its participating provider groups (TINs) participated in such programs during each of the 5 performance years prior to the start of the ACOs agreement

[300] Refer to the Participation Options Report available to applicant ACOs on the Accountable Care Organization-Management System (ACO-MS) for other Innovation Center ACO models including ACO REACH.

period. ACOs that are inexperienced with performance-based risk Medicare ACO initiatives can typically qualify for certain participation options in the Shared Savings Program that are not otherwise available.

(2) Proposed Growth Adjustment to the Historical Benchmark

Relying on our authority under section 1899(d)(1)(B)(ii) of the Act, we are proposing a growth adjustment to the historical benchmark applicable to ACOs in agreement periods beginning on January 1, 2027, and in subsequent years. The proposed growth adjustment would offer a method of upwardly adjusting an ACO's historical benchmark that would be applied in addition to the existing regional adjustment, prior savings adjustment, and population adjustment, up to the proposed cap of 5 percent of ACO risk-adjusted national per capita expenditures, if finalized; otherwise, it will remain as the existing 5 percent of national per capita expenditures. The intent of the growth adjustment is to directly target those ACOs that are actively engaged in expanding their beneficiary population and provide a financial incentive to reward growth above what we typically observe. To promote growth in the Shared Savings Program, this upward adjustment to the historical benchmark is designed to reward ACOs for recruiting ACO professionals inexperienced with value-based care arrangements who are also serving beneficiaries new to value-based care. Through the growth adjustment, we intend to provide a greater financial incentive for ACOs to recruit ACO professionals who are inexperienced with value-based care arrangements and serve more beneficiaries new to value-based care by increasing the likelihood that an ACO would earn shared savings and by potentially increasing the amount of shared savings earned.

Under proposed § 425.652(a)(8)(iii), an ACO would receive a growth adjustment, if applicable, in addition to the highest of the positive adjustments for which it is eligible, either the regional adjustment, prior savings adjustment, or population adjustment to the benchmark § 425.652(a)(8)(ii)(B). An ACO would be required to meet the eligibility criteria as described elsewhere in this section of this proposed rule to receive the growth adjustment to the historical

benchmark. We note that the proposed risk-adjustment of the 5 percent cap (see section III.G.5.e. of this proposed rule), if finalized, would operate synergistically with the proposed growth adjustment, in that ACOs that are eligible for a growth adjustment may receive a greater adjustment with a risk-adjusted cap if the beneficiaries newly assigned to their ACO through newly recruited ACO professionals are also medically complex and high-risk beneficiaries.

Additionally, we note that, if finalized, the proposed modifications to the prior savings adjustment to increase the scaling factor (described in section III.G.5.d. of this proposed rule) would complement the proposed growth adjustment. Specifically, ACOs that receive a growth adjustment could generate larger performance year gross savings that would be accounted for in the calculation of future prior savings adjustments, thereby carrying a portion of the growth adjustment forward to a subsequent agreement period. Additionally, should we finalize our proposal to increase the prior savings adjustment scaling factor from 50 percent to 75 percent, ACOs that receive a growth adjustment and generate gross savings would then be able to carry a larger portion of that growth adjustment forward to the subsequent agreement period through the larger prior savings adjustment. The use of a proration factor, which is not subject to modifications under this proposed rule, to calculate the prior savings adjustment based on changes in the assigned beneficiary population size also helps ensure that growth adjustments that might be awarded in the prior agreement period are only carried forward to the subsequent agreement period if the ACO maintains its overall size. If the ACO were to decrease in size, the ACO would receive a smaller prior savings adjustment and thus carry forward a smaller portion of the growth adjustment from the prior agreement period.

We propose to calculate the growth adjustment as the product of the ACO's "new growth" share described in section III.G.5.f.(2)(a) of this proposed rule and the incentive factor described in section III.G.5.f.(2)(b) of this proposed rule.

(a) Determine the ACO's "New Growth" Share of Assigned Beneficiary Person Years

To identify the ACO's new growth share of assigned beneficiary person years, CMS would first need to identify the ACO's new growth. By new growth, we mean the number of beneficiaries (in person year terms) that are new to the Shared Savings Program that are brought into the program by ACO professionals who are inexperienced in shared savings initiatives. We propose to identify shared savings initiatives for the purpose of determining the growth adjustment (as defined at § 425.664(b)(1)) as an initiative implemented by CMS, including the Shared Savings Program (as defined at § 425.664(b)(1)(i)), the Innovation Center ACO models ((as defined at § 425.664(b)(1)(ii)) (for example, ACO REACH, LEAD, etc.), or other initiatives that may be specified by CMS ((as defined at § 425.664(b)(1)(ii)) [301].

We specify the proposed criteria to meet this proposed definition throughout this section of this proposed rule under § 425.664. To identify the ACO's new growth, we must first identify the ACO professionals who are inexperienced in shared savings initiatives. The second step is then to determine the number of beneficiaries (in person year terms) that are new to the Shared Savings Program that are brought into the program by these inexperienced ACO professionals.

Therefore, we first propose to define ACO professionals inexperienced with shared savings initiatives under § 425.664(b)(2) similar to the way we define how ACOs are "experienced with performance-based risk Medicare ACO initiatives" and "inexperienced with performance-based risk Medicare ACO initiatives" in § 425.20. Under § 425.664(b)(2), we propose that for an ACO professional to be considered inexperienced in a shared savings initiative for the growth adjustment (as defined at § 425.664(b)(1)), the ACO professional must not have billed primary care services through a participant in the Shared Savings Program, or participated in an Innovation Center ACO model, or other initiative specified by CMS for one or more performance years in any of the 5 performance years directly preceding the start of the ACO's current agreement period. In other words, for an ACO professional to be considered

[301] We will monitor for other similar models and initiatives in the future.

experienced in a shared savings initiative, described as follows, the ACO professional must have billed primary care services through a participant in the Shared Savings Program, or participated in an Innovation Center ACO model, or other initiative specified by CMS, for one or more performance years of any of the 5 performance years directly preceding the start of the ACO's current agreement period.

Among the ACO professionals who we determine to be inexperienced in a shared savings initiative under § 425.664(b)(2), we then determine the number of beneficiaries (in person year terms) that are new to the Shared Savings Program that are brought into the program by these inexperienced ACO professionals under § 425.664(b)(3). To determine the number of these beneficiaries (in person year terms), we first need to determine an assigned beneficiary's experience in shared savings initiatives. To do so, we propose applying a similar definition as used to identify inexperienced ACO professionals to determine beneficiary experience in shared savings initiatives under § 425.664(b)(2). Thus, under § 425.664(b)(3) we propose that for an ACO assigned beneficiary to be considered inexperienced with a shared savings initiative, the ACO assigned beneficiary was not included in assignment in financial reconciliation to a Shared Savings Program ACO, Innovation Center ACO model, or other initiative specified by CMS in the performance year that corresponds to the ACO's BY3[302] under § 425.664(b)(3). In other words, for an ACO assigned beneficiary to be considered experienced with a shared savings initiative, the beneficiary would have to have been assigned to a Shared Savings Program ACO, Innovation Center ACO model, or other initiative specified by CMS and included in financial reconciliation for the performance year that corresponds to the ACO's BY3.

[302] Throughout this section, the assignment associated with the performance year that corresponds to the ACO's BY3 refers to the point in time from which to determine growth in assigned beneficiaries. For example, for an ACO that may begin an agreement period on January 1, 2027, we mean the final assignment list for PY 2026; we do not mean the benchmark year assignment list for BY 2026, which is the ACO's BY3. We use this as the point of comparison, so that we can determine the growth in assignment that occurred prior to the start of the agreement period relative to the applicable performance year, which will not be as clearly reflected if we used the current agreement period's participant list and BY3 assignment.

Under § 425.664(b)(4), we propose to measure new growth for each ACO in a given performance year as: 1) the number of assigned beneficiary person years inexperienced with a shared savings initiative; that 2) have an ACO professional who is inexperienced with a shared savings initiative as the ACO professional who provided the highest number of primary care services (as defined at § 425.20) at the ACO within the assignment window, or to whom the beneficiary was voluntarily aligned. To qualify as new growth, both characteristics must be present. Under § 425.664(b)(4), we propose to determine which ACO professional provided the highest number of primary care services (as defined at § 425.20) included in assignment for each assigned beneficiary at the ACO during the assignment window for the relevant performance year, or to whom the beneficiary voluntarily aligned. Refer to the example provided in Step 1.

TABLE B-G19: HYPOTHETICAL ACO GROWTH ADJUSTMENT CALCULATION FOR PY1, STEP 1

Step 1: Calculate an ACO's new growth for the applicable performance year	New Growth = Number of assigned beneficiary person years inexperienced with a shared savings initiative that have an ACO professional inexperienced with shared savings initiatives as the primary ACO professional that provided the highest count of primary care services. New Growth = 3,000 assigned beneficiary person years.

As a guardrail to ensure that measured new growth is contributing to overall growth in the program, only ACOs that grow and maintain their size, as measured by the count of assigned beneficiary person years, are eligible to receive an incentive, we propose to cap new growth. We propose to cap new growth to ensure ACOs are not only recruiting inexperienced ACO professionals and beneficiaries but additionally are maintaining their existing practitioner and beneficiary populations over the course of their agreement period, thus contributing to overall growth in the program. Under § 425.664(c), the first step to determine whether the cap on new growth applies, is to determine the overall growth as the difference between the number of beneficiary person years assigned to the ACO during final assignment in the performance year and the number of beneficiary person years assigned to the ACO during final assignment in the PY that corresponds to the ACO's BY3. If the ACO is a new entrant or re-entering ACO, the

overall growth is equal to the number of assigned beneficiary person years in the performance year.

For re-entering ACOs, defined under § 425.20, overall growth will also be set equal to the number of assigned beneficiaries in the performance year. We propose to handle re-entering ACOs in this way because they may have had a multi-year gap in participation since their prior participation agreement, be heavily comprised of ACO participants from multiple prior ACOs, or may have split off from another ACO. Therefore, for ACOs that are new or re-entering, we would not have a comparable way to measure overall growth as we do for ACOs that are not new or re-entering (for example, using the performance year that corresponds to the ACO's BY3 from which to calculate the ACO's overall growth for the performance year). In an analysis of all re-entering ACOs between PY 2022 and PY 2026, two-thirds of re-entering ACOs had a smaller assigned beneficiary population than in their prior participation agreement. The complex nature of re-entering ACOs' composition makes it difficult to determine a fair and accurate beneficiary count to be used in determining a baseline for capped new growth. Only providing the incentive to inexperienced ACO professionals and beneficiary who have not been assigned to an ACO in the final assignment for the PY that corresponds to the ACO's BY3 ensures that only the new growth is counted toward the incentive and acts as a guardrail to mitigate any unintended incentives created by the treatment of re-entering ACOs as new entrants. For example, any currently participating ACOs that terminate and immediately re-enter, or that split into multiple new re-entering ACOs would still need to add additional inexperienced ACO professionals and beneficiaries to their organization to receive the growth adjustment. ACO professionals and beneficiaries added during the previous agreement period, prior to terminating and re-entering would not be considered inexperienced, and therefore would not count towards the incentive. This mitigates against the possibility that an ACO might terminate and re-enter to set their baseline count of beneficiaries to zero.

TABLE B-G20: HYPOTHETICAL ACO GROWTH ADJUSTMENT CALCULATION FOR PY1, STEP 2

Step 2: Determine overall growth	overall growth = Number of assigned beneficiary person years in the PY minus the number of assigned beneficiary person years in the PY that corresponds to the ACO's BY3 (if applicable). If the ACO is a new entrant or re-entering, the overall growth is equal to the number of assigned beneficiary person years in the PY Continuing ACO Example: Number of assigned beneficiary person years in the PY = 11,000 Number of assigned beneficiary person years in the PY that corresponds to the ACO's BY3 = 5,000 overall growth = 11,000 - 5,000 = 6,000 assigned beneficiary person years New Entrant or Re-Entering ACO Example: Number of assigned beneficiary person years in the PY = 11,000 Number of assigned beneficiary person years in the PY that corresponds to the ACO's BY3 = 0 overall growth = 11,000 - 0 = 11,000 assigned beneficiary person years

The third step to determine the cap on the new growth is to take the lesser of the new growth and the overall growth under § 425.664(d) (refer to Example Tables 1 through 4 for examples of this calculation). For new entrant ACOs that did not participate prior to the current agreement period, assuming zero assigned beneficiary person years for the performance year corresponding to the ACO's BY3, the overall growth in the number of assigned beneficiary person years, which will determine the cap on the new growth, will be equivalent to the total number of assigned beneficiary person years in the current performance period. As described elsewhere in this section of this proposed rule, we propose to treat re-entering ACOs the same as new entrant ACOs for the purposes of this calculation as well. We note as proposed, the cap effectively would not apply for new entrant ACOs and re-entering ACOs because new growth and the total number of assigned beneficiaries in a performance year will always be the same. Refer to the example provided in Step 3.

TABLE B-G21: HYPOTHETICAL ACO GROWTH ADJUSTMENT CALCULATION FOR PY1, STEP 3

Step 3: Determine capped new growth	Capped new growth = the lesser of the new growth determined in Step 1 and the overall growth determined in Step 2. overall growth = 6,000 assigned beneficiary person years new growth = 3,000 assigned beneficiary person years capped new growth = 3,000 assigned beneficiary person years

We recognize that there are typically new ACO professionals who join Shared Savings Program ACOs annually, as well as new beneficiaries assigned to Shared Savings Program

ACOs annually. The intent of the growth adjustment is to provide a financial incentive to reward growth above what we typically observe. Accordingly, under § 425.664(e), we propose to apply the minimum new growth thresholds in Table B-G22 for each performance year of an agreement period above which the ACO would need to grow with ACO professionals that have not previously participated in shared savings initiatives and beneficiaries that have not previously been assigned to an ACO to receive the growth adjustment.

Under § 425.664(e), we propose determining the minimum new growth threshold on a relative basis, defined as the person years of the minimum new growth divided by total assigned beneficiary person years, and on an absolute basis, defined as the number of person years of the minimum new growth for the PY according to Table B-G22. We propose to determine the threshold on both an absolute and relative basis to ensure parity and equal opportunity for ACOs of various sizes to receive the incentive. For example, the relative threshold creates an incentive for ACOs that are smaller, in which small additions in assigned beneficiaries would substantially impact the ACO's relative size. Whereas, the absolute threshold creates an incentive for ACOs that are larger to recruit practices that may not otherwise substantially impact the relative size of those ACOs. We propose the following absolute and relative minimum new growth thresholds for PY1 through PY5:

TABLE B-G22: ABSOLUTE AND RELATIVE MINIMUM "NEW GROWTH" THRESHOLDS OVER AN AGREEMENT PERIOD

	PY 1	PY 2	PY 3	PY 4	PY 5
Absolute Minimum New Growth Threshold	100	300	600	900	1200
Relative Minimum New Growth Threshold	0.5%	1.5%	3.5%	5.5%	7.5%

We identified these proposed minimum thresholds by analyzing Shared Savings Program ACO program data from 2017 through 2026. To identify a proposed minimum threshold for each performance year, we looked at ACOs that began their second or subsequent agreement period (that is, not new or re-entering ACOs) on or before January 1, 2022 that were still participating through the start of 2026 and experienced new growth (as we now propose to define it). CMS then set the threshold at the 25th percentile of new growth, based on the observed inflection

point in the distribution of new growth for each performance year. While we understand that many ACOs experience some natural growth, we intend the growth adjustment as an incentive for ACOs to actively engage in expanding their beneficiary population that is inexperienced and expand their ACO participants who are inexperienced. We determined that setting the threshold at the 25th percentile[303] was sufficient to make the distinction between natural population variation and those ACOs that were actively recruiting new participants and growing their ACOs, while maintaining reasonable growth rates for ACOs of all sizes, as demonstrated by ACOs in this analysis. We propose that only ACOs that exceed this threshold in a given year would qualify for the growth adjustment.

This analysis showed that new growth steadily increased among ACOs in this sample in each year relative to the PY that corresponds to the ACO's BY3, but the rate of increase was not consistent or linear. The proposed thresholds approximately matched observed rates of growth year to year among the ACOs in this sample. The proposed thresholds increase in each subsequent performance year to account for natural changes in the assigned beneficiary and ACO professional populations.[304] Thus we propose to measure new growth relative to the performance year that corresponds to the ACO's BY3. The larger thresholds in later performance years ensures that measured new growth is primarily the result of ACOs targeting intentional growth and not natural composition changes. We propose that we will periodically re-evaluate the determined thresholds, and if changes to these thresholds are needed we would expect the updates to be on a performance year basis (rather than agreement period basis). We would

---

[303] The absolute and relative distribution of new growth among all ACOs *and* ACOs experiencing growth was a right-skewed L-shaped distribution with many ACOs experiencing little to no growth, a few experiencing extreme growth, and the middle set experiencing some growth. The first slope change (that is, inflection point) distinguished the majority of ACOs who experienced little to no new growth as defined in this proposed rule and in § 425.664(b)(4) from those who may have made composition changes to increase their ACO size. Among ACOs who participated for a full agreement period and experienced new growth, the first inflection point occurred at approximately the 25th percentile.

[304] In other words, the composition of ACOs' beneficiary and ACO professional populations are not static. ACOs experience population changes as time passes. As more time passes, more changes will occur. These changes are the natural result of employment changes among ACO professionals, and changes in care patterns among beneficiaries - both of which occur even in organizations not engaged in actively expanding. Since growth is measured against a fixed time period, and the number of changes increases over time, the thresholds need to increase as the time relative to the PY corresponding to the ACO's BY3 increases.

propose changes to the minimum new growth thresholds in rulemaking. We expect that updates to these thresholds will be infrequent to provide additional predictability in the proposed growth adjustment.

Under § 425.664(e), we propose to determine which minimum new growth threshold is applied to an ACO by taking the lesser of the absolute and relative thresholds after we convert the relative threshold to beneficiary person years by multiplying the relative threshold by the ACO's total assigned beneficiary person years in the PY. Refer to the example provided in Step 4.

TABLE B-G23: HYPOTHETICAL ACO GROWTH ADJUSTMENT CALCULATION FOR PY1, STEP 4

Step 4: Determine which minimum new growth threshold is applied	Minimum new growth threshold applied = the lesser of the relative minimum new growth threshold and the absolute minimum new growth threshold. Absolute minimum new growth threshold = 100 assigned beneficiary person years. Relative minimum new growth threshold = 0.5% assigned beneficiary person years x total assigned beneficiary person years (11,000) = 55 assigned beneficiary person years. Minimum new growth threshold applied = 55 assigned beneficiary person years.

The new growth above the minimum and below the cap is the amount of newly assigned beneficiary person year growth eligible for the growth incentive. Under § 425.664(f), we propose to calculate new growth above the minimum and below the cap, which is the portion of new growth for which ACOs may be eligible to receive a growth adjustment, as the difference between the new growth and the minimum new growth threshold, or 0, if negative. We propose to calculate new growth above the minimum and below the cap in this way so that ACOs are rewarded for contributing to overall growth in the Shared Savings Program. The minimum thresholds in conjunction with the cap ensures CMS is rewarding ACOs engaged in actively expanding their assigned population with beneficiaries not currently in an accountable care relationship. Refer to the example provided in Step 5.

TABLE B-G24: HYPOTHETICAL ACO GROWTH ADJUSTMENT CALCULATION FOR PY1, STEP 5

Step 5: Determine new growth above minimum and below the cap	New growth above the minimum and below the cap = the difference of capped new growth determined in Step 3 and the minimum new growth threshold applied in Step 4. Capped New Growth = 3,000 assigned beneficiary person years Minimum new growth threshold applied = 55 assigned beneficiary person years New growth above the minimum and below the cap = 3,000 - 55 = 2,945 assigned beneficiary person years.

To facilitate the calculation of a per capita growth adjustment to be applied to the historical benchmark, we must first calculate this new growth as a proportion of the ACO's total assigned beneficiary person years. Therefore, we propose to determine an ACO's new growth share. Under § 425.664(g), we propose to determine the new growth share as the ratio of the new growth above the minimum and below the cap divided by the ACOs number of assigned beneficiary person years for the PY. This value will be multiplied by the incentive factor to determine the growth adjustment to the historical benchmark. Refer to the example provided in Step 6.

TABLE B-G25: HYPOTHETICAL ACO GROWTH ADJUSTMENT CALCULATION FOR PY1, STEP 6

Step 6: Calculate new growth share	New Growth Share = new growth above the minimum and below the cap determined in Step 5 divided by the number of assigned beneficiary person years in the PY. New growth above the minimum and below the cap = 2,945 Number of assigned beneficiary person years in the PY = 11,000 New growth share = 2,945 / 11,000 = 0.268.

We provide four example scenarios for determining the new growth share for hypothetical ACOs over an agreement period to illustrate the multiple steps of the calculation, using the minimum new growth thresholds established in Table B-G22.

EXAMPLE 1: NEW GROWTH CAPPED BY OVERALL GROWTH OVER AN AGREEMENT PERIOD

		Base	PY1	PY2	PY3	PY4	PY5
	Total assigned person years	5000	11000	11000	12000	13000	7000
Step 1	New growth person years		3000	1500	2000	2500	3000
Step 2	Overall growth [Total assigned person years in PY - Base]		6000	6000	7000	8000	2000
Step 3	Capped new growth [Step 1 ≤ Step 2]		3000	1500	2000	2500	2000
Step 4	Minimum new growth threshold applied		55	165	420	715	490
Step 5	New growth above the minimum and below the cap [Step 3 – Step 4]		2945	1335	1580	1785	1510
Step 6	New growth share [Step 5 ÷ Total assigned person years in PY]		0.268	0.121	0.132	0.137	0.216

EXAMPLE 2: LARGE ACO WITH ABSOLUTE THRESHOLD APPLIED OVER AN AGREEMENT PERIOD

		Base	PY1	PY2	PY3	PY4	PY5

	Total assigned person years	50000	55000	56000	57000	58000	56000
Step 1	New growth person years		1000	1500	2000	2500	3000
Step 2	Overall growth [Total assigned person years in PY - Base]		5000	6000	7000	8000	6000
Step 3	Capped new growth [Step 1 ≤ Step 2]		1000	1500	2000	2500	3000
Step 4	Minimum new growth threshold applied		100	300	600	900	1200
Step 5	New growth above the minimum and below the cap [Step 3 – Step 4]		900	1200	1400	1600	1800
Step 6	New growth share [Step 5 ÷ Total assigned person years in PY]		0.016	0.021	0.025	0.028	0.032

EXAMPLE 3: NEW ENTRANT OR RE-ENTERING ACO WHERE BASE EQUALS ZERO OVER AN AGREEMENT PERIOD

		Base	**PY1**	**PY2**	**PY3**	**PY4**	**PY5**
	Total assigned person years	0	10000	11000	12000	13000	11000
Step 1	New growth person years		1000	1500	2000	2500	3000
Step 2	Overall growth [Total assigned person years in PY - Base]		10000	11000	12000	13000	11000
Step 3	Capped new growth [Step 1 ≤ Step 2]		1000	1500	2000	2500	3000
Step 4	Minimum new growth threshold applied		50	165	420	715	770
Step 5	New growth above the minimum and below the cap [Step 3 – Step 4]		950	1335	1580	1785	2230
Step 6	New growth share [Step 5 ÷ Total assigned person years in PY]		0.095	0.121	0.132	0.137	0.203

EXAMPLE 4: SLOW "NEW GROWTH" AND GROWTH DECLINED IN LATER PY OVER AN AGREEMENT PERIOD

		Base	**PY1**	**PY2**	**PY3**	**PY4**	**PY5**
	Total assigned person years	5000	5000	6000	7000	8000	6000
Step 1	New growth person years		100	150	250	50	0
Step 2	Overall growth [Total assigned person years in PY - Base]		0	1000	2000	3000	1000
Step 3	Capped new growth [Step 1 ≤ Step 2]		0	150	250	50	0
Step 4	Minimum new growth threshold applied		25	90	245	440	420
Step 5	New growth above the minimum and below the cap [Step 3 – Step 4]		0	60	5	0	0
Step 6	New growth share [Step 5 ÷ Total assigned person years in PY]		0	0.01	0.001	0	0

(b) Determine the ACO's Incentive Factor

To determine a dollar amount for the proposed adjustment to the historical benchmark, under § 425.664(h), we propose to establish an incentive factor, which would be the per capita dollar amount that would convert the new growth share into dollar terms. The proposed incentive factor would be based on a percentage of the ACO's per capita historical benchmark and when multiplied against the new growth share will determine the dollar amount added to an ACO's historical benchmark. We propose to determine an ACO's incentive factor as an ACO-specific per capita dollar amount. We propose to calculate this per capita dollar amount as 5 percent of the per capita historical benchmark before the regional adjustment, prior savings adjustment, or population adjustment is applied, expressed as a single value. The CMS Office of the Actuary (OACT) provided information to support that 5 percent of the ACO's unadjusted historical benchmark is sufficient to incentivize recruitment of inexperienced ACO professionals while

balancing savings in the program, and is described in the Regulatory Impacts Analysis, in section VII. of this proposed rule. Calculating the incentive factor as a percentage of the ACO's unique historical benchmark ensures the adjustment is specific to the ACO and provides a greater incentive, especially for ACOs caring for medically complex high-cost beneficiaries, than just a flat dollar for all ACOs. Refer to the example of the determination of the Incentive Factor provided in Step 7.

TABLE B-G26: HYPOTHETICAL ACO GROWTH ADJUSTMENT CALCULATION FOR PY1, STEP 7

Step 7: Determine the incentive factor	Incentive factor = 5% of historical benchmark before adjustment is applied historical benchmark before adjustment is applied = $13,000 incentive factor = $13,000 x 5% = $650

To follow is an example scenario of determining the ACO's incentive factor for a hypothetical ACO over an agreement period.

TABLE B-G27: CALCULATION OF THE INCENTIVE FACTOR OVER AN AGREEMENT PERIOD

		PY1	PY2	PY3	PY4	PY5
	Historical Benchmark before Adjustments are Applied ($)	13,000	15,500	14,500	16,000	15,750
	Percentage Applied to the Historical Benchmark	5%	5%	5%	5%	5%
Step 7	Incentive Factor ($)	650.00	775.00	725.00	800.00	787.50

(c) Determine the ACO's Growth Adjustment to the Historical Benchmark

Under § 425.664(I)(1), we propose to calculate the growth adjustment as the product of the ACO's new growth share, defined in section III.G.5.f.(2)(a) of this proposed rule, and the ACO's incentive factor, defined in section III.G.5.f.(2)(b) of this proposed rule. Refer to the example provided in Step 8.

TABLE B-G28: HYPOTHETICAL ACO GROWTH ADJUSTMENT CALCULATION FOR PY1, STEP 8

Step 8: Determine the growth adjustment to the historical benchmark	Determine the growth adjustment to the historical benchmark = new growth share determined in Step 6 and the incentive factor determined in Step 7 new growth share = 0.268 incentive factor = $650 growth adjustment to the historical benchmark = $174.02

Under § 425.652(a)(8)(iii), we propose that the growth adjustment amount would be added to the highest of the positive regional adjustment, prior savings adjustment, and population adjustment, or no adjustment, and the total amount could not exceed 5 percent of national per capita OM expenditures, adjusted for risk (if finalized), as discussed in section III.G.5.e of this proposed rule, otherwise if not finalized, the total amount could not exceed the existing 5 percent of national per capita OM expenditures, not adjusted for risk. Refer to the example provided in Step 9.

TABLE B-G29: HYPOTHETICAL ACO GROWTH ADJUSTMENT CALCULATION FOR PY1, STEP 9

Step 9: Determine the final adjustment to the historical benchmark	Final adjustment to the historical benchmark = sum of the growth adjustment to the historical benchmark determined in Step 8 and the highest of the regional adjustment, prior savings adjustment, and the population adjustment, not to exceed 5% of the risk-adjusted national assignable FFS expenditures expressed as a single value; otherwise, the existing 5% of national per capital OM expenditures, not adjusted for risk. growth adjustment to the historical benchmark = $174.02 highest of the regional, prior savings, or population adjustment if applicable = $125 5% of the national FFS expenditures expressed as a single value = $350 final adjustment to the historical benchmark = $299.02

To follow is an example scenario of determining an ACO's growth adjustment and Final Adjustment to the Historical Benchmark.

TABLE B-G30: DETERMINATION OF THE GROWTH ADJUSTMENT AND FINAL ADJUSTMENT TO THE BENCHMARK OVER AN AGREEMENT PERIOD

		PY1	PY2	PY3	PY4	PY5
Step 6	"New Growth" Share	0.268	0.121	0.132	0.137	0.216
Step 7	Incentive Factor ($)	650.00	775.00	725.00	800.00	787.50
Step 8	Growth Adjustment ($)	174.02	94.06	95.46	109.85	169.88
	Regional, Prior Savings, or Population Adjustment, if Applicable ($)	125.00	230.00	75.00	350.00	410.00
Step 9	Growth Adjustment + Highest Applicable Adjustment ($)	299.02	324.06	170.46	459.85	579.88

	Risk-Adjusted Cap on Adjustments to the Benchmark, not to exceed 5% of National Assignable FFS Expenditures, expressed as a Single Value, if finalized. Otherwise, the Existing 5% National Assignable FFS Expenditures, expressed as a Single Value Not Adjusted for Risk. ($)	350.00	400.00	475.00	500.00	500.00
	Final Adjustment to the Benchmark ($)	299.02	324.06	170.46	459.85	500.00

We summarize the proposed steps of the calculation of the growth adjustment as follows in Table B-G31.

TABLE B-G31: HYPOTHETICAL ACO GROWTH ADJUSTMENT CALCULATION FOR PY1

Step 1: Calculate an ACO's new growth for the applicable performance year	new growth = number of assigned beneficiary person years inexperienced with a shared savings initiative that have an ACO professional inexperienced with shared savings initiatives as the primary ACO professional that provided the highest count of primary care services new growth = 3,000 assigned beneficiary person years
Step 2: Determine overall growth	overall growth = number of assigned beneficiary person years in the PY minus the number of assigned beneficiary person years in the PY that corresponds to the ACO's BY3 (if applicable). If the ACO is a new entrant or re-entering, the overall growth is equal to the number of assigned beneficiary person years in the PY Continuing ACO Example: Number of assigned beneficiary person years in the PY = 11,000 Number of assigned beneficiary person years in the PY that corresponds to the ACO's BY3 = 5,000 overall growth = 11,000 - 5,000 = 6,000 assigned beneficiary person years New Entrant or Re-Entering ACO Example: Number of assigned beneficiary person years in the PY = 11,000 Number of assigned beneficiary person years in the PY that corresponds to the ACO's BY3 = 0 overall growth = 11,000 - 0 = 11,000 assigned beneficiary person years
Step 3: Determine capped new growth	Capped new growth = the lesser of the new growth determined in Step 1 and the overall growth determined in Step 2. overall growth = 6,000 assigned beneficiary person years new growth = 3,000 assigned beneficiary person years capped new growth = 3,000 assigned beneficiary person years
Step 4: Determine which minimum new growth threshold is applied	Minimum new growth threshold applied = the lesser of the relative minimum new growth threshold and the absolute minimum new growth threshold absolute minimum new growth threshold = 100 assigned beneficiary person years relative minimum new growth threshold = 0.5% assigned beneficiary person years x total assigned beneficiary person years (11,000) = 55 assigned beneficiary person years minimum new growth threshold applied = 55 assigned beneficiary person years
Step 5: Determine new growth above minimum and below the cap	New growth above the minimum and below the cap = the difference of capped new growth determined in Step 3 and the minimum new growth threshold applied in Step 4 capped new growth = 3,000 assigned beneficiary person years minimum new growth threshold applied = 55 assigned beneficiary person years new growth above the minimum and below the cap = 3,000 - 55 = 2,945 assigned beneficiary person years
Step 6: Calculate new growth share	New growth share = new growth above the minimum and below the cap determined in Step 5 divided by the number of assigned beneficiary person years in the PY new growth above the minimum and below the cap = 2,945

	number of assigned beneficiary person years in the PY = 11,000 new growth share = 2,945 / 11,000 = 0.268
Step 7: Determine the incentive factor	Incentive factor = 5% of historical benchmark before adjustment is applied historical benchmark before adjustment is applied = $13,000 incentive factor = $13,000 x 5% = $650
Step 8: Determine the growth adjustment to the historical benchmark	Determine the growth adjustment to the historical benchmark = new growth share determined in Step 6 and the incentive factor determined in Step 7 new growth share = 0.268 incentive factor = $650 growth adjustment to the historical benchmark = $174.02
Step 9: Determine the final adjustment to the historical benchmark	Final adjustment to the historical benchmark = sum of the growth adjustment to the historical benchmark determined in Step 8 and the highest of the regional adjustment, prior savings adjustment, and the population adjustment, not to exceed 5% of the risk-adjusted national assignable FFS expenditures expressed as a single value; otherwise, the existing 5% of national per capital OM expenditures, not adjusted for risk. growth adjustment to the historical benchmark = $174.02 highest of the regional, prior savings, or population adjustment if applicable = $125 5% of the national FFS expenditures expressed as a single value = $350 final adjustment to the historical benchmark = $299.02

We seek comment on the proposal to apply a growth adjustment to the historical benchmark in addition to the existing regional, prior savings and population adjustments, up to the existing 5 percent cap on upward adjustments to the historical benchmark, or if finalized, the risk-adjusted 5 percent cap described in section III.G.5.e. of this proposed rule for agreement periods beginning on January 1, 2027, and in subsequent years.

(3) Timing of Applicability

We propose to apply the growth adjustment proposal for agreement periods beginning on January 1, 2027, and in subsequent years. If finalized, for ACOs with agreement periods beginning on January 1, 2027, we would use CY 2021 through CY 2026 as the 5-year period used to determine whether ACO professionals are inexperienced with shared savings initiatives. For ACOs with agreement periods beginning on January 1, 2027, we would use CY 2026 as the 1-year period to determine whether beneficiaries are inexperienced with shared savings initiatives for ACOs.

We seek comment on this proposal.

g. Proposal to Reform the Accountable Care Prospective Trend (ACPT) Component of the Benchmark Update Factor

(1) Background

As finalized in the December 2018 final rule (83 FR 68024 through 68030), we used our statutory authority under section 1899(i)(3) of the Act to adopt the policy under which we update the historical benchmark using a blend of national and regional growth rates, rather than the projected absolute amount of growth in national per capita expenditures for Parts A and B services under the original Medicare FFS program as required under section 1899(d)(1)(B)(ii) of the Act. In accordance with § 425.601(b), applicable for agreement periods beginning on or after July 1, 2019, and before January 1, 2024,[305] we update the historical benchmark for an ACO for each performance year using a blend of national and regional growth rates between BY3 and the performance year. To update the benchmark, we make separate calculations for expenditure categories for each of the following populations of beneficiaries based on Medicare enrollment type: ESRD, disabled, aged/dual eligible for Medicare and Medicaid, aged/non-dual eligible for Medicare and Medicaid (§ 425.601(b)(1)).

The national-regional blend is a weighted average of national FFS and regional growth rates between BY3 and the performance year for the applicable Medicare enrollment type (§ 425.601(b)(4)). The national growth rates are computed using CMS Office of the Actuary national Medicare expenditure data for BY3 and the performance year for assignable beneficiaries (as defined at § 425.20) identified for the 12-month calendar year corresponding to each year (§ 425.601(b)(2)). Regional growth rates are computed using expenditures for the ACO's regional service area for BY3 and the performance year (§ 425.601(b)(3)). To calculate regional expenditures, we determine the counties included in the ACO's regional service area based on the ACO's assigned beneficiary population for the year and determine the ACO's

[305] § 425.652 applies to ACOs that started agreement periods in 2025 and 2026. However, for simplicity, we have cited the provisions in § 425.601 in this background section to describe how the ACPT fits into the bigger picture of benchmark adjustments, and the same policies apply to ACOs to which § 425.652 applies.

regional expenditures as specified under § 425.601(c) and (d) and § 425.601(b)(3)(i) (ii).

As noted, the national and regional growth rates are blended together by taking a weighted average of the two. The weight assigned to the national component of the national-regional blend for a given Medicare enrollment type is calculated as the share of assignable beneficiaries in the ACO's regional service area that are assigned to the ACO for the applicable performance year (as calculated in § 425.601(a)(5)(v) and (§ 425.601(b)(4)(i)). The weight assigned to the regional component of the national-regional blend for a given Medicare enrollment type is equal to 1 minus the weight applied to the national growth rate (§ 425.601(b)(4)(ii)). Under this approach, as an ACO's penetration in its regional service area increases, the weight applied to the national component of the national-regional blend increases and the weight applied to the regional component decreases.

The national and regional growth rates are blended together by taking a weighted average of the two. Specifically, for each Medicare enrollment type, the national-regional blended growth rate is equal to the sum of the following: (1) the growth rate for national assignable FFS expenditures for BY3 to the performance year multiplied by the weight assigned to the national component; and (2) the average growth rate for regional FFS expenditures for BY3 to the performance year based on the ACO's regional service area multiplied by the weight assigned to the regional component (87 FR 69881). In accordance with § 425.601(a)(5), we also use blended national-regional growth rates to trend forward expenditures for each benchmark year (BY1 and BY2) to BY3 dollars, making separate calculations for each Medicare enrollment type.

We summarized commenters' concerns about using the blended national-regional growth rates for benchmarking in the CY 2023 PFS final rule (87 FR 69879 through 69881). Specifically, ACOs and other interested parties expressed concerns regarding the dynamic under which an ACO that reduces costs for its own assigned beneficiaries also reduces its average regional costs, resulting in a relatively lower benchmark for the ACO under the blended national-regional growth rates used to trend and update the ACO's historical benchmark. As summarized

in the CY 2022 PFS final rule, ACOs and other interested parties also have suggested that this dynamic particularly disadvantages ACOs with high market penetration in their regional service areas, which may tend to be ACOs operating in rural areas (86 FR 65296 through 65299).

In the CY 2023 PFS final rule, we implemented new policies effective beginning with performance year 2024 to address these concerns by incorporating a prospectively set projected administrative growth factor, a variant of the modified United States Per Capita Cost (USPCC) called the Accountable Care Prospective Trend (ACPT), into a three-way blend with national and regional growth rates to update an ACO's historical benchmark for each performance year in the ACO's agreement period (87 FR 69882 through 69898). Incorporating this prospective trend in the update to the benchmark insulates a portion of the annual update from any savings occurring as a result of the actions of ACOs participating in the Shared Savings Program and helps to address the impact of increasing market penetration by ACOs in a regional service area on a growth factor that only uses blended national-regional rates. Because the ACPT is set prospectively at the outset of an agreement period, any savings generated by ACOs during the agreement period are not reflected in the ACPT. Accordingly, incorporation of the ACPT allows for benchmarks to increase beyond actual spending growth rates as ACOs slow spending growth. We noted that the use of the three-way blend to update ACOs' benchmarks should incentivize both greater savings by ACOs and greater program participation. We also noted that we believed that because incorporating the ACPT into the update would reduce the degree to which an ACO's savings negatively impact its benchmark through the regional trend component of the update, the ACPT would help to address the disproportionate impact of an ACO's savings on the benchmark update for ACOs with a high market share (87 FR 69882).

In addition, as discussed in the Regulatory Impact Analysis for the CY 2023 PFS proposed rule (87 FR 46427), we projected that this proposed approach for use of an ACPT/national- regional three-way blended update factor, in combination with other proposed changes to the statutory payment model in the CY 2023 PFS proposed rule, as well as then-

current policies established using the authority of section 1899(i)(3) of the Act (87 FR 46403 through 46404), would not increase program expenditures relative to those under the statutory payment model. Since we have established the three-way blended update factor, we have continued to reexamine this projection to ensure that the requirement under section 1899(i)(3)(B) of the Act that an alternative payment model not result in additional program expenditures continues to be satisfied, and we have found continue compliance with section 1899(i)(3)(B) of the Act.

Under § 425.660, the three-way blend is calculated as the weighted average of the ACPT (one-third) and the existing national-regional blend (two-thirds) for use in updating an ACO's historical benchmark between BY3 and the performance year. We calculate the ACPT component of the blended annual update using an annualized growth rate based on 5-year projections in per capita spending as of the start of an ACO's agreement period as specified in § 425.660(b)(2)(ii). We use an annualized growth rate based on 5-year projections in per capita spending as of the start of an ACO's agreement period to align the ACPT with the 5-year agreement periods used under the Shared Savings Program. The CMS Office of the Actuary projects the ACPT, which is a modification of the FFS United States Per Capita Cost (USPCC) growth trend projections used annually for establishing Medicare Advantage rates. We set the ACPT growth factors for an ACO's entire 5-year agreement period near the start of the agreement period (87 FR 46163). The ACPT factors remain unchanged throughout the ACO's agreement period, providing a degree of certainty to ACOs.

Similar to the production of FFS USPCCs, for a given agreement period cohort (that is, ACOs with the same agreement period start date) and performance year, OACT produces two separate, modified USPCC values for ESRD and non-ESRD aged/disabled populations (as described in § 425.660(b)(2)). In the CY 2023 PFS final rule (87 FR 69882), we described the modified USPCC values as reflecting an exclusion of payments for indirect medical education (IME), disproportionate share hospitals (DSH), and supplemental payment for IHS/Tribal

Hospitals and hospitals located in Puerto Rico, and including payments associated with hospice claims (87 FR 69882). Subsequently, for a given ACO and performance year, the two modified USPCCs serve as inputs into the calculation of four separate ACPT values, one for each of four Medicare enrollment types: ESRD, disabled, aged/dual eligible for Medicare and Medicaid, and aged/non-dual eligible for Medicare and Medicaid (87 FR 69882). In turn, each of these enrollment-type specific ACPT values is used to calculate an ACO's four enrollment-type specific three-way blended update factors (as described in § 425.652(b)(4)).

As we have previously noted (87 FR 69896), we expect in any year the ACPT could overestimate or underestimate the actual growth rate of expenditures of the national assignable population. In the CY 2023 PFS final rule (87 FR 69882-69888), we included the following factors in the design of the three-way blended update factor to mitigate impacts in differences between the ACPT and the actual growth rate of expenditures for the national assignable population:

- The ACPT is one-third of the three-way blended update factor; the remaining two-thirds of the blend are based on the national-regional trend, which reflects actual national and regional spending growth.
- As part of the ACPT calculation, the ACPT is expressed as a flat dollar amount and is risk-adjusted, which may benefit low growth/low spending ACOs and ACOs serving medically complex populations.
- We established a guardrail policy where, if an ACO generates losses for a performance year that meet or exceed its minimum loss rate (MLR) (for two-sided model ACOs) or negative minimum savings rate (MSR) (for one-sided model ACOs) under the three-way blended update factor, we will recalculate the ACO's updated benchmark using the two-way national-regional blended update factor. If the ACO generates a smaller amount of losses using the two-way blend, we will use this smaller amount to determine the ACO's responsibility for shared losses, if applicable.

- If we determine that expenditure growth has differed significantly from projections made at the start of the agreement period due to unforeseen circumstances, such as an economic recession, pandemic, or other factors, a reduction in the weight placed on the ACPT may be considered. We have sole discretion to determine whether an unforeseen circumstance exists that warrants a reduction to the weight of the ACPT and the reduced weight that will apply to the ACPT.

The CY 2024 modified USPCC cumulative growth rates (2023 to 2024) that were corrected and posted in July 2026 and used to calculate ACPT values for ACOs with an agreement period starting on January 1, 2024, were 5.5 percent for the aged/disabled population and 5.1 percent for the ESRD population.[306,307] However, the CY 2024 actual cumulative growth rate of expenditures for the national assignable population was 8.4 percent for the aged/disabled population (2.9 percentage points higher than projected) and 6.9 percent for the ESRD population (1.8 percentage points higher than projected).[308] When the ACPT is lower than the actual national FFS expenditure growth, it could reduce or eliminate shared savings for ACOs. For CY 2024, we determined that unforeseen circumstances occurred, as it was observed that there were unanticipated billing patterns and unexpectedly high increases in multiple categories of Part A and B spending, most notably Part B drugs. This represented a substantial discrepancy between projected and actual growth rates for CY 2024, and it materialized in the context of the COVID-19 Public Health Emergency that imparted material and complex effects on Medicare trend experience over a multi-year period extending into the first half of 2023. This difference between the projected and actual growth rates for CY 2024 represented a material impact across

---

[306] Shared Savings and Losses, Assignment and Quality Performance Standard Methodology: Specifications of the Accountable Care Prospective Trend (ACPT) and Three-Way Blended Benchmark Update Factor (Version 5). Page 16. *https://www.cms.gov/files/document/medicare-ssp-acpt-specifications.pdf*. Centers for Medicare and Medicaid Services (2026).

[307] Centers for Medicare and Medicaid Services (2026). Announcement of Calendar Year (CY) 2026 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies. Page 14-15. [2026 Announcement]. *https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics/announcements-and-documents/2026*

[308] Observed cumulative growth in national assignable expenditures for the aged/disabled population and ESRD populations applicable to financial reconciliation for PY 2024 were determined in an internal analysis conducted by CMS.

the Shared Savings Program and led to our decision to reduce the ACPT's weight in the three-way blend from one-third (1/3) to one-sixth (1/6) in CY 2024. In CY 2024, the three-way blend for the growth factor was based on 5/6th weight of the national-regional trend and 1/6th weight on the ACPT.[309, 310]

(2) Proposed Revisions

(a) Performance Year-Specific Modified USPCC Annualized Growth Rates Used to Construct ACPT Values

For agreement periods beginning on or after January 1, 2027, we propose to establish performance year-specific modified USPCC annualized (year-over-year) growth rates used to construct ACPT values, that would apply to the performance year regardless of an ACO's agreement period start date. This would replace the current approach under which the modified USPCC annualized growth rates used to construct ACPT values are established on an agreement period-specific basis, as illustrated in Table B-G32. This proposal would not change the methodology by which CMS would calculate the modified USPCC annualized growth rates for any given performance year. This proposal would only change the timing of the calculation and publicly reporting of modified USPCC annualized growth rates.

TABLE B-G32: STATUS QUO AND PROPOSED BASES FOR CALCULATING ANNUALIZED GROWTH RATES

Approach	Agreement Period Start Year	Basis for Calculating Modified USPCC Annualized Growth Rates
Status Quo	2024	Agreement Period
	2025	
	2026	
Proposed	2027	Performance Year
	2028	
	2029	

[309] Information regarding the announcement for the CY 2024 actual cumulative growth rates and the determination that unforeseen circumstance occurred resulting in the decision to reduce ACPT's weight in the three-way blend was disseminated to Accountable Care Organizations via the June 30, 2025, Issue 7 Spotlight Article, an internal communication distributed by the Centers for Medicare & Medicaid Services (CMS) to ACOs.

[310] CY 2024 Projected ESRD Modified USPCC Annualized Growth Rates and Aged/Disabled Modified USPCC Annualized Growth Rates are available at: Shared Savings and Losses, Assignment and Quality Performance Standard Methodology: Specifications of the Accountable Care Prospective Trend (ACPT) and Three-Way Blended Benchmark Update Factor. Pages 6-7. *https://www.cms.gov/files/document/medicare-ssp-acpt-specifications.pdf*. Centers for Medicare and Medicaid Services (2025).

Specifically, for agreement periods beginning on or after January 1, 2027, and in subsequent years, we are proposing that CMS would no longer calculate a fixed five-year schedule of annualized growth rates at the start of an ACO's agreement period. Instead, in the summer of the year preceding a given performance year, CMS would calculate and publicly report the modified USPCC annualized growth rates applicable to that performance year. This means that, although ACOs would no longer receive a five-year set of enrollment type-specific ACPT values near the beginning of the agreement period, they would still receive advance notice of the modified USPCC annualized growth rate used to calculate enrollment type-specific ACPT values for a given performance year in the year preceding that performance year. As illustrated in Table B-G33, in the late spring or early summer preceding the start of the first performance year of an agreement period, an ACO would be able to review the performance year-specific modified USPCC annualized growth rates publicly reported, applicable to the first performance year. For example, ACOs entering agreement periods in 2027 would receive their 2027 ACPT (PY 1 ACPT) in the late spring or early summer of 2026. Then, during each subsequent performance year through the remainder of the agreement period, the ACO would receive a newly calculated set of ACPT values based on the performance year-specific modified USPCC annualized growth rates calculated and published in the summer preceding that performance year. For example, ACOs entering agreement periods in 2027 would receive their 2028 ACPT (PY 2 ACPT) in the late spring or early summer of 2027.

TABLE B-G33: APPLICATION OF PERFORMANCE YEAR-SPECIFIC MODIFIED USPCC ANNUALIZED GROWTH RATES FOR ACOS ENTERING AGREEMENT PERIODS BEGINNING ON JANUARY 1, 2027, AND IN SUBSEQUENT YEARS

Year rate is published[1]	Performance year to which rate applies	ACOs entering agreement periods in 2027	ACOs entering agreement periods in 2028	ACOs entering agreement periods in 2029
2026	CY 2027: Values based on 2027 modified USPCC annualized growth rates	Receives PY1 ACPT	-	-
2027	CY 2028: Values based on 2028 modified USPCC annualized growth rates	Receives PY2 ACPT	Receives PY1 ACPT	-
2028	CY 2029: Values based on 2029 modified USPCC annualized growth rates	Receives PY3 ACPT	Receives PY2 ACPT	Receives PY1 ACPT
Under this approach, overlapping agreement period cohorts would use the same modified USPCC annualized growth rate for the same calendar year corresponding to a performance year. Note 1: Modified USPCC would be published in late spring or early summer of the year the rate is published.				

As illustrated in Table B-G34, under the current approach, modified USPCC annualized growth rates calculated on an agreement period basis may differ across agreement period cohorts.

TABLE B-G34: SUMMARY OF PROJECTED ESRD AND AGED/DISABLED MODIFIED USPCC ANNUALIZED GROWTH RATES, CORRESPONDING TO AGREEMENT PERIODS BEGINNING ON JANUARY 1, 2024, AND JANUARY 1, 2025

Population	Agreement Period Start Year	PY1	PY2	PY3	PY4	PY5
ESRD	2024	5.1%	7.5%	5.5%	5.5%	8.0%
	2025	7.5%	5.7%	5.5%	5.2%	5.6%
Aged/Disabled	2024	5.5%	4.8%	5.7%	5.8%	4.3%
	2025	5.6%	5.7%	6.0%	5.0%	6.1%

Notes: The projected ESRD and Aged/Disabled modified USPCC annualized growth rates that are planned to be updated in July 2026.
Source: Shared Savings and Losses, Assignment and Quality Performance Standard Methodology, Specifications of the Accountable Care Prospective Trend (ACPT) and Three-Way Blended Benchmark Update Factor, Version 5

Establishing performance year-specific modified USPCC annualized growth rates would improve consistency across agreement periods by ensuring that, for a given performance year, the same modified USPCC annualized growth rates for that year would apply to all ACOs regardless of agreement period start date. For example, at reconciliation for PY 2028, the same modified USPCC annualized growth rates would apply to ACOs that entered agreement periods on January 1, 2027, and January 1, 2028. That is, neither cohort of ACOs would face different modified USPCC annualized growth rates for that performance year solely because their agreement periods began in different years.

We continue to believe that the prospective character of the ACPT is an important feature that benefits ACOs by providing a degree of certainty regarding their annual benchmark updates. However, as we acknowledged in the CY 2023 PFS final rule, establishing modified USPCC annualized growth rates at the start of an ACO's agreement period means that ACOs entering agreement periods in different years could be subject to higher or lower updates based on how projections differ across agreement periods. Thus, the current approach poses a tradeoff between long-term predictability (over a 5-year agreement period) and inconsistency across agreement period cohorts. Under the proposed approach, our goal is to thoughtfully recalibrate the balance of that tradeoff by forgoing some predictability in favor of greater consistency and, in turn, fairness across agreement period cohorts. Specifically, although ACOs would no longer receive a fixed five-year schedule of modified USPCC annualized growth rates near the beginning of the agreement period, they would receive advance notice of the modified USPCC annualized growth rates in the late spring or early summer of the year preceding a given performance year, thus preserving the ACPT's core design as a prospectively-set external factor that provides ACOs with a degree of certainty regarding their annual benchmark update, as originally intended, albeit on a shorter time horizon (1 year rather than 5 years). At the same time, applying a consistent modified USPCC annualized growth rate to all ACOs reconciled for a given performance year, regardless of their agreement period start date, would promote greater fairness by reducing the disparities that currently arise when different start dates result in different growth rates, which can advantage or disadvantage certain ACOs. Lastly, the proposed approach may reduce operational complexity by ensuring that, in a given performance year, there is a single set of underlying modified USPCC annualized growth rates used to calculate ACPT values, rather than a unique set of modified USPCC annualized growth rates that are specific to each agreement period cohort of ACOs being reconciled for that performance year.

(b) Guardrail on the Difference Between the Modified USPCC Cumulative Growth Rate and the Actual Cumulative Growth Rate of Expenditures for the National Assignable Population for Agreement Periods Beginning on or after January 1, 2027

For agreement periods beginning on or after January 1, 2027, we propose to establish a guardrail on instances in which the modified USPCC cumulative growth rates used to construct ACPT values differ substantially from observed cumulative growth in national assignable expenditures. Specifically, we propose to establish a guardrail that would not allow the modified USPCC cumulative growth rate for each of the ESRD population and the Aged/Disabled population to be more than 1.0 percentage point below or 1.5 percentage points above the corresponding observed cumulative growth in national assignable expenditures for that population, respectively (where the percentage point thresholds are rounded to the nearest tenth of a percentage point). We would apply the guardrail at reconciliation for a given performance year. Hereafter, we refer to the difference between the modified USPCC cumulative growth rate and observed cumulative growth in national assignable expenditures as "delta modified USPCC."

Establishing guardrail thresholds that are fixed over an agreement period, rather than thresholds that widen or narrow, acknowledges that the realized path of delta modified USPCC over an agreement period cannot be known in advance with sufficient certainty. That is, the extent to which delta modified USPCC widens or narrows over an agreement period depends on the extent to which projection errors in a given year offset the projection error that's accumulated over prior years. This is an outcome that can only be known at financial reconciliation for a given performance year. Therefore, whereas establishing thresholds that widen or narrow reflects a prospective assumption about the trajectory that delta modified USPCC will take over an agreement period, establishing fixed thresholds applies a consistent tolerance for delta modified USPCC to each performance year in recognition of the fact that delta modified USPCC may widen or narrow over an agreement period.

Proposing to set the guardrail threshold levels asymmetrically at -1.0 percentage point and +1.5 percentage points, as opposed to a tighter, wider, or symmetrical guardrail range, primarily reflects a policy judgment about the appropriate approach to limit the effects of unusually large delta modified USPCC at financial reconciliation for a given performance year. The proposed threshold levels are not based on predictions of the path that delta modified USPCC will take over an agreement period. Rather, they establish the bounds within which delta modified USPCC would be addressed. In proposing these levels, we aim to balance several considerations: protection of ACOs from the financial consequences of unusually large cumulative under-projection (substantially negative delta modified USPCC); protection of the Medicare Trust Funds from the financial consequences of unusually large cumulative over-projection (substantially positive delta modified USPCC); and preservation of the original policy aims of the ACPT (that is, to allow for benchmarks to increase beyond actual spending growth even as ACOs slow spending growth).

In proposing these levels, we also considered alternative approaches. For example, a tighter guardrail threshold would provide greater protection to ACOs and the Medicare Trust Funds from delta modified USPCC. However, it could also undermine the prospective design of the ACPT if it results in the frequent application of the guardrail. Conversely, a wider guardrail was also considered and such a guardrail could be applied less frequently than a tighter guardrail and, in turn, may preserve the prospective design of the ACPT to a greater degree, but the wider guardrail could also potentially expose the Medicare Trust Funds and ACOs to harms associated with substantially positive or substantially negative delta modified USPCC. We also considered a symmetrical guardrail that would apply equally in cases of both substantially positive and substantially negative delta modified USPCC. However, we believe that an asymmetric guardrail that imposes a tighter bound on substantially negative delta modified USPCC and a wider bound on substantially positive delta modified USPCC would more directly protect ACOs from the harms associated with substantially negative delta modified USPCC while still allowing ACOs to

benefit from modestly positive delta modified USPCC, consistent with the prospective design of the ACPT. Lastly, while historical delta modified USPCC values have informed the reasonableness of the proposed thresholds, they have not determined the threshold levels themselves, as the path that delta modified USPCC takes over any agreement period cannot be known in advance and may differ across agreement periods. Taken together, the proposed threshold levels of -1.0 percentage point and +1.5 percentage points are best understood as reasonable policy calibrations that, we believe, strike an acceptable balance of the considerations discussed previously. We also believe that the guardrail as proposed would be consistent with the original policy aims of the ACPT, as well as program goals of predictability, fairness, and administrative feasibility. We seek comment on the proposed threshold levels, including whether a tighter guardrail, a wider guardrail, or a modification of any of the approaches discussed in this paragraph, would represent a better balance of the considerations discussed previously.

The following steps illustrate how the proposed guardrail on delta modified USPCC would operate in practice at reconciliation for a given performance year for agreement periods beginning on or after January 1, 2027:

Step 1: Calculate the applicable delta modified USPCC values.

As illustrated in Table B-G35, at reconciliation for a given performance year, CMS would calculate two delta modified USPCC values for each agreement period cohort: one for the ESRD population, and one for the Aged/Disabled population. For a given population, delta modified USPCC would be equal to the modified USPCC cumulative growth rate minus the observed cumulative growth in national assignable expenditures. Because delta modified USPCC values are constructed at the agreement period cohort, performance year, and population levels, they apply uniformly to all ACOs within a given cohort for a given performance year.

TABLE B-G35: HYPOTHETICAL EXAMPLE OF STEP 1 (CALCULATE THE APPLICABLE DELTA MODIFIED USPCC VALUES)

Population	Modified USPCC Cumulative[1] Growth Rate	Observed Cumulative[1] Growth in National Assignable Expenditures	Delta Modified USPCC[2]
ESRD	4.0%	4.5%	-0.5 percentage points

Aged / Disabled	3.0%	5.0%	-2.0 percentage points

Notes:
[1] – "Cumulative" reflects the period from a given ACO's BY3 to the applicable performance year.
[2] – At reconciliation for a given performance year, delta modified USPCC for each population and agreement period cohort equals the modified USPCC cumulative growth rate minus observed cumulative growth in national assignable expenditures.

Step 2: Determine whether each delta modified USPCC falls outside the guardrails.

As illustrated in Table B-G36, once calculated, each population-specific delta modified USPCC value would then be compared with the previously mentioned guardrail thresholds (-1.0 percentage point and +1.5 percentage points). If delta modified USPCC for either population falls within the guardrail thresholds (that is, greater than or equal to -1.0 percentage point and less than or equal to +1.5 percentage points), no guardrail adjustment would apply for a population, and the corresponding enrollment type-specific ACPT values initially calculated for that performance year would remain unchanged. If delta modified USPCC falls outside the guardrail thresholds (that is, less than -1.0 percentage point or greater than +1.5 percentage points) for one or both of the populations, a guardrail adjustment would apply.

TABLE B-G36: HYPOTHETICAL EXAMPLE OF STEP 2 (DETERMINE WHETHER EACH DELTA MODIFIED USPCC FALLS OUTSIDE THE GUARDRAILS)

Population	Delta Modified USPCC	Guardrails[1]		Does Guardrail Adjustment Apply?
		Lower Bound	Upper Bound	
ESRD	-0.5 percentage points	-1.0 percentage point	+1.5 percentage points	No (delta modified USPCC falls inside bounds)
Aged / Disabled	-2.0 percentage points	-1.0 percentage point	+1.5 percentage points	Yes (delta modified USPCC falls outside bounds)

Notes:
[1] - The lower and upper bounds shown here reflect fixed thresholds of -1.0 percentage point (lower bound) and +1.5 percentage points (upper bound) applied to both the ESRD delta modified USPCC and the Aged/Disabled delta modified USPCC.

Step 3. Calculate the guardrail-adjusted modified USPCC cumulative growth rate, as applicable.

As illustrated in Table B-G37, for a given population, if delta modified USPCC falls below the lower guardrail threshold, the applicable modified USPCC cumulative growth rate would be replaced with a guardrail-adjusted value equal to the observed cumulative growth in national assignable expenditures minus 1.0 percentage points. If delta modified USPCC falls above the upper guardrail threshold, the applicable modified USPCC cumulative growth rate

would be replaced with a guardrail-adjusted value equal to the observed cumulative growth in national assignable expenditures plus 1.5 percentage points.

TABLE B-G37: HYPOTHETICAL EXAMPLE OF STEP 3 (CALCULATE THE GUARDRAIL-ADJUSTED MODIFIED USPCC CUMULATIVE GROWTH RATE)

Population	Delta Modified USPCC (Step 1)	Applicable Guardrail (Step 2)	Observed Cumulative Growth in National Assignable Expenditures	Original Modified USPCC Cumulative Growth Rate	Guardrail-Adjusted Modified USPCC Cumulative Growth Rate
ESRD[1]	-0.5 percentage points	Not Applicable	4.5%	4.0%	No adjustment (4.0% used)
Aged / Disabled[2]	-2.0 percentage points	-1.0 percentage point	5.0%	3.0%	4.0%

Notes:
1 – For the ESRD population, there would be no guardrail adjustment because the ESRD delta modified USPCC calculated in Step 1 would have been determined to fall within the guardrail thresholds in Step 2. Therefore, the ESRD-specific ACPT values initially calculated for that performance year would still apply.
2 – For the Aged/Disabled population, the guardrail-adjusted modified USPCC cumulative growth rate would equal 4.0 percent, or the observed cumulative growth in national assignable expenditures minus 1.0 percentage points because the Aged/Disabled delta modified USPCC calculated in Step 1 would have been determined to fall below the lower guardrail threshold in Step 2. In turn, the ACPT values for the Disabled, Aged/Dual, and Aged/Non-Dual populations initially calculated for that performance year would be recomputed in Step 4 using the guardrail-adjusted modified USPCC cumulative growth rate.

Step 4. Recompute ACPT values, as applicable.

If a guardrail adjustment applies (as determined in Step 2), the corresponding enrollment type-specific ACPT values initially calculated for that performance year would be recomputed using the guardrail-adjusted modified UPSCC cumulative growth rate (calculated in Step 3) rather than the original modified USPCC cumulative growth rate. For the ESRD population, the guardrail-adjusted modified USPCC cumulative growth rate would be used to recompute ACPT values applicable to the ESRD enrollment type. For the Aged/Disabled population, the guardrail-adjusted modified USPCC cumulative growth rate would be used to recompute ACPT values applicable to the Disabled, Aged/Dual-Eligible, and Aged/Non-Dual-Eligible enrollment types. The recomputed ACPT values would then be used to construct the three-way blended update factors, updated historical benchmarks, and, in turn, shared savings and losses calculations for the applicable performance year.

The procedures described previously would be applied at financial reconciliation for each performance year of an ACO's agreement period. The application of a guardrail on delta modified USPCC in a given performance year would affect only the ACO-level ACPT values and downstream shared savings and losses calculations applicable to that performance year. This

is appropriate because delta modified USPCC is, by definition, a comparison of the cumulative modified USPCC growth rate to the cumulative observed growth in national assignable expenditures. Thus, the guardrail calculation of each performance year already accounts for projection error accumulated through prior years by construction. For example, in Table B-G38, the delta modified USPCC for PY3 reflects cumulative projection error through PY3. As a result, any guardrail adjustment applied in PY1 or PY2 would not need to be carried forward into PY3 because the cumulative structure of the guardrail calculation for PY3 would have incorporated the cumulative effect of projection errors from PY1 and PY2.

TABLE B-G38: ILLUSTRATIVE APPLICATION OF THE PY-SPECIFIC GUARDRAIL APPLICATION (EFFECTS IN ONE PY DO NOT CARRY OVER TO SUBSEQUENT PYS)

Performance Year	Modified USPCC Annualized Growth Rate	Modified USPCC Cumulative Growth Rate	Observed Cumulative Growth in National Assignable Expenditures	Delta Modified USPCC	Does Guardrail Adjustment Apply?	Guardrail-Adjusted Modified USPCC Cumulative Growth Rate Used to Recompute PY ACPT
PY1	5.7%	5.7%	6.8%	-1.1%	Yes, lower bound	5.8%
PY2	5.4%	11.4%	12.3%	-0.9%	No	No adjustment (11.4% used)
PY3	5.4%	17.4%	14.0%	3.4%	Yes, upper bound	15.5%

Notes:
The guardrail applies in PY1 and PY3, but not in PY2. The PY1 adjustment affects only the PY1 ACPT and does not carry forward into PY2. Instead, the guardrail is reassessed independently in each performance year using the delta modified USPCC applicable to that performance year.

We seek comments on this proposal.

(c) Retroactive Guardrail on Substantially Negative Delta Modified USPCC for Agreement Periods Beginning on January 1, 2024, and Before January 1, 2027

For agreement periods beginning on or after January 1, 2024, and before January 1, 2027, we propose to establish a guardrail on instances in which the modified USPCC cumulative growth rates used to construct ACPT values are substantially lower than observed cumulative growth in national assignable expenditures. Specifically, beginning at reconciliation for PY 2025 for ACOs currently in an agreement period, and for future performance years in their agreement periods, we propose to establish a guardrail that would not allow the modified USPCC cumulative growth rate to be more than 1.0 percentage point below the corresponding observed

cumulative growth in national assignable expenditures (where the percentage point threshold is rounded to the nearest tenth of a percentage point). In other words, this proposed retroactive guardrail would be applied at reconciliation for any remaining performance years for agreement periods that began on January 1, 2024 (that is, PY 2025 through 2028), January 1, 2025 (that is, PY 2025 through 2029), and January 1, 2026 (that is, PY 2026 through 2030).

We propose to apply this proposal retroactively because it adjusts the methodology used in determining shared savings and losses for a performance year and for agreement periods that have already started. Applying this proposal retroactively would either have no effect or a positive effect on an ACOs' determinations of shared savings and losses, and no ACOs would be harmed by retroactively applying this proposed policy. Section 1871(e)(1)(A) of the Act prohibits substantive changes in regulations, manual instructions, interpretive rules, statements of policy, or guidelines of general applicability under Title XVIII of the Act from being applied retroactively to items and services furnished before the effective date of the change unless, as permitted under paragraph (ii), the Secretary determines that failing to apply the change retroactively would be contrary to the public interest. We believe it is appropriate to extend this retroactive applicability to PY 2025 for consistency with future performance years and for the reasons described in the subsequent paragraph.

Failing to apply this proposed policy retroactively for agreement periods beginning on January 1, 2024, and before January 1, 2027, would be contrary to the public interest. Some ACOs may feel unfairly punished by forcing them to assume financial risk when the modified USPCC is a substantial under-projection compared to actual growth, and no ACO would experience reduced shared savings or increased shared losses by retroactively applying this proposed policy. This is especially the case in comparison to ACOs with agreement periods beginning on or after January 1, 2027, that would be protected from financial risk if the delta modified USPCC is substantially negative simply because their agreement period would start after the potential implementation date of the proposed policy. A substantially negative delta

modified USPCC would cause greater harm to ACOs with agreements starting January 1, 2024, January 1, 2025, or January 1, 2026, than for ACOs with agreement periods beginning on or after January 1, 2027, especially because of the potential for these negative projection and mis-estimation errors to compound over multiple years. Specifically, for a given ACO, substantially negative delta modified USPCC would result in corresponding lower ACPT values, which would, in turn, potentially result in lower shared savings or greater shared losses than would occur for a similar ACO with an agreement period beginning on or after January 1, 2027. Such a consequence would be outside an ACO's control, potentially undermining both participation in and the sustainability of the Shared Savings Program and the public's faith in CMS as a fair partner. We are compelled to propose a retroactive remedy for a substantially negative delta modified USPCC because all ACOs covered by this proposed policy will either benefit from it or will be unaffected by it. Also, the proposed policy likely will not place additional administrative burden upon ACOs, CMS, or other interested parties.

ACOs participating in the Shared Savings Program and other ACOs that may be considering joining the Shared Savings Program may be less likely to join or continue to participate in a program where applications of policy based on agreement period start date, which such ACOs may perceive to be arbitrary, can reduce shared savings or increase shared losses. Having more ACOs than what is typical terminating their participation in the Shared Savings Program could negatively affect the sustainability of the program. The Shared Savings Program financial methodology and the procedures we have utilized in the past to address projection errors in the ACPT provide a means to account for instances of substantially negative delta modified USPCC. However, these remedies to address projection errors under our current policies can only be used if an unforeseen circumstance occurs and we determine the negative effects of an under-projected delta modified USPCC to be substantial enough to affect ACOs. As a result, this can create uncertainty for ACOs on whether CMS would address projection errors with delta modified USPCC. The delta modified USPCC is a factor that directly affects whether

an ACO receives shared savings, and ACOs can easily measure the impact of the delta modified USPCC on their shared savings. In recognition of the differing circumstances that could warrant accounting for errors, we have not established a set amount of difference between the modified USPCC and national expenditure trends that we consider to be a substantial enough under-projection to implement a remedy. This uncertainty can create challenges for ACOs to be able to plan what their benchmark could be and how they will achieve savings against such benchmark.

For some ACOs, the uncertainty in the difference between the modified USPCC and national expenditure trends may either discourage new ACOs from joining the Shared Savings Program or cause some ACOs to leave the program, which goes against our goal to encourage more ACOs to participate in the Shared Savings Program. If we do not remedy projection errors in update factors that directly affect the amount of shared savings earned by ACOs, this could cause a loss of faith by ACOs, health care providers, and the public in CMS's ability to effectively administer the Shared Savings Program, substantially reducing ACO and health care provider participation in the program. Reduced participation, in turn, would significantly diminish the savings to the Medicare Trust Funds, the quality of care improvements for Medicare beneficiaries resulting from ACOs participants in the Shared Savings Program, and reduce the coordination of care performed for Medicare beneficiaries when obtaining items and services from ACO providers and suppliers. For these reasons, it would be contrary to the public interest for CMS to fail to retroactively apply our proposed policy mitigating this issue. With our proposed policy, ACOs will know the lower-bound limit on the difference between the modified USPCC and national expenditure trends for the duration of their entire agreement period and have more confidence participating in the Shared Savings Program.

The following steps illustrate how the proposed guardrail on substantially negative delta modified USPCC would operate in practice at reconciliation for a given performance year, beginning with reconciliation for PY 2025, for agreement periods beginning on or after January 1, 2024, and before January 1, 2027. Note that Step 1 and Step 4 (with the exception of

calculating benchmark-based loss sharing limits for ACOs participating in a two-sided risk track) would be operationally identical to those applied to agreement periods beginning on or after January 1, 2027. Moreover, in Steps 2 and 3, the only methodological difference relative to Steps 2 and 3 applied to agreement periods beginning on or after January 1, 2027, is that we would not apply an upper guardrail threshold of 1.5 percentage points on delta modified USPCC for agreement periods beginning on or after January 1, 2024, and before January 1, 2027.

For completeness and clarity, all four steps are illustrated.

Additionally, similar to the two-sided guardrail on delta modified USPCC in a given performance year for agreement periods beginning on or after January 1, 2027, the application of a guardrail on substantially negative delta modified USPCC in a given performance year for agreement periods beginning on or after January 1, 2024, and before January 1, 2027, would only impact the ACPT values and downstream shared savings and losses calculations applicable to that performance year. The effects of applying a guardrail on substantially negative delta modified USPCC in one performance year would not carry over into subsequent performance years.

Step 1: Calculate the applicable delta modified USPCC values.

As illustrated in Table B-G39, at reconciliation for a given performance year, beginning with PY 2026, CMS would calculate two delta modified USPCC values for each agreement period cohort: one for the ESRD population, and one for the Aged/Disabled population. For a given population, the delta modified USPCC would be equal to the modified USPCC cumulative growth rate minus the observed cumulative growth in national assignable expenditures. Because delta modified USPCC values are constructed at the agreement period cohort, performance year, and population levels, they apply uniformly to all ACOs within a given cohort for a given performance year.

TABLE B-G39: HYPOTHETICAL EXAMPLE OF STEP 1 (CALCULATE THE APPLICABLE DELTA MODIFIED USPCC VALUES)

Population	Modified USPCC Cumulative[1] Growth Rate	Observed Cumulative[1] Growth in National Assignable Expenditures	Delta Modified USPCC[2]
ESRD	6.5%	4.5%	+2.0 percentage points
Aged / Disabled	3.0%	5.0%	-2.0 percentage points

Notes:
[1] – "Cumulative" reflects the period from a given ACO's BY3 to the applicable performance year.
[2] – At reconciliation for a given performance year, delta modified USPCC for each population and agreement period cohort equals the modified USPCC cumulative growth rate minus observed cumulative growth in national assignable expenditures.

Step 2: Determine whether each delta modified USPCC is less than -1.0 percentage point.

As illustrated in Table B-G40, once calculated, each population-specific delta modified USPCC value would then be compared with the previously mentioned guardrail threshold (- 1.0 percentage point). If delta modified USPCC is greater than or equal to -1.0 percentage point, no guardrail adjustment would apply, and the corresponding enrollment type-specific ACPT values initially calculated for that performance year would remain unchanged. If delta modified USPCC is less than -1.0 percentage point, a guardrail adjustment would apply.

TABLE B-G40: HYPOTHETICAL EXAMPLE OF STEP 2 (DETERMINE WHETHER EACH DELTA MODIFIED USPCC IS LESS THAN -1.0 PERCENTAGE POINT)

Population	Delta Modified USPCC	Guardrails[1]		Does Guardrail Adjustment Apply?
		Lower Bound	Upper Bound	
ESRD	+2.0 percentage points	-1.0 percentage point	None	No (Upper bound guardrail does not apply for ACOs that began an agreement period prior to January 1, 2027)
Aged / Disabled	-2.0 percentage points	-1.0 percentage point	None	Yes (delta modified USPCC less than lower bound)

Notes:
1 - The lower and upper bounds shown here reflect a fixed threshold of -1.0 percentage point applied to both the ESRD delta modified USPCC and the Aged/Disabled delta modified USPCC.

Although the ESRD delta modified USPCC of +2.0 percentage points is greater than the upper guardrail threshold of +1.5 percentage points for agreement periods beginning on or after January 1, 2027, this threshold would not apply for ACOs in agreement periods beginning on or after January 1, 2024, and before January 1, 2027.

Step 3. Calculate the guardrail-adjusted modified USPCC cumulative growth rate, as applicable.

As illustrated in Table B-G41, for a given population, if delta modified USPCC is less than the lower guardrail threshold, the applicable modified USPCC cumulative growth rate would be replaced with a guardrail-adjusted value equal to the observed cumulative growth in national assignable expenditures minus 1.0 percentage point.

TABLE B-G41: HYPOTHETICAL EXAMPLE OF STEP 3 (CALCULATE THE GUARDRAIL-ADJUSTED CUMULATIVE GROWTH RATE)

Population	Delta Modified USPCC (Step 1)	Applicable Guardrail (Step 2)	Observed Cumulative Growth in National Assignable Expenditures	Original Modified USPCC Cumulative Growth Rate	Guardrail-Adjusted Modified USPCC Cumulative Growth Rate
ESRD[1]	+2.0 percentage points	Not Applicable	4.5%	6.5%	No adjustment (6.5% used)
Aged / Disabled[2]	-2.0 percentage points	-1.0 percentage points	5.0%	3.0%	4.0%

Notes:
1 - For the ESRD population, there would be no guardrail adjustment because the ESRD delta modified USPCC calculated in Step 1 would have been determined to fall above the guardrail threshold in Step 2. Therefore, the ESRD-specific ACPT values initially calculated for that performance year would still apply.
2 - For the Aged/Disabled population, the guardrail-adjusted modified USPCC cumulative growth rate would equal 4.0 percent, or the observed cumulative growth in national assignable expenditures minus 1.0 percentage points because the Aged/Disabled delta modified USPCC calculated in Step 1 would have been determined to fall below the guardrail threshold in Step 2. In turn, the ACPT values for the Disabled, Aged/Dual, and Aged/Non-Dual populations initially calculated for that performance year would be recomputed in Step 4 using the guardrail-adjusted modified USPCC cumulative growth rate.

Step 4. Recompute ACPT values, as applicable.

If a guardrail adjustment applies (as determined in Step 2), the corresponding enrollment type-specific ACPT values initially calculated for that performance year would be recomputed using the guardrail-adjusted MUPSCC cumulative growth rate (calculated in Step 3) rather than the original modified USPCC cumulative growth rate. For the ESRD population, the guardrail-adjusted modified USPCC cumulative growth rate would be used to recompute ACPT values applicable to the ESRD enrollment type. For the Aged/Disabled population, the guardrail-adjusted modified USPCC cumulative growth rate would be used to recompute ACPT values applicable to the Disabled, Aged/Dual-Eligible, and Aged/Non-Dual-Eligible enrollment types.

The recomputed ACPT values would then be used to construct the three-way blended update factors, updated historical benchmarks, and, in turn, shared savings and losses calculations for the applicable performance year. However, in calculating the benchmark-based loss recoupment limit for a given ACO participating in a two-sided risk track, we would use as its basis the lesser of the two updated benchmarks calculated before and after application of the retroactive guardrail. This would be done to account for the unlikely scenario in which an ACO's benchmark-based loss recoupment limit increases under the retroactive guardrail and, as a result of that increase, the ACO is rendered liable for greater shared losses than would otherwise occur in the absence of the retroactive guardrail. This would ensure that no ACO could be harmed as a result of implementing this proposed policy.

We seek comments on this proposal.

(d) Delay in Financial Reconciliation for Performance Year 2025

Proposing to implement this guardrail to take effect starting with PY 2025, including PY 2025 financial reconciliation, will result in a delay in PY 2025 financial reconciliation and delay providing financial results and shared savings payments to ACOs, pending the issuance of the CY 2027 PFS final rule and confirmation that we ultimately finalize the proposal for the lower bound guardrail policy. CMS plans to issue PY 2025 financial results and distribute shared savings payments in November 2026 and December 2026, respectively, in accordance with the finalized policy. This is necessary because, to complete the reconciliation process, we need to have a final value established for the ACPT for PY 2025.

Under our proposed retroactive, lower-bound guardrail policy, the ACPT for ACOs with agreement periods starting in PY 2024 would be 15.3 percent for ESRD beneficiaries and 14.7 percent for Aged/Disabled beneficiaries. For ACOs with agreement periods starting in PY 2025 under our proposed policy, the ACPT would be 7.7 percent for ESRD beneficiaries and 5.7 percent for Aged/Disabled beneficiaries. As described in section III.G.5.g.(2)(c). of this proposed rule, all of the ACOs covered by our proposed policy for PY 2025 financial reconciliation would either benefit from it or would be unaffected by it.

If our proposed policy is not implemented and no other action is taken to adjust the ACPT, the unadjusted ACPT for ACOs with agreement periods starting in PY 2024 would be 13.0 percent for ESRD beneficiaries and 10.6 percent for Aged/Disabled beneficiaries. For ACOs with agreement periods starting in PY 2025 if the ACPT is not changed, the unadjusted ACPT would be 7.5 percent for ESRD beneficiaries and 5.6 percent for Aged/Disabled beneficiaries. If we do not implement our proposed policy, ACOs with agreement periods starting in either 2024 or 2025 would otherwise receive less shared savings or have no change in their shared savings payments.

The goal of this proposed policy is to address the under-estimate of the modified USPCC compared to national expenditure trends. The proposal also would ensure that as soon as

PY 2025 financial reconciliation occurs, ACOs would not be subject to the risk of modified USPCC values being included in the three-way blended growth factor that are substantially lower than the national assignable expenditure trends solely because of the starting date of an ACO's agreement period. The proposed ACPT lower bound policy also can be applied in the same manner for ACOs with agreement periods starting either January 1, 2024, or January 1, 2025, which would lead to a consistent ACPT lower bound policy regarding the relationship between the ACPT and the national assignable expenditures, if we finalize our proposal to establish a guardrail as described in section III.G.5.g.(2)(b). of this proposed rule. For the reasons noted in this section, we believe that a delay to financial reconciliation is necessary so that ACOs that participated in PY 2025 can immediately benefit if this proposed lower bound guardrail policy is finalized.

(e) Proposed Amendments to Shared Savings Program Regulation We propose the following amendments to § 425.605:

- Revise paragraph (i)(2)(i) introductory text to remove the phrase "paragraph (i)(2)(ii) of this section" and add in its place the phrase "paragraph (i)(2)(ii) or (i)(2)(iii) of this section, as applicable".

- Add new paragraph (i)(2)(iii) to specify that for agreement periods beginning on or after January 1, 2024, and before January 1, 2027, applicable to performance years 2025 and subsequent performance years remaining in these agreement periods, CMS calculates the benchmark-based loss recoupment limit as follows:

++ Calculates the value for total benchmark expenditures as the product of an ACOs per capita updated benchmark expenditures for the performance year prior to the recomputation of the ACPT as specified in § 425.660(c)(1) and an ACO's assigned beneficiary person years for the performance year.

++ Calculates the value for total benchmark expenditures as the product of an ACO's per capita updated benchmark expenditures for the performance year after the recomputation of the

ACPT as specified in § 425.660(c)(1) and an ACO's assigned beneficiary person years for the performance year.

++ Calculates the product of the percentage specified in paragraph (d)(1)(iii)(D)(2), (d)(1)(iv)(D)(2), and (d)(1)(v)(D)(2) of this section, as applicable, and the lesser of the ACO's total benchmark expenditures calculated according to paragraphs (i)(2)(iii)(A) and (i)(2)(iii)(B) of this section.

We propose the following amendments to § 425.610:

- In paragraph (l)(2) introductory text, remove the phrase "paragraph (l)(3) of this section" and add in its place the phrase "paragraphs (l)(3) or (l)(4) of this section, as applicable";
- Add new paragraph (l)(4) to specify that for agreement periods beginning on or after January 1, 2024, and before January 1, 2027, applicable to performance years 2025 and subsequent performance years remaining in these agreement periods, the amount of shared losses for which an eligible ACO is liable may not exceed 15 percent of the lesser of the following:

++ Total benchmark expenditures calculated as the product of an ACO's per capita updated benchmark expenditures for the performance year prior to the recomputation of the ACPT as specified in § 425.660(c)(1) and an ACO's assigned beneficiary person years for the performance year.

++ Total benchmark expenditures calculated as the product of an ACO's per capita updated benchmark expenditures for the performance year after the recomputation of the ACPT as specified in § 425.660(c)(1) and an ACO's assigned beneficiary person years for the performance year.

We propose to revise the entirety of § 425.660 with provisions on the ACPT. In summary, we propose the following amendments to § 425.660:

Revise paragraph (a) to provide a general explanation of the ACPT and specify that the methodology by which CMS calculates and adjusts a projected growth rate called the Accountable Care Prospective Trend (ACPT) is described in § 425.660. We would also specify

that CMS incorporates the ACPT into the blended update factor described in § 425.652(b) when updating an ACO's benchmark for each performance year of the agreement period, for agreement periods beginning on January 1, 2024, and in subsequent years.

Revise paragraph (b) on the determination of the ACPT to specify in the introductory text that an ACPT is a flat dollar amount calculated using one or more annualized growth rates based on national FFS Medicare expenditures projected by the CMS Office of the Actuary. We would specify in paragraphs (b)(1) through (b)(6), the provisions on CMS' determination of the ACPT for a Medicare enrollment type for each performance year, as follows:

Proposed paragraph (b)(1) of § 425.660 specifies provisions on CMS' calculation of annualized projected growth rates. This provision explains that the annualized projected growth rates are calculated as an annual rate of growth in projected expenditures relative to the prior year. Further, CMS projects annualized per capita growth in Parts A and B FFS expenditures for each performance year of the ACO's agreement period. In calculating the annualized projected growth rates, CMS would do all of the following:

- Exclude IME and DSH payments, and the supplemental payment for IHS/Tribal hospitals and Puerto Rico hospitals;
- Make separate expenditure calculations for the ESRD and Aged/Disabled populations; and
- Calculate one or more annualized projected growth rates for the ESRD population of beneficiaries, and one or more annualized growth rates for the Aged/Disabled population of beneficiaries, as follows:

++ Using a uniform annualized projected rate of growth over each of the 5 performance years of the 5-year agreement period (for agreement periods beginning on or after January 1, 2024, and before January 1, 2027), or for each performance year (for agreement periods beginning on January 1, 2027, and in subsequent years), as applicable; or

++ If using an uniform annualized projected rate of growth is determined not to reasonably fit the anticipated growth curve (for example, if growth is expected to be above- or below-average in the short-run and return to more typical levels later in the agreement period), We would apply an alternative annualization technique using two or more annualized growth rates reflecting the projected rates of growth during the 5 performance years comprising the 5-year agreement period (for agreement periods beginning on or after January 1, 2024, and before January 1, 2027), or for each performance year (for agreement periods beginning on January 1, 2027, and in subsequent years), as applicable.

Proposed paragraph (b)(2) of § 425.660 specifies that, for each performance year, CMS calculates cumulative projected growth rates relative to the ACO's benchmark year (BY) 3, using the annualized projected growth rates, determined in accordance with proposed paragraph (b)(1) of § 425.660, for each population of beneficiaries: the ESRD population and the Aged/Disabled population.

Proposed paragraph (b)(3) of § 425.660 specifies provisions on CMS' calculations to express a cumulative projected growth rate as a flat dollar amount. Accordingly, for each performance year, CMS would multiply the applicable cumulative projected growth rate described in proposed paragraph (b)(2) of § 425.660 by BY3 truncated national per capita FFS Medicare expenditures for assignable beneficiaries for each Medicare enrollment type (ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, and aged/non-dual eligible Medicare and Medicaid beneficiaries) identified for the 12-month calendar year corresponding to BY3 to express the cumulative projected growth rate as a flat dollar amount as follows:

- The ESRD cumulative projected growth rate would be used for the ESRD population.
- The Aged/Disabled cumulative projected growth rate would be used for the following populations: disabled, aged/dual eligible Medicare and Medicaid beneficiaries, and aged/non-dual eligible Medicare and Medicaid beneficiaries.

Under proposed paragraph (b)(4) of § 425.660, we would maintain the existing provision

on risk adjusting the flat dollar amount but add a related description to serve as a heading for clarity and consistency.

Under proposed paragraph (b)(5) of § 425.660, we would maintain the existing provision on calculating ACO-specific ACPT growth rates but add a related description to serve as a heading and make other revisions for clarity and consistency.

Under proposed new paragraph (b)(6) of § 425.660, we would specify provisions on the timing of calculations, which include the following:

- Under new paragraph (b)(6)(i), with provisions applicable for agreement periods beginning on or after January 1, 2024, and before January 1, 2027, we would specify the following:

++ At the beginning of the ACO's agreement period, CMS calculates the annualized projected growth rates for all performance years of the ACO's agreement period in accordance with proposed paragraph (b)(1) of § 425.660. These annualized projected growth rates remain fixed over the ACO's agreement period.

++ For a given performance year, CMS calculates an ACO-specific ACPT value, in accordance with proposed paragraphs (b)(2) through (b)(5) of § 425.660, using the annualized projected growth rates calculated at the beginning of the ACO's agreement period.

- Under new paragraph (b)(6)(ii), with provisions applicable for agreement periods beginning on January 1, 2027, and in subsequent years, we specify the following:

++ In the calendar year preceding a given performance year, CMS calculates the annualized projected growth rates in accordance with proposed paragraph (b)(1) § 425.660 for that performance year.

++ For a given performance year, CMS calculates an ACO-specific ACPT value, in accordance with proposed paragraphs (b)(2) through (b)(5) of § 425.660, using the annualized projected growth rates calculated in the preceding calendar year.

Under proposed new paragraph (c) of § 425.660, we would specify provisions on the recomputation of the ACPT based on the guardrail policies described in sections III.G.5.g.(2).(b)and III.G.5.g.(2).(c) of this proposed rule. Specifically, at financial reconciliation for a given performance year, CMS may recompute the ACO-specific ACPT value for a Medicare enrollment type initially determined at proposed paragraph (b)(5) of § 425.660 for that performance year, to address under-projection or over-projection of the ACPT (as applicable), as follows:

- In paragraph (c)(1), for agreement periods beginning on or after January 1, 2024, and before January 1, 2027.

++ For performance year 2025, and any subsequent performance years of the ACO's agreement period, CMS separately calculates for the ESRD and Aged/Disabled populations the difference between the cumulative projected growth rates calculated in proposed paragraph (b)(2) of § 425.660 and the cumulative observed growth in per capita expenditures for the national assignable FFS population.

++ For the ESRD and Aged/Disabled populations separately, if this difference is less (more negative) than -1.0 percentage point (for example, -1.5, -2.0, -3.0), CMS would recompute the ACO-specific ACPT value for the corresponding enrollment type(s) initially determined at proposed paragraph (b)(5) of § 425.660. CMS would calculate an ACO-specific ACPT value for the corresponding enrollment type(s), in accordance with proposed paragraphs (b)(3) through (b)(5) of § 425.660, using the cumulative observed growth in expenditures for the national assignable FFS population minus 1.0 percentage point.

++ If this difference is greater than (less negative) or equal to -1.0 percentage point (for example, -0.9, -0.5, 0.5), CMS would not recompute the ACO-specific ACPT value for the corresponding enrollment type(s) initially determined at proposed paragraph (b)(5) of § 425.660.

- In paragraph (c)(2) of § 425.660, for agreement periods beginning on January 1, 2027, and in subsequent years.

++ CMS separately calculates for the ESRD and Aged/Disabled populations the difference between the cumulative projected growth rates calculated in proposed paragraph (b)(2) of § 425.660 and the cumulative observed growth in per capita expenditures for the national assignable FFS population.

++ For the ESRD and Aged/Disabled populations separately, if this difference is less (more negative) than -1.0 percentage point (for example, -1.5, -2.0, -3.0), CMS would recompute the ACO-specific ACPT value for the corresponding enrollment type(s) initially determined at proposed paragraph (b)(5) of § 425.660. CMS would calculate an ACO-specific ACPT value for the corresponding enrollment type(s), in accordance with proposed paragraphs (b)(3) through (b)(5) of § 425.660, using the cumulative observed growth in expenditures for the national assignable FFS population minus 1.0 percentage point.

++ If this difference is greater than or equal to +1.5 percentage points, CMS would recompute the ACO-specific ACPT value for the corresponding enrollment type(s) initially determined at proposed paragraph (b)(5) of § 425.660. CMS would calculate an ACO-specific ACPT value for the corresponding enrollment type(s), in accordance with proposed paragraphs (b)(3) through (b)(5) of § 425.660, using the cumulative observed growth in expenditures for the national assignable FFS population plus 1.5 percentage point.

++ If this difference is greater than (less negative) or equal to -1.0 percentage point and less than or equal to +1.5 percentage points (for example, between -1.0 and +1.5, inclusive), CMS would not recompute the ACO-specific ACPT value for the corresponding enrollment type(s) initially determined at proposed paragraph (b)(5) of § 425.660.

We seek comment on our proposed revisions to § 425.660.

6. Beneficiary Engagement

a. Proposal to Allow ACOs To Reduce or Eliminate Part B Cost Sharing

(1) Background

We believe that ACOs play a key role in strengthening beneficiary engagement in their care; accordingly, we intend to continue expanding the tools available to ACOs to support this work. Improving beneficiary engagement allows the benefits of receiving care from providers who are part of an ACO be more tangible and may ultimately result in improved quality and efficiency of care for beneficiaries, helping us meet our goals of improving beneficiary outcomes and reducing unnecessary spending.

As part of the effort to strengthen beneficiary engagement, in the CY 2025 Physician Fee Schedule final rule, CMS finalized the prepaid shared savings option (89 FR 98132). This payment option is available to current Shared Savings Program ACOs with a history of earning shared savings and is intended to expand access to performance year savings that encourages investment in staffing, healthcare infrastructure, and additional services for beneficiaries. Under § 425.640(e)(1), ACOs participating in the prepaid shared savings option are required to spend a specific portion of the prepaid shared savings amount on direct beneficiary services, improving the quality of care beneficiaries receive. As discussed elsewhere in section III.G.6. of this proposed rule, ACO interest in receiving prepaid shared savings has been limited, and CMS is proposing to discontinue the participation option in future years. However, we believe a component of prepaid shared savings, providing ACOs the ability to reduce or eliminate cost sharing for certain Part B items and services, is a valuable tool to offer eligible ACOs. Cost sharing support for Part B items and services was offered in the ACO REACH model and allows ACO participants not to collect cost sharing amounts (in whole or in part) from eligible beneficiaries for eligible Part B items and services. In the ACO REACH model, ACOs and ACO participants enter into cost sharing support arrangements for the ACO to reimburse the ACO participant for beneficiary cost sharing amounts not collected. In the ACO REACH model, ACOs have wide flexibility to determine the beneficiaries and items and services that will be eligible for cost sharing support, but ACOs are prohibited from waiving Part B cost sharing

support for items that may have a higher risk of fraud, waste, or abuse, such as durable medical equipment, prosthetics, orthotics, prescription drugs or supplies.

Part B cost sharing support is the third most used Beneficiary Engagement Incentive in the ACO REACH model with 41 percent of ACOs reporting that they had implemented it by 2025 or were planning to implement in 2026.[311] Additionally, interested parties have identified Part B cost sharing support as a valuable tool for ACOs to engage beneficiaries in their care.[312]

In 2026, the standard Medicare Part B monthly premium is $202.90, with a $283 annual deductible.[313] After the deductible is met, beneficiaries generally pay 20 percent of the Medicare-approved amount for items and services, such as doctor visits and durable medical equipment, with no limit on out-of-pocket costs. While most beneficiaries have supplemental insurance that covers the 20 percent cost sharing, including Medigap plans, employer sponsored plans, and Medicaid, some beneficiaries do not. In 2023, 3.5 million Medicare FFS beneficiaries (13 percent) lacked additional supplemental coverage.[314] These beneficiaries were more likely to have modest incomes (between $20,000 and $40,000 per person) compared to all Medicare FFS beneficiaries in 2023.[315] Beneficiaries with higher out of pocket costs receive less medical care than those with supplemental coverage.[316] While not all of this difference in care may be due to financial concerns, higher out of pocket costs may cause patients to skip or postpone necessary care and result in worsening health outcomes.[317] Offering Part B cost sharing support would

---

[311] CMS Innovation Center. December 2025. ACO REACH Pulse Check Survey Preliminary Results. Internal Analysis.
[312] HCTTF and NAACOS: Reimagining Beneficiary Engagement in Accountable Care Models. 2026. Available at *https://www.naacos.com/wp-content/uploads/2026/03/Reimagining-Beneficiary-Engagement-in-Accountable-Models_2026.pdf*.
[313] 2026 Medicare Parts A & B Premiums and Deductibles, Fact Sheet, November 14, 2025. Available at *https://www.cms.gov/newsroom/fact-sheets/2026-medicare-parts-b-premiums-deductibles.*
[314] Cubanski J, Neuman T and Ochieng N, KFF. A Snapshot of Sources of Coverage Among Medicare Beneficiaries. 2025. Available at: *https://www.kff.org/medicare/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries/*
[315] Ibid.
[316] Roberts E, Glynn A, Donohue J, et al. Consequences of Health Insurance Cost Sharing Among Low-Income Medicare Beneficiaries: Evidence from Benefit Cliffs in Medicaid and Medicare's Prescription Drug Subsidy Program. Health Serv Res. 2020;55(Suppl 1):98-99. https://doi.org/10.1111/1475-6773.13470.
[317] Hamel L, Lopes L, Montero A, Presiado M, and Sparks G. Americans' Challenges with Health Care Costs. KFF. 2026. Available at *https://www.kff.org/health-costs/americans-challenges-with-health-care-costs/*.

allow ACOs to remove cost barriers for beneficiaries to receive items and services that will positively impact their health, which is consistent with the goals of the Shared Savings Program of improved quality and efficiency of care for beneficiaries.

While only one Shared Savings Program ACO receiving prepaid shared savings chose to reduce or eliminate Part B cost sharing support in the first year, that experience may not reflect future demand for this flexibility, given that only four ACOs elected to receive prepaid shared savings. Based on the ACO REACH model experience and the number of Medicare FFS beneficiaries without supplemental insurance, Shared Savings Program ACOs may be very interested in using this flexibility, were it available, simple to administer, and easy to implement. Additionally, we think providing ACOs the ability to reduce or eliminate Part B cost sharing support would better enable them to bill the new modifiers where appropriate as described in section II.D of this proposed rule, should they be finalized, without increasing costs for ACO beneficiaries. These modifiers are intended to better account for the complexity of visits in the ACO context, including the cognitive work of providing longitudinal care and accountability for a beneficiary's total cost of care.

As discussed in section III.G.6.a.(2)(f) of this proposed rule, if this proposal is finalized, CMS expects to make a determination that the anti-kickback statute safe harbor for CMS-sponsored model arrangements and CMS-sponsored model patient incentives (§§ 1001.952(ii)(1) and (2) of this title) is available to protect remuneration exchanged under Part B cost sharing support arrangements and patient incentives in the form of Part B cost sharing support furnished to beneficiaries under the Shared Savings Program that meets the requirements of this section and the anti-kickback statute safe harbor requirements set forth at § 1001.952(ii) of this title.

(2) Proposed Revisions

(a) Eligibility, Application Procedure and Contents

To establish the ability for ACOs to offer Part B cost sharing support, we propose in § 425.304(e)(1) that eligible ACOs may, subject to certain conditions and safeguards, enter into

Part B cost sharing support agreements with ACO participants, under which ACO participants reduce or eliminate cost sharing for those categories of eligible Part B items and services and eligible beneficiaries identified by the ACO. This cost sharing support could include both Medicare FFS deductible and coinsurance amounts, or either of the two.

To help ensure that only ACOs capable of complying with program requirements have the ability to offer cost sharing support, we propose to limit the ability to reduce or eliminate Part B cost sharing support to those eligible ACOs that have submitted a Part B cost sharing support application and for which CMS has approved their application to participate for that agreement period or the remainder of that agreement period.

In addition to the eligibility requirement, CMS would design application criteria to collect information important for determining ACO compliance with the requirements of new § 425.304(e) while minimizing administrative burden to ACOs. ACOs would be required to submit an implementation plan in their application to provide Part B cost sharing support. ACOs will have substantial flexibility to design a Part B cost sharing support implementation plan that will be operationally and financially feasible for the ACO. As long as ACOs follow CMS procedures and accurate information is submitted to CMS, ACOs may independently determine the categories of beneficiaries and items and services for which they will reduce or eliminate Part B cost sharing.

We propose to establish the application procedures in § 425.304(e)(3)(i). An ACO must submit a Part B cost sharing support implementation plan in the form and manner and by a deadline specified by CMS. The implementation plan must include the following:

- The categories of eligible beneficiaries for which the ACO plans to make Part B cost sharing support available.
- The categories of eligible Part B items and services for which the ACO plans to make Part B cost sharing support available.

- A description of how the ACO's planned Part B cost sharing support strategy meets at least one of the clinical goals in § 425.304(e)(4)(iii).

- The procedures the ACO will implement to ensure that ACO participants that have entered into a Part B cost sharing support arrangement with the ACO have access to the most current list of beneficiaries eligible to receive Part B cost sharing support.

- A requirement for the ACO to submit to CMS a complete and accurate list of ACO participants that have entered into a Part B cost sharing support arrangement according to paragraph (e)(5)(i) of this section.

- An attestation that, in any marketing or communications regarding the availability of Part B cost-sharing support, the ACO and its ACO participants will not represent such support as a substitute for supplemental insurance coverage or encourage beneficiaries to reduce or terminate such coverage. Of note, this requirement would not prohibit ACOs from communicating the availability of Part B cost-sharing support, provided such communication complies with this limitation and those outlined at § 425.310.

- Such other information as may be specified by CMS.

We intend this application process to ensure that ACOs have a fully developed strategy that complies with § 425.304(e) prior to implementing a strategy for reducing or eliminating Part B cost sharing support for eligible beneficiaries. To allow ACOs to participate as quickly as possible, if this proposal is finalized, CMS plans to collect applications in early 2027 and approve participation by the second quarter of 2027, with a target date of April 1, 2027. After the first application review period, CMS would conduct the application cycle for ACOs to reduce or eliminate Part B cost sharing as part of, and in conjunction with, the Shared Savings Program application process under § 425.202, with instructions and timelines published on the Shared Savings Program's website.[318] We would provide further information regarding the process, including the application format and specific requirements, such as the deadline for submitting

[318] *https://www.cms.gov/medicare/payment/fee-for-service-providers/shared-savings-program-ssp-acos.*

applications, through sub-regulatory guidance. The Part B cost sharing support application review process will provide an ACO with feedback and an opportunity to clarify or revise their application. In conjunction with the application process laid out at § 425.202, ACOs would have their next opportunity (after the first application review period) to apply to provide beneficiaries with Part B cost sharing support in the summer of 2027 with an effective start date of January 1, 2028. CMS posts the annual Application and Change Request Cycle on the Shared Savings Program website annually, which would be updated to include information regarding the timing for submitting an application to provide Part B cost sharing support to beneficiaries for the remainder of an ACO's agreement period.

We propose at § 425.304(e)(3)(ii) that CMS would evaluate an ACO's application to determine whether the ACO satisfies the requirements of § 425.304 and would approve or deny the application. CMS could reject the ACO's application to reduce or eliminate Part B cost sharing on the basis of one or more of the following:

- The ACO's and the ACO participant's history of noncompliance in the Shared Savings Program.
- The ACO's history of noncompliance in CMS Innovation Center ACO models.
- Whether the implementation plan complies with the requirements of § 425.304.
- Such other factors as we deem reasonable to protect the integrity of the Shared Savings Program, including concerns that the use of Part B cost sharing support may contribute to fraud, waste or abuse.

Part B cost sharing support can impact beneficiaries and ACO participants financially and therefore requires an ACO to maintain compliance with the requirements and guardrails laid out in this section to protect beneficiaries and ACO participants. We believe historical compliance with Shared Savings Program requirements and CMS Innovation Center model requirements is important for establishing experience that suggests the ACO is capable of providing Part B cost sharing support in alignment with program requirements. For example, if an ACO or an ACO

participant has a history of noncompliance and we therefore issued pre-termination actions under § 425.216, we would want to review the facts of those actions to determine whether the ACO's application to provide Part B cost sharing support should be approved. Additionally, if CMS receives additional information through claims analysis or other avenues that suggest that particular usage patterns of the Part B cost sharing support may be contributing to fraud, waste or abuse, CMS may not accept an ACO's application that proposes similar strategies.

In the event that an ACO wants to make a change to its implementation plan, we propose at § 425.304(e)(3)(iii) that the ACO must submit a description of the change to CMS in a form and manner and by a deadline or deadlines specified by CMS. CMS would evaluate the proposed change and either approve or reject it based on whether it complies with the factors outlined at proposed § 425.304(e)(3)(ii). CMS intends to provide further information regarding the process for updating the implementation plan through sub-regulatory guidance.

We seek comments on these proposals.

(b) Part B Cost Sharing Support Requirements

We propose in § 425.304(e)(4) to specify the program requirements for reducing or eliminating Part B cost sharing. We intend our proposal to allow ACOs to reduce or eliminate Part B cost sharing to improve the quality and efficiency of items and services furnished to Medicare beneficiaries by giving ACOs additional tools to encourage beneficiaries to utilize high value care. We recognize that there are a multitude of strategies that could be successful when reducing or eliminating Part B cost sharing for beneficiaries, and these strategies will likely differ by ACO. Our goal with this proposal is to provide ACOs with significant flexibility to design a strategy that works for their organization while still maintaining safeguards for beneficiaries, health care providers, and CMS.

In § 425.304(e)(4)(i), we propose the basic eligibility requirements for a beneficiary to receive Part B cost sharing support for a specific item or service. An eligible beneficiary must be an assignable beneficiary as defined at § 425.20 and must not have secondary insurance that

covers the associated Part B cost sharing support obligation. Examples of secondary insurance could include a Medigap plan, Medicaid coverage, or other supplemental coverage through a beneficiary's employer or union. A beneficiary's eligibility may vary based on the item or service for which the ACO intends to reduce or eliminate cost sharing, based on their secondary insurance coverage. If a beneficiary's secondary insurance covers cost sharing support for some items and services but not all, ACOs may reduce or eliminate cost sharing support reductions for items and services that are not covered by the secondary insurance. This requirement would ensure the beneficiaries receive the benefits of reducing or eliminating cost sharing, and not insurers. To ensure that Part B cost sharing support is focused on improving the quality and efficiency of items and services beneficiaries receive, ACOs may only reduce or eliminate Part B cost sharing for beneficiaries whose overall health is expected to be improved or maintained by receiving the associated Part B item or service. This requirement is in place to reiterate that ACOs and ACO participants may not reduce or eliminate Part B cost sharing simply to increase reimbursements to health care providers through the provision of unnecessary items and services to beneficiaries.

Proposed § 425.304(e)(4)(ii) would allow ACOs to reduce or eliminate beneficiary cost sharing for all Medicare FFS Part B items and services except durable medical equipment, prosthetics, orthotics, supplies, and prescription drugs. We believe these excluded items have a higher risk potential for fraud, waste and abuse related to reducing or eliminating cost sharing, and this proposed policy aligns with the excluded items in the ACO REACH model. We intend to continue monitoring potential high-risk items and services and may add or remove items and services from this list in future years through notice and comment rulemaking.

While ACOs would have significant flexibility to determine the groups of beneficiaries and items and services for which they intend to reduce or eliminate Part B cost sharing, we propose in § 425.304(e)(4)(iii) that an ACO's Part B cost sharing support must meet one or more of the following clinical goals for each beneficiary:

- Adherence to a treatment regime.
- Adherence to a drug regime.
- Adherence to a follow-up care plan.
- Management of a chronic disease or condition.

This is intended to focus ACO use of cost sharing support on goals that will improve or maintain the overall health of eligible beneficiaries. While ACOs would have substantial flexibility to design their strategy for reducing or eliminating Part B cost sharing, CMS believes it is important that these strategies focus on a clear theory of action for meeting certain clinical goals.

Additionally, we seek comment on whether CMS should make information regarding beneficiaries' supplemental health insurance coverage available to ACOs to assist them with determining beneficiary eligibility for and implementing Part B costs sharing support in accordance with the proposed requirements discussed above. We also seek comment on the specific data elements ACOs would need for this purpose, how frequently such information should be provided and any appropriate limitations or safeguards governing its use.

CMS currently shares certain beneficiary-identifiable data with ACOs under our regulations at 42 CFR part 425, subpart H. We believe the disclosure of this additional information would be consistent with our existing data sharing framework, which is based on HIPAA Privacy Rule provisions governing disclosures for ‘‘health care operations,’’ provided the relevant regulatory conditions are satisfied. Under 45 CFR § 164.506(c)(4), a covered entity may disclose protected health information to another covered entity for the recipient’s health care operations when each entity has or had a relationship with the individual who is the subject of the information, the information pertains to that relationship, and the disclosure is for a health care operations activity described in paragraphs (1) or (2) of the definition of “health care operations” at 45 CFR § 164.501. Those activities include quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs,

and evaluating practitioner or provider performance. CMS would offer only the information reasonably necessary to support implementation of Part B cost-sharing support and would establish appropriate limitations and safeguards governing its use and redisclosure.

We seek comment on whether supplemental coverage information would help enable ACOs to administer Part B cost-sharing support effectively; the particular data elements, level of detail and frequency of updates needed; and whether additional data would be necessary for ACOs to operationalize this flexibility. After consideration of comments on this topic, CMS may finalize policy to share supplemental coverage information with ACOs.

We propose to add § 425.304(e)(4), to establish standards for the implementation of Part B cost sharing support. We seek comments on these proposals.

(c) Part B Cost Sharing Support Arrangements

When an ACO chooses to reduce or eliminate Part B cost sharing, it must partner with ACO participants to implement this reduction or elimination of cost sharing for beneficiaries. In practice, the ACO would reduce or eliminate the cost sharing for an eligible beneficiary in partnership with the ACO participant, which would not collect cost sharing amounts (in whole or in part) from eligible beneficiaries for certain eligible Part B items and services. As this may have significant financial implications for practitioners, ACOs may only establish Part B cost sharing support arrangements with their ACO participants on a voluntary basis, as described below. ACOs must also communicate the relevant implementation information, including how ACO participants will be reimbursed for reduced or waived Part B cost sharing, prior to ACO participants agreeing to participate. In § 425.304(e)(5)(i), we propose that ACOs must have a written agreement with each ACO participant that has agreed to reduce or eliminate Part B cost sharing for eligible beneficiaries under a Part B cost sharing support arrangement with the ACO. The terms of the cost sharing support agreement must specify all of the following:

- The categories of eligible beneficiaries and eligible Part B items and services for which the ACO participant may reduce or eliminate cost sharing.

- A requirement that the ACO participant reduce or eliminate cost sharing in accordance with the ACO's approved implementation plan.

- The amount and frequency with which the ACO will reimburse the ACO participant for the cost sharing amounts not collected.

- A requirement for ACO participants to maintain copies of records that identify each beneficiary who received a reduction or elimination of Part B cost sharing, the type and date of service for which cost sharing support was provided, and the dollar amount of the cost sharing support.

- The ability for the ACO or ACO participant to terminate the Part B cost sharing support agreement if the ACO or ACO participant fails to comply with the requirements of this section.

- A requirement that the ACO or ACO participants will not market to beneficiaries the availability of the Part B cost sharing support as a substitute for their supplemental insurance coverage.

All cost sharing support provided to beneficiaries must be provided in accordance with the ACO's implementation plan and the cost sharing support agreement between the ACO and ACO participant. We propose in § 425.304(e)(5)(ii)(A) and (B) that an ACO participant cannot be required by an ACO to participate in an ACO's Part B cost sharing support arrangement and, alternatively, an ACO can participate in Part B cost sharing support, under an approved implementation plan, even if not all of its ACO participants agree to participate. While we believe reducing or eliminating Part B cost sharing is an important tool to offer ACOs, ACOs should not pressure their ACO participants into providing Part B cost sharing support. ACOs would be required to permit ACO participants to choose whether they wish to participate. CMS expects that some ACO participants would decide not to participate and that ACOs would be able to implement a reduction or elimination of Part B cost sharing for eligible beneficiaries if only a portion of their ACO participants were to opt in.

Additionally, to avoid inappropriate conflicts of interest, we propose in § 425.304(e)(5)(iii) that the ACO would be required to finance all payments made to ACO participants under the cost sharing support agreements from the ACO's own funds. For example, ACOs may not partner with local businesses outside the ACO to fund copay reimbursements to health care providers.

We propose to add § 425.304(e)(5) to establish the standards discussed previously in this section for the cost sharing support agreements ACOs must develop for ACO participants that choose to reduce or eliminate Part B cost sharing. We seek comments on these proposals.

(d) Record Retention

To maintain the ability for CMS to monitor the implementation of the reduction or eliminating Part B cost sharing and resolve any identified compliance issues, we propose to require that ACOs must keep detailed records on the reduction or elimination of Part B cost sharing for beneficiaries. We propose in § 425.304(e)(6)(i) that the ACO must maintain copies of the written cost sharing support agreements with ACO participants, as well as the following records.

- Records that identify each beneficiary who received a reduction or elimination of Part B cost sharing.
- Records that document the type and date of the Part B item or service for which Part B cost sharing was reduced or eliminated.
- Records that document the dollar amount of Part B cost sharing that was reduced or eliminated; and
- Records that document the ACO participant that furnished the item or service for which cost sharing support was reduced or eliminated.

Additionally, we propose at § 425.304(e)(6)(ii) that the ACO must provide the records specified in paragraph (e)(6)(i) upon CMS' request. For example, CMS may request these records if disputes arise that are elevated to CMS or if CMS has any reason to believe there may

be non-compliance with a cost sharing support requirement. We may also conduct periodic audits to ensure compliance with this requirement.

We propose to add § 425.304(e)(6) to establish the standards discussed previously in this section for the record retention related to the reduction or elimination of Part B cost sharing. We seek comments on these proposals.

(e) Addressing Compliance Problems

To protect both beneficiaries and health care providers, CMS proposes in § 425.304(e)(7) that at any time, CMS may suspend or prohibit the ACO or any ACO participant from participating in a Part B cost sharing support arrangement if CMS determines that the ACO or ACO participant has failed to comply with any of the requirements of Part 425. This suspension or prohibition will be effective, in CMS's discretion, regardless of whether the ACO has corrected or otherwise resolved the noncompliance.

We propose to add § 425.304(e)(7) to establish the standards discussed previously in this section for compliance and enforcement policies related to the reduction or elimination of Part B cost sharing. We seek comments on these proposals.

(f) OIG Safe Harbor Authority

We expect to make a determination, if this rule is finalized, that the Federal anti-kickback statute safe harbor for CMS-sponsored model arrangements and CMS-sponsored model patient incentives (§§ 1001.952(ii)(1) and (2) of this title) is available to protect remuneration exchanged under certain financial arrangements and patient incentives that may be permitted under the final rule. Specifically, we expect to determine that the CMS-sponsored models safe harbor would be available to protect the following: remuneration exchanged under Part B cost sharing support arrangements between the ACO and ACO participant and patient incentives in the form of Part B cost sharing support furnished to eligible beneficiaries.

We propose to add new § 425.304(e)(2) that notes that CMS has determined that the Federal anti-kickback statute safe harbor for CMS-sponsored model arrangements and CMS-

sponsored model patient incentives (§§ 1001.952(ii)(1) and (2) of this title) is available to protect remuneration exchanged under Part B cost sharing support arrangements between ACOs and ACO participants, and patient incentives in the form of Part B cost sharing support furnished to eligible beneficiaries under the Shared Savings Program that meet all of the requirements of this section and the anti-kickback statute safe harbor requirements set forth at § 1001.952(ii) of this title.

We seek comments on this proposal to allow ACOs to reduce or eliminate Part B cost sharing beginning in 2027, with a target date of April 1, noting that the application process for this first performance year will occur during early 2027.

b. Proposal to Discontinue Availability of the Option for Prepaid Shared Savings

(1) Background

In the CY 2025 PFS final rule (89 FR 97710), CMS finalized prepaid shared savings, a payment option for ACOs that meet the eligibility criteria under § 425.640 (89 FR 98134). This new payment option provides prepaid shared savings to ACOs with a history of earning shared savings while participating in the Shared Savings Program (89 FR 98134). These payments would be distributed on a quarterly basis and would be recouped from shared savings CMS determines the ACO to have earned during the annual financial reconciliation cycle (89 FR 98134). Prepaid shared savings are the advanced payment of shared savings that are expected to be earned by the ACO and are covered under the Shared Savings Distribution Waiver (89 FR 98134 referencing 80 FR 66726).

In the CY 2025 PFS final rule, certain policies, including both existing policies and new policies adopted in the final rule, relied upon the authority granted in section 1899(i)(3) of the Act to use other payment models that the Secretary determined would improve the quality and efficiency of items and services furnished under the Medicare program, and that would not result in program expenditures greater than those that would result under the statutory payment model (89 FR 98085). This included allowing eligible ACOs to receive prepaid shared savings, as

described in the final rule (89 FR 98085). Such a change to our payment methodology for prepaid shared savings was expected to improve the quality and efficiency of care and was not expected to result in a situation in which the payment methodology resulted in more spending under the program than would have resulted under the statutory payment methodology in section 1899(d) of the Act (89 FR 98085). As described in the Regulatory Impact Analysis in the CY 2025 PFS final rule, the impact of prepaid shared savings alone was projected to be nominal. Both at the mean and at the 90th percentile the projected net impacts on Medicare spending rounded to zero (89 FR 98526). We noted at the time that there was a high degree of uncertainty regarding whether (a) a meaningful number of ACOs would choose this option given the requirements for how prepayments must be spent, and (b) the potential impact (if any) that participation in this option would have on the cost of care (89 FR 98525).

Uptake of this payment option has been very low. Only four ACOs participated in prepaid shared savings in 2026, the first year the payment option was available. This is likely due to a number of factors, many of which were raised by commenters during CY 2025 PFS rulemaking (89 FR 98136).

As part of the prepaid shared savings option under § 425.640(e)(1)(ii), ACOs participating in prepaid shared savings must spend at least 50 percent of prepaid shared savings on direct beneficiary services in each performance year. These include, but are not limited to: cost-sharing support for Part B beneficiaries; certain vision, hearing and dental services; beneficiary meals; nutrition support; tenancy support and sustaining services, housing assistance, utility support, caregiver support services; services to address social isolation, home visits; and transportation services.[319] Under § 425.640(e)(1)(i), ACOs may also elect to spend up to 50 percent of their prepaid shared savings on staffing (for example, hiring physicians or mid-level providers or staff education) and healthcare infrastructure investments (for example,

[319] See Prepaid Shared Savings Guidance, May 2025 Version 1 *https://www.cms.gov/files/document/prepaid-shared-savings-guidance.pdf.*

improving practice management or electronic health record systems) in each performance year. ACOs participating in prepaid shared savings are prohibited from using prepaid shared savings for any expense other than those allowed under § 425.640(e)(1), including but not limited to the following: management company or parent company profit; performance bonuses; provision of medical services covered by Medicare; cash or cash equivalent payments to patients; and items or activities unrelated to ACO management and operations of an ACO or beneficiary care (§ 452.640(e)(2)). In the CY 2025 PFS final rule (89 FR 98141), we stated that the prepaid shared savings policy was developed to improve the quality and efficiency of items and services furnished to Medicare beneficiaries. We explained that the requirement that ACOs spend at least 50 percent of their prepaid shared savings on direct beneficiary services is important for meeting those goals. Direct beneficiary services like vision, hearing and dental, and other services that are evidence-based and medically appropriate for the beneficiary based on clinical risk factors, have the potential to improve beneficiary health outcomes, reduce costs, and improve beneficiary engagement and willingness to receive care from a provider affiliated with an ACO. We believed financially successful ACOs are likely to have already made significant investments in staffing and healthcare infrastructure, as they are necessary for the functioning of an ACO. We also noted the restriction on using prepaid shared savings for expenses like provider bonuses is important for ensuring that prepaid shared savings are used for expenses that directly improve beneficiary care (89 FR 98141).

Additionally, to monitor compliance with ACO use of the prepaid shared savings, CMS requires ACOs to submit an annual spend plan under § 425.640(d) detailing their planned use of prepaid shared savings to CMS as well as publicly report the total amount of prepaid shared savings received, investments made, beneficiary groups served, changes to ACO's spend plan, and an itemization of how prepaid shared savings were spent during the performance year (§ 425.308(b)(10) and § 452.640(i)). In the CY 2025 PFS final rule (89 FR 98138), we noted that we understood that submitting a detailed spend plan on the use of prepaid shared savings

requires administrative work for participating ACOs. However, detailed spend plans which include information on (1) direct beneficiary services that would be provided to ACO beneficiaries; and (2) investments that would be made in the ACO with prepaid shared savings are important for monitoring that ACOs use prepaid shared savings consistent with the requirements for use and management of prepaid shared savings under § 425.640(e) (89 FR 98138). CMS expressed that it was particularly important for us to ensure ACOs use prepaid shared savings consistent with those use and management requirements because prepaid shared savings are advances of shared savings to ACOs prior to ACOs actually earning the shared savings, and should be focused on improving beneficiary outcomes and quality of care, reducing costs, improving ACO efficiency, and improving beneficiary engagement and willingness to receive care from a provider affiliated with an ACO. Those requirements also promote transparency in how ACOs are using prepaid shared savings. That transparency improves the coordination and quality of care provided by participating ACOs by facilitating their efforts to share information with each other, CMS, and the public about how they effectively used prepaid shared savings to improve the quality and efficiency of the care they provided to their beneficiaries (89 FR 98138).

In the CY 2025 PFS final rule (89 FR 98141), commenters noted that the restrictions on use of prepaid shared savings and the amount of documentation required would create significant administrative burden beyond what is already required by the Shared Savings Program. Many commenters asserted that the restrictions on the use of prepaid shared savings are unnecessary and likely to negatively impact ACO participation in prepaid shared savings (89 FR 98141). Most of the commenters disagreed with the requirement that ACOs spend at least 50 percent of prepaid shared savings on direct beneficiary services (89 FR 98141). They also commented that providing written spend plans would generate additional burden for ACOs (89 FR 98138). CMS acknowledged commenter concerns but implemented the policy largely as proposed. CMS subsequently heard similar feedback from ACOs during the first application period for prepaid

shared savings, PY 2026, including that the requirement to spend at least 50 percent of prepaid shared savings on direct beneficiary services is unrealistic as there is a lack of evidence that services identified as "direct beneficiary services" generates sufficient return on investment for ACOs.

We continue to believe that these guardrails on the use and reporting of prepaid shared savings are important for ensuring ACOs direct these funds in a way that improves the quality and efficiency of items and services furnished to Medicare beneficiaries; however, we believe that commenters were also correct that these guardrails significantly limited participation. In CY 2025 PFS final rule (89 FR 98141), CMS anticipated that the restrictions in prepaid shared savings could reduce the number of ACOs that ultimately decide to participate in prepaid shared savings. During the PY 2026 application cycle, 23 ACOs submitted an application for prepaid shared savings and only 4 were ultimately approved to participate. The majority of applicants withdrew from consideration or were denied participation due to deficiencies with their applications. Examples of the deficiencies included submitted spend plans that did not align with the requirement that 50 percent of the funding be spent on direct beneficiary services. We believe the low participation rate reflects the administrative burden and limited financial incentive of the prepaid shared savings option for ACOs. At this time, we believe we can achieve similar outcomes with less burden and less financial risk to CMS through an alternative approach that offers ACOs the ability to reduce or eliminate Part B cost sharing as described in section III.G.6.a. of this proposed rule, as ACOs are already permitted to use their earned shared savings to invest in staffing and healthcare infrastructure.

(2) Proposed Revisions

Based on our experience with the prepaid shared savings option to date, we are proposing to remove the prepaid shared savings option from the Medicare Shared Savings Program.

Although our prior analysis assumed up to 30 ACOs per year might elect the option,[320] actual uptake has been significantly lower with only four ACOs currently participating.

We believe this limited uptake constrains the option's ability to meaningfully advance the goals for which it was established, including improving beneficiary engagement and outcomes and reducing unnecessary expenditures. At the same time, maintaining the option requires CMS to maintain annual application cycles for the prepaid shared savings option, monitor ACO participation under prepaid shared savings, distribute payments, and assume the risk of unpaid debt.

Furthermore, based on early experience with the program with few ACOs opting to participate and feedback from eligible ACOs, we anticipate that participation in the prepaid shared savings option as currently written is likely to remain limited, as we do not believe we can resolve the ACOs' concerns with the payment option while meeting the option's original goals and safeguards. For example, the requirement that ACOs spend at least 50 percent of the funding on direct beneficiary services is necessary for impacting beneficiary health outcomes and reducing costs. Similarly, spend plan requirements are necessary for monitoring and transparency purposes. Removing or substantially weakening these requirements would materially change the purpose and expected effects of the option. Given the very limited participation to date as well as limited anticipated future participation, we do not believe continuing to maintain this option is an effective and efficient use of CMS program resources.

As such, we plan to sunset the prepaid shared savings option over the course of currently participating ACOs' agreement periods.

We propose to revise § 425.640(b) to end ACO eligibility for prepaid shared savings beginning on January 1, 2027. Section 425.640(b)(1)(i) will be revised to read, the ACO is a renewing ACO as defined under § 425.20 entering an agreement period beginning on January 1, 2026 or January 1, 2027. We will accept one final cohort of ACOs during the

[320] 89 FR 98525.

PY 2027 application cycle but will no longer accept applications for this prepaid shared savings payment option after this year. We propose to revise § 425.640(c)(1) to read, "For an ACO renewing to enter into an agreement period beginning on January 1, 2026 or January 1, 2027, to obtain a determination regarding whether the ACO may receive prepaid shared savings, the ACO must submit a complete supplemental application with its application to renew for a new agreement period in the Shared Savings Program (submitted under § 425.224) in the form and manner and by a deadline specified by CMS."

Additionally, we propose to revise § 425.640(f)(1) to no longer distribute prepaid shared savings to ACOs after December 31, 2027. Section 425.640(f)(1)(i) will be revised to state, "An eligible ACO entering an agreement period beginning on January 1, 2026, or January 1, 2027 will receive quarterly prepaid shared savings payments through December 31, 2027, unless the payment is withheld or terminated under paragraph (h) of this section." A similar change will be made to § 425.640(f)(1)(ii), which will be revised to read, "An eligible ACO participating in an agreement period beginning on January 1, 2025, will receive quarterly prepaid shared savings payments starting with the performance year beginning on January 1, 2026, through December 31, 2027, unless the payment is withheld or terminated under paragraph (h) of this section. The ACO will not receive additional or catch-up payments for performance year 2025." Currently participating ACOs who receive payments for 2026 and 2027 will not receive prepaid shared savings payments beginning in 2028. Any ACO who begins participating in 2027 will receive one year of payments in 2027 and will not receive payments beginning in 2028. We intend to provide further information regarding the timing of final quarterly payments through sub-regulatory guidance.

We do not anticipate significant disruption among ACOs participating in the option or their beneficiaries due to 1) the low number of participants, 2) the ample notice we propose giving ACOs to plan for the sunsetting of the prepaid shared savings option and 3) the ability of ACOs to continue to provide any "direct beneficiary services" through their earned shared

savings. With the exception of beneficiary cost sharing support, ACOs are currently permitted to use their earned shared savings to pay for anything that is currently being covered by prepaid shared savings as both funding sources qualify for protection under the Shared Savings Program ACO Final Waivers (80 FR 66726). As discussed in section III.G.6.a. of this proposed rule, CMS is proposing to allow ACOs to offer beneficiary cost sharing support outside of prepaid shared savings in early 2027 so there will be no gap in an ACO's ability to offer beneficiary cost sharing support if they opt to offer it under earned prepaid shared savings.

Those ACOs who participate in the prepaid shared savings participation option in 2026 or 2027 will not see changes to the requirements of the program for the prepaid shared savings they receive. Specifically, ACOs that receive prepaid shared savings in 2026 or 2027 will continue to be able to spend the funding as outlined in § 425.640(e). ACOs will be required to continue to participate in the monitoring and reporting requirements of prepaid shared savings until all prepaid shared savings have been repaid to CMS.

We still believe there is value in encouraging ACOs to engage beneficiaries with strategies and tools designed to support their health and believe there is value in supporting cash flow mechanisms for ACOs. However, the combination of these two goals in prepaid shared savings does not appear viable. We are proposing under § 425.304(e) to allow all eligible ACOs to offer cost sharing support to beneficiaries beginning early 2027 as noted previously in this section. We are interested in feedback on tools ACOs would find valuable for engaging beneficiaries in hopes to expand policies in this area in future years. We are also interested in additional ways to support ACO cash flow and are looking for feedback on this topic as outlined in the Request for Information on primary care capitation in section II.E. of this proposed rule.

We seek comments on the proposal to eliminate the prepaid shared savings option as of January 1, 2028, noting that the last opportunity for a cohort to elect to participate in the option will be for PY 2027.

7. Proposal to Modify the Methodology and Use Description for Advance Investment Payments

(a) Background

In the CY 2023 PFS final rule (87 FR 69782 through 87 FR 69805), we finalized the availability of the advance investment payment option, beginning on January 1, 2024. Advance investment payments are available to eligible low revenue ACOs inexperienced with performance-based risk Medicare ACO initiatives and that are new to the Shared Savings Program. These ACOs may receive an up-front, one-time fixed payment of $250,000 and per beneficiary quarterly payments for the first two performance years of their agreement period. Eligible ACOs that apply for and receive advance investment payments receive payments determined under the methodology described in § 425.630(f)(2). Furthermore, ACOs' use of advance investment payments is subject to the requirements set forth in § 425.630(e). ACOs are permitted to use the advanced investment payments to invest in increased staffing, healthcare infrastructure, and the provision of accountable care for underserved beneficiaries. Advance investment payments are intended to reduce upfront costs that prevent providers and suppliers from forming ACOs, caring for beneficiaries in underserved communities, and achieving long-term success in the Shared Savings Program. For more information about the history and development of the advance investment payment option and goals for the program, refer to the CY 2023 PFS final rule (87 FR 69782 through 87 FR 69805).

(1) Area Deprivation Index

In the CY 2023 PFS final rule (87 FR 69792 through 69800), we finalized that the amount of advance investment payments that eligible ACOs can receive over the two years of quarterly payments was based on assigned beneficiaries' area deprivation index (ADI) score, Medicare Part D Low Income Subsidy (LIS) status, and dual eligibility for Medicare and Medicaid. The maximum amount was finalized as $45 per eligible beneficiary per quarter and there was a 10,000-beneficiary cap for the calculation of quarterly payments. LIS/dual eligibility

grants an ACO the maximum $45 per eligible beneficiary, whereas ADI scores provide a range of payment amounts for beneficiaries without LIS/dual eligibility.

The quarterly advance investment payment calculation methodology finalized in the CY 2023 PFS final rule (87 FR 69792 through 69800) results in an increase in payments when more beneficiaries who are LIS/dually eligible or who live in areas with high deprivation (measured by ADI), or both, are assigned to the ACO. Regarding ADI, the risk factors-based score was set to the ADI national percentile rank of the census block group in which the beneficiary resides, and higher risk factors-based scores resulted in ACOs receiving higher payment amounts for assigned beneficiaries (87 FR 69794 and 69795). ADI scores range in payment amounts from $0 for those with a risk factors-based score between 1 and 24 to the maximum $45 for those with a risk factors-based score between 85 and 100 (§ 425.630(f)(2)(iii)). The quarterly payments intend to compensate for variable ongoing operating costs that are related to the provision of care for the ACO's assigned beneficiaries.

We stated in the CY 2023 PFS final rule (87 FR 69793 and 69794) that we believed using ADI was a method for indicating beneficiaries with high needs, specifically to capture local socioeconomic factors correlated with medical disparities and underservice. We stated that the inclusion of ADI as a criterion for quarterly advance investment payments furthered CMS's goal to reduce financial barriers for new, low revenue, and inexperienced ACOs. Since the option became available January 1, 2024, we have reviewed the characteristics of ACOs electing to participate in the advance investment payment option and how ADI as well as LIS/dual eligibility are impacting ACOs' quarterly advance investment payments.

(2) Advance Investment Payment Program Post-Implementation

In PY 2024, 19 newly formed ACOs in the Shared Savings Program were participating in the new advance investment payment option, receiving more than $25.7 million in advance investment payments in their first performance year.[321] Analysis of ACOs receiving advance

[321] Counts based on internal analysis of ACOs participating in the Advance Investment Payment option in PY 2024.

investment payments show that the payment option is encouraging ACOs to form in areas where ACOs may not have otherwise formed and where other Medicare payment and delivery innovations were less likely to be present. In its first year of implementation, the advance investment payment option appeared to attract new ACOs in these communities. Compared to non-advance investment payment ACO starters in 2024, the advance investment payment ACOs were caring for more beneficiaries residing in a health provider shortage area (51.2 percent versus 34 percent) and residing in a rural location (42.1 percent versus 27.0 percent).[322] Our analysis of the advance investment payments made in PYs 2025 and 2026 also investigated which beneficiary characteristics were impacting the quarterly payment amount received by ACOs receiving advance interest payments. This analysis showed that the average share of quarterly payments attributed to ADI beneficiaries, as opposed to LIS/dual eligible beneficiaries, fluctuated by 13 percentage points between PY 2025 and PY 2026.[323]

After publication of the CY 2023 PFS final rule for the advance investment payment option, we were made aware of concerns with the lack of standardization of ADI: Scores were heavily influenced by the median home value indicator, which is one out of the 17 indicators included in the calculation of ADI.[4] The 17 indicators are combined directly and, as such, the median home value indicator, which a combination of being in large dollar units and having large variance, impacts ADI scores more than other indicators, in particular, the percent-based indicators (for example, percent living in poverty). Cost-of-living when primarily captured by a region's median home value is incomplete and not perfectly aligned with area deprivation, as current research testing ADI indicates. For example, analyses have shown that many regions with high median home values were flagged as low deprivation based on their ADI scores, but these areas were experiencing deprivation when looking at other ADI variables such as poverty

[322] Counts based on internal analysis of ACOs participating in the Advance Investment Payment model in PY 2024.
[323] Counts based on internal analysis of ACOs participating in the Advance Investment Payment model in PYs 2025 and 2026.

and unemployment rates.[324,325] We do not believe it is appropriate to continue using an indicator that is not meeting its stated goals of identifying area deprivation, and propose to revise the advance investment payment methodology to simplify and refocus on the intended outcome of reducing upfront costs that prevent providers and suppliers from forming ACOs, caring for beneficiaries in underserved communities, and achieving long-term success in the Shared Savings Program.

(b) Proposed Revisions

(1) Proposed Removal of the Area Deprivation Index from the Advance Investment Payment Methodology

We propose to remove ADI from the advance investment payments methodology at § 425.630(f)(2). Our proposal to remove ADI from the quarterly payment amount methodology and remove the risk factors-based score (as described below in section III.G.7.2.b) necessitates adjustments to § 425.630(f)(2)(ii) and is intended to better meet the objectives of the advance investment payment option policy.

(2) Proposed Addition of the Rural Criterion to the Advance Investment Payment Methodology

While we are proposing to remove ADI, we want to continue to encourage low-revenue ACOs that are inexperienced with risk to participate in the Shared Savings Program, including rural ACOs as noted previously in this section. Rural ACOs are currently underrepresented in the Shared Savings Program, with only 14.5 percent of TINs participating in Shared Savings Program ACOs located in rural areas in comparison to 20 percent of non-Shared Savings Program TINs.[326] This analysis of FY 2024 assigned beneficiaries, provided in section III.G.7.1.b. of this proposed rule, highlights a smaller proportion of these beneficiaries

---

[324] Edward L. Hannan, Yifeng Wu, Kimberly Cozzens, and Brett Anderson, Health Affairs 2023. Available at *https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2022.01406.*

[325] Alexander M, Azar K, Smits K, Tio A, deGhetaldi L. Health Affairs Forefront. February 2023. ACO Benchmarks Based On Area Deprivation Index Mask Inequities. Available at *https://www.healthaffairs.org/content/forefront/aco-benchmarks-based-area-deprivation-index-mask-inequities.*

[326] Counts based on internal analysis of ACOs participating in the Shared Savings Program in PY 2026.

live in rural communities. We propose adding a rural component to the payment amount calculation for determining quarterly advance investment payments and believe this addition, in conjunction with the current components targeting beneficiaries enrolled in the Medicare Part D LIS or dually eligible for Medicare and Medicaid, will contribute to the advance investment payment option's increasing ACO's population health management capabilities, including the provision of accountable care for underserved beneficiaries, while simplifying the calculation (87 FR 69788). This also aligns with work CMS is carrying out through the Rural Health Transformation Program that was authorized by section 71401 of the Working Families Tax Cut legislation (Pub. L. 119-21, July 4, 2025).

Through the Rural Health Transformation Program, CMS is working to strengthen rural communities across America by improving healthcare access, quality, and outcomes by transforming healthcare delivery. Encouraging ACO formation in rural areas directly supports these goals.[327] Primary residence in rural areas can be associated with barriers to accessing care, including geographic isolation, provider shortages, transportation challenges, limited broadband or technology infrastructure, and fewer locally available health care resources. We had hoped to address some of these access-related challenges through the inclusion of ADI in the advance investment payments methodology. However, rural residence captures a distinct set of geographic and infrastructure-related barriers.

Our internal analysis of ACO beneficiaries indicates there is limited overlap between LIS/duals eligibility and beneficiaries living in a rural area. As a result, adding a rural residence component would allow the methodology to better identify and direct the maximum quarterly payment amount to additional underserved beneficiaries who may face access-related barriers that are not otherwise captured by LIS/dual eligibility status.

[327] CMS Rural Health Transformation (RHT) Program. 2026 Available at *https://www.cms.gov/priorities/rural-health-transformation-rht-program/overview*.

As noted, we believe rurality is an appropriate geographic proxy for access-related challenges, including differences in health care infrastructure and workforce availability. These factors may affect an ACO's ability to form, participate, and succeed in rural areas and therefore ACOs therefore may need a higher amount of advance investment payments to consider participating. We seek to encourage formation of ACOs in areas experiencing medical disparities and underservice, and have recognized through internal analysis of assigned beneficiary characteristics that the LIS/dual eligibility statuses do not fully capture rural beneficiaries. Therefore, we propose introducing a rural component to the advance investment payments methodology.

To calculate the advance investment payment for an eligible ACO based on the number of their rural assigned beneficiaries, we propose establishing a beneficiary's rural residence from their latest mailing address in the CMS data systems at the time of determining advance investment payments. Furthermore, we propose using the most recently available version of the United States Census Bureau Delineation File to determine whether a beneficiary resides in a rural county.[328] The Office of Management and Budget (OMB) makes the delineation file publicly available on the Census.gov website. OMB provides the delineation file and other reference files as a reliable standard for academic research and public policy development. The delineation file defines an area as micropolitan or metropolitan as having a population of 10,000 to 50,000 individuals or a population greater than 50,000 individuals, respectively. Areas where the population is less than 10,000 are considered noncore. Noncore areas are defined by identifying Federal Information Processing Standards State and County codes that are not included in the delineation file. OMB does not characterize counties as rural or urban, and we propose to use the Federal Office of Rural Health Policy (FORHP), in the Health Resources and Services Administration, interpretation of these county designations, which considers all non-

[328] Refer *to https://www.census.gov/geographies/reference-files/time-series/demo/metro-micro/delineation-files.html.*

metro counties as rural.[329] We propose that beneficiaries will be considered to be residing in a rural county for the purposes of the advance investment quarterly payment calculation, if they are non-metro, that is residing in a micropolitan or noncore area. As of July 2023, 13.8 percent of the U.S. population is living in the micropolitan or noncore areas.[330]

For the purpose of implementing changes to the advance investment payments, the use of county level data would allow for timelier implementation and sharing of data with ACOs since the delineation file is readily available and already used by CMS for internal analyses of ACOs by region. Counties are also well understood by providers and stable over time, which reduces complexity and burden for ACOs working to understand the methodology. We believe that this rural definition, in combination with the maximum payments based on beneficiary LIS/dual eligibility status, will support ACOs in caring for beneficiaries in underserved communities.

(3) Proposed Amount for All Beneficiaries to the Advance Investment Payment Methodology

We intend for these changes to the advance investment payments methodology to encourage the formation of new ACOs in underserved communities and describe the proposed rural criteria for determining advance investment payments above. However, as we stated in the CY 2023 PFS final rule (87 FR 69785), we do not believe in limiting advance investment payment option eligibility only to ACOs serving rural areas or areas with a high proportion of beneficiaries dually eligible for Medicaid and Medicare or Part D LIS is in line with the policy's goals. We recognize that there are beneficiaries who reside in other areas who could also benefit from the high-quality coordinated care an ACO provides. With the removal of ADI and its tiered scoring structure using risk factors-based scores, we propose an alternative payment methodology that also accounts for non-rural beneficiaries who are not LIS/dually eligible and whose assignment may have resulted in some payment under the current advance investment

[329] Health Resources and Services Administration. How we Define Rural. Available at *https://www.hrsa.gov/rural-health/about-us/what-is-rural.*

[330] US Census Bureau. Metropolitan and Micropolitan. Available at *https://www.census.gov/programs-surveys/metro-micro.html.*

payments methodology. Our experience implementing the advance investment payment option over the last few years leads us to believe ACO participation in the payment option could be more attractive with the addition of a lower flat payment amount for all beneficiaries assigned to the ACO, up to the 10,000 beneficiaries cap. Therefore, we propose that all non-rural beneficiaries who are not LIS/dually eligible beneficiaries would result in ACOs receiving a flat rate of $25 per beneficiary as part of setting each ACO's quarterly payments.

We anticipate that the proposed change to remove ADI and add rurality as well as a payment amount for all beneficiaries not identified as LIS/dual eligible or rural will provide similar aggregate quarterly payment amounts to new advance investment payment option participants and, in keeping in line with the intent of the advance investment payment option, any new methodology developed should encourage ACOs serving populations that need financial support to begin participation in value-based care. We conducted an analysis that compared the quarterly advance investment payments for PY 2024 using the existing methodology utilizing ADI and the proposed methodology using a rural component. Results indicated that, compared to the current methodology, the proposed methodology will provide the vast majority (89.5 percent) of advance investment payment ACOs with slightly higher payments (totaling about $889,000 more per quarter or $3.6 million more per year distributed among all ACOs), which align with payment goals outlined previously in this section.[331] While we believe these proposed policy adjustments will increase support for ACO formation in rural areas, this analysis demonstrates that our proposed policies maintain support for ACOs regardless of location.

Section 1899(i)(3)(A) of the Act requires CMS to determine that advance investment payments would improve the quality and efficiency of items furnished to Medicare to make such payments. We believe that the updated methodology will meet this standard and improve our ability to target the populations that CMS seeks to support. Section 1899(i)(3)(B) of the Act

[331] Based on internal analysis of ACOs participating in the Advance Investment Payment model in PY 2024.

requires CMS to determine that advance investment payments, when implemented in combination with existing modifications made to the Shared Savings Program specified in section 1899(d) of the Act, will not result in additional program expenditures. In evaluation of current program performance, the structure of advance investment payment program is successful in not increasing program expenditures, and the changes to the methodology will not affect this outcome as the overarching structure the advance investment payment option remains the same. In accordance with section 1899(i)(3) of the Act authorizing the use of alternative payment models, we propose to update the steps at § 425.630(f)(2) to allow ACOs participating in the advance investment payment option will receive a maximum payment of $45 if the assigned beneficiary is enrolled in the Medicare Part D LIS or is dually eligible for Medicare and Medicaid or is residing in a Micropolitan or "Noncore" Census Status (henceforth "rural"). Additionally, for beneficiaries outside of these categories, ACOs will receive a flat rate of $25 per beneficiary as part of setting each ACOs quarterly payments.

(4) Implementation Timeline for Revisions to the Advance Investment Payments Methodology

We propose that changes to remove ADI and to add rurality to the quarterly payment methodology would be implemented for ACOs who apply for the advance investment payment option with an effective date of January 1, 2028, as well as for the second year of payments for ACOs who began receiving advance investment payments in 2027. This timeline allows ACOs planning to apply to the Shared Savings Program to understand the proposed methodology for the advance investment payment option prior to applying to the program in the summer of 2027.We believe that as the vast majority of the ACOs will receive slightly higher payments under the new methodology, it is a more efficient use of agency resources to move to using the updated methodology for all ACOs at the same time, instead of running two separate methodologies simultaneously.

We seek public comment on the proposed timeline for implementing changes to the advance investment payments methodology effective January 1, 2028. Specifically, we are seeking public comment on the following proposed revisions to the regulation text at § 425.630:

- At paragraph (f)(2)(ii) add the introductory phrase “For performance years 2023 through 2027.”
- At paragraph (f)(2)(iii), we propose to specify how CMS determines the amount each assigned beneficiary adds to an ACOs quarterly payment amount. At new paragraph (f)(2)(iii)(A), we describe the existing requirements on how we determine the payment amount that corresponds to the beneficiary's risk factors-based score, and related table, which we propose to specify would be applicable for PYs 2023 through 2027. In new paragraph (f)(2)(iii)(B), we are proposing to specify how we would determine the quarterly payment amount for PY 2028 and subsequent PYs. For each beneficiary in the assigned population identified in paragraph (f)(2)(i) of this section, CMS determines the quarterly payment amount for two categories of beneficiaries. First, an ACO will receive a quarterly payment of $45 for each beneficiary that meets any of the following criteria:
  - Is enrolled in the LIS.
  - Is dually eligible for Medicare and Medicaid.
  - Is residing in a county with rural census status (as defined at § 425.20). CMS determines the county of residence for the beneficiary based on the beneficiary’s mailing address.

Then, an ACO will receive a quarterly payment of $25 for each beneficiary who does not meet any of the criteria listed in paragraph (f)(2)(iii)(B)(1) of this section.

At paragraph (f)(2)(iv), we propose to specify how CMS calculates an ACO’s quarterly payment amount. In new paragraph (f)(2)(iv)(A), we describe the existing process that the quarterly payment amount is the sum of the beneficiary payment amounts corresponding to each assigned beneficiary's risk factors-based score, capped at 10,000 beneficiaries, which we propose

to specify would be applicable for PYs 2023 through 2027. In new paragraph (f)(2)(iv)(B), we are proposing a new methodology for PY 2028 and subsequent PYs. We propose that the ACO's quarterly payment amount will be the sum of the beneficiary payment amounts corresponding to the quarterly payments specified in paragraph (f)(2)(iii)(B) of this section. If the ACO has more than 10,000 assigned beneficiaries according to paragraph (f)(2)(i) of this section, we will calculate the quarterly payment amount based on the 10,000 assigned beneficiaries with the highest quarterly payment determined according to paragraph (f)(2)(iii)(B) of this section.

We are also seeking public comment on the proposed revisions to the regulation text at § 425.20:

Add new definition for the term "Rural County Status" to mean beneficiary residence in a mailing address with United States county status of Micropolitan (population of 10,000 to 50,000 individuals) or Noncore (population less than 10,000 individuals) per the Federal Office of Rural Health Policy (FORHP) county designation using the most recently available version of the United States Census Bureau Delineation File.

(5) Proposed Revisions to the Terminology of Allowable Uses

At § 425.630(e)(1), we state that an ACO must use an advance investment payment to improve the quality and efficiency of items and services furnished to beneficiaries by investing in increased staffing, health care infrastructure, and the provision of accountable care for underserved beneficiaries, which may include addressing social determinants of health. We believe that the term "social determinants of health" is not as precise as we would prefer, and propose to replace the term with "upstream drivers of health." Specifically, while the terms are similar in describing non-medical factors that can shape beneficiaries' health, "upstream drivers of health" more clearly describes the focus on the upstream or root causes of health outcomes. This framing does not change the types of investments that advance investment payments can be spent on, but instead more clearly identifies these investments, which include, but are not limited to, transportation, utilities and housing-related assistance, as well as services to encourage

improved fitness and nutrition and promote a healthy environment. Specifically, we propose to revise § 425.630(e)(1) to read: "Allowable uses. An ACO must use an advance investment payment to improve the quality and efficiency of items and services furnished to beneficiaries by investing in increased staffing, health care infrastructure, and the provision of accountable care for underserved beneficiaries, which may include addressing upstream drivers of health. Expenditures of advance investment payments must comply with the beneficiary incentive provision at § 425.304, paragraph (e)(2) of this section, and all other applicable laws and regulations." We seek comments on this proposal.

8. Identifying ACOs Experienced with Performance-Based Risk Medicare ACO Initiatives

a. Background

In the December 31, 2018 Shared Savings Program final rule (83 FR 67816), referred to as the Pathways to Success, CMS finalized the definition of the term, "performance-based risk Medicare ACO initiative," to mean an initiative implemented by CMS that requires an ACO to participate under a two-sided model during its agreement period (83 FR 67904). This includes Levels C, D and E of the BASIC track, and the ENHANCED track of the Shared Savings Program. This definition also includes other Medicare ACO initiatives involving two-sided risk, such as two-sided risk CMS Innovation Center ACO Models, as may be specified by CMS (83 FR 67904).

In the December 2018 final rule, we explained that the risk experience of ACOs and their ACO participants in Medicare ACO initiatives is considered in determining which agreement track (BASIC or ENHANCED) the ACO is eligible to enter as well as the applicability of policies that phase in over time, namely the equal weighting of benchmark year expenditures, the policy of adjusting the benchmark based on regional FFS expenditures, and the phase-in of pay-for-performance under the program's quality performance standards (83 FR 67904–67907). As a factor in determining an ACO's participation options, we established requirements for evaluating whether an ACO is inexperienced with performance-based risk Medicare ACO initiatives such

that the ACO would be eligible to enter into an agreement period under the BASIC track's glide path or whether the ACO is experienced with performance-based risk Medicare ACO initiatives and therefore limited to participating under the higher-risk tracks of the Shared Savings Program (either an agreement period under the maximum level of risk and potential reward for Level E of the BASIC track or the ENHANCED track) (83 FR 67894).

We later identified a policy refinement around identifying ACOs experienced with risk based on an ACO Participant TIN's prior participation in the CY 2024 PFS final rule published on November 16, 2023, adding that "an ACO participant is considered to have participated in a performance-based risk Medicare ACO initiative if the ACO participant TIN was or will be included in financial reconciliation for one or more performance years under such initiative during any of the 5 most recent performance years," to the definitions of "experienced with performance-based risk Medicare ACO initiatives" and "inexperienced with performance-based risk Medicare ACO initiatives" under § 425.20 (88 FR 79219 through 79220; 79543 through 79544). This was not a policy change, but an attempt to more clearly communicate ongoing operational policy.

Accordingly, as codified under § 425.20, we defined "experienced with performance-based risk Medicare ACO initiatives" to mean an ACO that CMS determines meets either of the following criteria:

(1) The ACO is the same legal entity as a current or previous ACO that is participating in, or has participated in, a performance-based risk Medicare ACO initiative as defined under this section, or that deferred its entry into a second Shared Savings Program agreement period under a two-sided model under § 425.200(e).

(2) Forty percent or more of the ACO's ACO participants participated in a performance-based risk Medicare ACO initiative, or in an ACO that deferred its entry into a second Shared Savings Program agreement period under a two-sided model under § 425.200(e), in any of the 5 most recent performance years. An ACO participant is considered to have participated in a

performance-based risk Medicare ACO initiative if the ACO participant TIN was or will be included in financial reconciliation for one or more performance years under such initiative during any of the 5 most recent performance years.

We defined “inexperienced with performance-based risk Medicare ACO initiatives” to mean an ACO that CMS determines meets both of the following criteria:

(1) The ACO is a legal entity that has not participated in any performance-based risk Medicare ACO initiative as defined under this section, and has not deferred its entry into a second Shared Savings Program agreement period under a two-sided model under § 425.200(e).

(2) Less than 40 percent of the ACO's ACO participants participated in a performance-based risk Medicare ACO initiative, or in an ACO that deferred its entry into a second Shared Savings Program agreement period under a two-sided model under § 425.200(e), in each of the 5 most recent performance years. An ACO participant is considered to have participated in a performance-based risk Medicare ACO initiative if the ACO participant TIN was or will be included in financial reconciliation for one or more performance years under such initiative during any of the 5 most recent performance years.

The established definitions of “experienced with performance-based risk initiatives” and “inexperienced with performance-based risk Medicare ACO initiatives” are intended to support both determinations of participation options and the phase-in of requirements over time by considering ACOs’ prior participation in the program (83 FR 67906).

Under § 425.20, the second prong of the “experienced with performance-based risk initiatives” definition relies on whether 40 percent or more of the ACO’s ACO participants participated in a performance-based risk Medicare ACO initiative in any of the 5 most recent performance years. For this purpose, an ACO participant is treated as having participated when the ACO participant TIN “was or will be included in financial reconciliation” for one or more performance years under a qualifying two-sided initiative during the 5-year lookback. This means the “experience” determination is sensitive to the ACO’s participant composition at the

TIN level. If an ACO's participant list includes a substantial number of TINs that were recently reconciled under two-sided risk (for example, under a prior ENHANCED track or another qualifying CMS initiative), those TINs count toward the 40 percent threshold. Conversely, if an ACO's participant TINs lack such recent two-sided reconciliation history, the ACO may be treated as inexperienced for purposes of participation options.

Consistent with our TIN-based approach to evaluating prior participation, these policies rely on the financial reconciliation history associated with specific billing TINs. These policies were intended to capture TINs that at least partially participated in a performance-based risk initiative, as TINs that participate in a full or partial year are generally still included in financial reconciliation. However, we have identified a category of TINs that are included in financial reconciliation for performance based-risk initiatives, but that do not have a written agreement to participate in the performance-based risk ACO initiative and thus are ineligible for the benefits of being in an ACO (such as shared savings). In ACO REACH, and other CMS Innovation Center ACO Models, a "Legacy TIN or CCN" means a TIN or CCN that a Participant Provider or Preferred Provider previously used for billing Medicare Parts A and B services but no longer uses to bill for those services, and includes a "sunsetted" Legacy TIN or CCN (a TIN or CCN that is no longer used for billing for Medicare Parts A and B services by any Medicare-enrolled provider or supplier) or an "active" Legacy TIN or CCN (a TIN or CCN that may be in use by a Medicare-enrolled provider or supplier that is not a Participant Provider or Preferred Provider).[332] The purpose of Legacy TINs or CCNs is to allow a provider/supplier who used to practice under an old TIN, but has begun practicing under a new TIN, to use the historical claims information to help establish an ACO's benchmark. Legacy TINs or CCNs are not considered to be "Participant Providers" in ACO REACH, as they do not have a written agreement to

[332] *ACO REACH Model Third Amended and Restated Participation Agreement.* Refer to page 12 under Article II Definitions for the definition of "Legacy TIN or CCN".

participate in the performance-based risk ACO initiative.[333] These TINs or CCNs do not receive any benefits of ACO participation, including ACO financial arrangements or use of model waivers and are not required to comply with ACO policies. Their claims history is solely used for financial reconciliation for the ACO.

However, given the current definitions of "Experienced with performance-based risk Medicare ACO initiatives" and "Inexperienced with performance-based risk Medicare ACO initiatives," Legacy TINs or CCNs are currently included in the calculation of whether 40 percent of ACO participants have prior experience with a performance-based risk Medicare ACO initiative, as they are included in financial reconciliation for the ACO REACH model ACO. The current or prior presence of a Legacy TIN or CCN on an ACO REACH model ACO's Participant Provider List can determine whether an ACO applying to the Shared Savings Program is eligible for entry into the BASIC track glide path or is instead limited to BASIC track Level E (if low revenue) or the ENHANCED track. CMS did not anticipate the interaction between the use of Legacy TINs in CMS Innovation Center ACO models and the definitions of experienced and inexperienced with performance-based Medicare ACO initiatives when these policies were developed. We identified this interaction when it impacted a few ACOs applying to the Shared Savings Program in recent years, limiting the participation options available to the ACOs.

We believe that the inclusion of Legacy TINs and CCNs in the definitions of experienced or inexperienced with performance-based risk is overly broad and not in line with the original goals of the definition, and we propose to amend the current regulation to exclude such TINs and CCNs from the calculation.

b. Proposed Revisions

Under the existing regulations codified in the December 2018 final rule, the definition of

---

[333] *ACO REACH Model PY 2026 Participant and Preferred Provider Management Guide*: *https://www.cms.gov/files/document/aco-reach-py26-part-pref-provider-mgmt-guide.pdf.*

an ACO experienced or inexperienced with performance-based risk Medicare ACO initiatives includes consideration of ACO participant TINs in determining whether an ACO has prior experience under performance-based risk. Specifically, an ACO participant TIN is considered to have such experience if it was or will be included in the financial reconciliation of a Medicare ACO for any of the 5 most recent performance years under a qualifying two-sided model (83 FR 67895). For purposes of this determination, an ACO participant is treated as having participated in a performance-based risk initiative when its TIN was or will be included in financial reconciliation for one or more performance years during the applicable 5-year lookback period (83 FR 67895; § 425.20). As a result, the determination of whether an ACO is experienced or inexperienced with performance-based risk can depend on the composition of the ACO participant list at the TIN level.

To ensure TINs that have only been used as Legacy TINs or CCNs in CMS Innovation Center models would not be considered as experienced with risk, we are proposing to exclude ACO participant TINs that did not have a written agreement to participate in a performance-based risk Medicare ACO initiative from our consideration of whether the ACO participant TIN participated in a performance-based risk Medicare ACO initiative. This consideration ultimately impacts an ACO's designation as experienced or inexperienced with performance-based risk within the Shared Savings Program. Because determining an ACO's experience with performance-based risk is based on the experience of the ACO participant TIN, we propose to modify the regulations at § 425.20 to exclude Legacy TINs or CCNs from the definition of "experienced with performance-based risk Medicare ACO initiatives" and "inexperienced with performance-based risk Medicare ACO initiatives." As future CMS Innovation Center models may not use the term "Legacy TIN or CCN" to identify these TINs or CCNs, we propose to exclude these and similarly situated ACO participant TINs and CCNs by excluding those that did not have a written agreement to participate with the performance-based risk Medicare ACO.

We propose revising the definition of experienced with performance-based risk Medicare

ACO initiatives under § 425.20 by adding to paragraph (2), ", unless the ACO participant TIN did not have a written agreement to participate in the performance-based risk Medicare ACO initiative." Similarly, we propose revising the definition of inexperienced with performance-based risk Medicare ACO initiatives under § 425.20 by adding to paragraph (2), ", unless the ACO participant TIN did not have a written agreement to participate in the performance-based risk Medicare ACO initiative."

These proposed additions would permit CMS to exclude Legacy TINs or CCNs from this calculation.

We propose that these modifications would be effective and applicable on January 1, 2027. Considering when the CY PFS final rule will be issued, and the Shared Savings Program application cycle for the January 1, 2027 start date (occurring in CY 2026), ACO applicants would have notice of this proposed change after the deadline for submitting their applications to participate in the Shared Savings Program. Additionally, under a previously established timeline for application actions and deadlines, the application cycle would require CMS deem an applicant ACO experienced with performance-based risk in October 2026,[334] which is before the CY 2027 PFS final rule is issued.

To mitigate the potential impact on ACO applicants, following issuance of the CY 2027 PFS final rule, we would communicate to ACOs their status as an ACO experienced or inexperienced with performance-based risk if these changes are finalized. We are committed to accurately identifying ACOs' experience with performance-based risk and providing them the opportunity to select their track/level of participation should we finalize these changes to these definitions in the CY 2027 PFS final rule. We believe it would be appropriate to accommodate this modification during the application cycle for the January 1, 2027 start date (occurring in CY 2026) to apply the most accurate definition for determining experience with performance-

[334] Medicare Shared Savings Program, Key Application Actions and Deadlines For Agreement Periods Beginning on January 1, 2027, available at https://www.cms.gov/files/document/key-application-actions-deadlines.pdf.

based risk based upon the outcome of the final rule and the potential for the inclusion of a legacy TIN on an applicant ACO's ACO participant list.

We seek comment on this proposal.

9. Beneficiary Notification Requirements

a. Background

The November 2011 final rule established requirements at § 425.312 for how a Shared Savings Program ACO must notify Medicare FFS beneficiaries receiving primary care services at the point of care that the physician, hospital or other provider is participating in a Shared Savings Program ACO (76 FR 67945 through 67946). Since then, the regulations at § 425.312 have been updated through subsequent rulemaking. Presently, under § 425.312(a)(1), an ACO is required to ensure that Medicare FFS beneficiaries are notified of the following: (i) each ACO participant and its ACO providers/suppliers are participating in the Shared Savings Program; (ii) the beneficiary's opportunity to decline claims data sharing; and (iii) the ability to, and process by which, the beneficiary may identify or change identification of a primary care provider for purposes of voluntary alignment.[335]

Section 425.312(a)(2) sets forth the manners in which ACOs or ACO participants are required to notify beneficiaries of this information. ACO participants must post signs in their facilities and, in settings in which beneficiaries receive primary care services, make standardized written notices available upon request (§ 425.312(a)(2)(i) and (ii)). In addition, ACOs must furnish standardized written notices to certain beneficiaries, with the timing depending on the ACO's assignment methodology. For ACOs that have selected preliminary prospective assignment with retrospective reconciliation, the ACO or ACO participant must provide each FFS beneficiary who received at least one primary care service from certain ACO professionals in the ACO during the assignment window (or expanded window) with a standardized written

---

[335] *See generally* Shared Savings Program Guidance & Specifications, Beneficiary Information section, *https://www.cms.gov/medicare/payment/fee-for-service-providers/shared-savings-program-ssp-acos/guidance-regulations#Beneficiary_Information.*

notice at least once per agreement period. The ACO or ACO participant must provide this notice prior to or at the first primary care visit of the performance year (§ 425.312(a)(2)(iii)). For ACOs that have selected prospective assignment, the ACO or ACO participant must provide the standardized written notice to each prospectively assigned beneficiary at least once per agreement period, during the performance year for which the beneficiary is prospectively assigned to the ACO (§ 425.312(a)(2)(iv)). Additionally, in the CY 2023 PFS final rule (87 FR 69404), we finalized that the ACO or ACO participant must provide a verbal or written follow-up communication to the beneficiary no later than 180 days from the date the standardized written notice was provided and maintain record of such notice (§ 425.312(a)(2)(v)).

Over the years, the Shared Savings Program has received ongoing feedback that these beneficiary communication requirements can be operationally burdensome and may confuse beneficiaries, including causing some beneficiaries to believe they are being targeted by a fraudulent actor or have been enrolled in a managed care plan,[336] which ACOs then must work to address. Interested parties have identified that the beneficiary notice requirements implemented in some CMS Innovation Center models may be less burdensome for ACOs to implement. For example, under the ACO REACH model, ACOs must distribute beneficiary information notices by CMS-specified dates, including for beneficiaries aligned to the ACO at the start of the performance year and for beneficiaries who become aligned during the performance year.[337] Specifically, ACOs that participate in the ACO REACH model are required to distribute a beneficiary information notice by May 30 for beneficiaries who start the year aligned to the ACO and remain aligned by April 1.[338] By contrast, under the Shared Savings Program, ACOs that

[336] Reimagining Beneficiary Engagement in Accountable Care Models, A Resource Published by HCTTF and NAACOS. *https://hcttf.org/wp-content/uploads/2026/03/HCTTF-NAACOS-2026-Resource-1.pdf*.
[337] ACO REACH Model Third Amended and Restated Participation Agreement (2023 Starters), Section 5.05 Beneficiary Notifications, Centers for Medicare & Medicaid Services, Center for Medicare and Medicaid Innovation, Last Modified: December 5, 2025.
[338] ACO REACH Model PY2025 Beneficiary Notification Process p. 2, Centers for Medicare & Medicaid Services, Center for Medicare and Medicaid Innovation.

have selected preliminary prospective assignment with retrospective reconciliation must provide the beneficiary information notice either at or before a beneficiary's first primary care visit. Additionally, while ACOs that have selected prospective assignment are required to provide the standardized written notice in the form and manner set by CMS, we have historically required them to align with the same timing of at or before the beneficiary's first primary care visit.

We believe that fixed deadlines would allow ACOs to better prepare for the distribution of the beneficiary notice, as they would have several months after the start of the year to organize their staff and resources, whereas the Shared Savings Program requirement tied to a beneficiary's first primary care visit, which could occur as early as the very beginning of the performance year, requires the ACO to be prepared to distribute the notice immediately at the start of the performance year.

b. Proposed Revisions

(1) Proposal To Revise Distribution Timing of Standardized Written Notices

We continue to believe that requiring ACOs to provide periodic beneficiary notifications affords ACOs and ACO participants an opportunity for direct engagement with beneficiaries, thereby serving to strengthen the beneficiary's relationship with the ACO and ACO participants from whom the beneficiary may receive care. The requirement to provide beneficiary notifications promotes transparency about ACO participants and their ACO providers/suppliers participating in the Shared Savings Program and educates beneficiaries on how ACO participation could improve their care experience.

At the same time, distributing these notices to beneficiaries imposes operational burden on ACOs and ACO participants. ACOs must accurately identify beneficiaries who require notification, operationalize workflows to distribute the notifications, and prepare for beneficiary questions and concerns.

We recognize that current operational timeframes can further contribute to implementation challenges. Operationally, CMS generally makes available the first beneficiary

assignment list report for each PY in the month of December. We recognize this can be a very tight turnaround for ACOs to prepare beneficiary outreach processes for beneficiaries who begin receiving primary care services in the following month.

We recognize that ACOs have developed processes, workflows or materials to meet the requirement for the timing for distributing the beneficiary notice. Under this proposal, ACOs would no longer be required to maintain those processes solely for purposes of complying with this requirement, which we believe would reduce ongoing administrative burden and expense. Nothing in this proposal would prohibit an ACO from continuing similar activities that it determines are beneficial, such as other beneficiary communications and marketing efforts, provided those activities comply with all otherwise applicable program requirements. We seek to have policies that balance the benefits of beneficiary education and engagement with the burden placed on ACOs, to maximize Shared Savings Program ACO participation and therefore the broad availability of ACOs and the benefits they can offer for beneficiaries. In the interest of an overall reduction in administrative burden, we propose to modify § 425.312(a)(2)(iii) and § 425.312(a)(2)(iv) with the following changes.

First, we propose to revise the requirement at § 425.312(a)(2)(iii) that "the standardized written notice must be furnished to all of these beneficiaries prior to or at the first primary care service visit during the first performance year in which the beneficiary receives a primary care service from an ACO participant." The revised language would read, "The standardized written notice must be furnished to all of these beneficiaries by May 30, unless CMS specifies a later date during the Performance Year." We also propose to add a similar change to § 425.312(a)(2)(iv) to add a new final sentence to that paragraph which states, "The standardized written notice must be furnished to all of these beneficiaries by May 30, unless CMS specifies a later date during the Performance Year." These deadlines align with those used in the ACO REACH model. Beneficiaries must still receive the notice, but we believe this would allow ACOs to better prepare to distribute the notices and better prepare to answer the subsequent

beneficiary questions they typically receive. We also believe that better aligning with CMS Innovation Center policies in this area would reduce burden for ACOs who compare policies across programs and models to determine the best fit for their organization. We do not believe this revised timing requirement would impact beneficiary engagement with the ACO or ACO participant. Beneficiaries would still receive the notification, and the ACO participants will have posted signs displayed in their facilities designed to alert beneficiaries to their practitioner's participation in an ACO (§ 425.312(a)(2)(i)) and allow the beneficiaries the opportunity to engage with the practitioner further. We remind interested parties that, irrespective of our proposal in this proposed rule, ACOs would continue to be permitted to communicate more frequently or thoroughly with beneficiaries if they wish to do so, as long as they comply with the marketing requirements detailed at § 425.310(a). This could include sharing supplemental ACO marketing materials alongside the beneficiary notification.

We propose that the change would have an effective date of January 1, 2027 and anticipate this approach would reduce the net burden to ACOs and ACO participants of providing the beneficiary notification.

We seek comments on this proposal.

(2) Proposal To Remove the Beneficiary Follow-Up Communication

In the CY 2023 PFS final rule (87 FR 70233), CMS finalized the requirement at § 425.312(a)(2)(v) that ACOs or ACO participants provide a verbal or written follow-up communication to the beneficiary no later than 180 days from the date the standardized written notice was provided. Currently, under § 425.312(a)(2)(v)(A), "The follow-up communication must occur no later than 180 days from the date the standardized written notice was provided." Section 425.312(a)(2)(v)(B) requires ACOs to retain a record of the follow-up communication and that all beneficiaries receive the follow-up communication, and to make the records available to CMS upon request.

In comments summarized in the CY 2023 PFS final rule (87 FR 69961–69963), most commenters opposed the requirement to provide beneficiary follow-up communications, expressing concern that the follow-up communication would increase administrative and operational burden for ACOs without creating meaningful additional beneficiary benefit. Commenters noted that follow-up communications may require substantial resources to operationalize, including workflows to identify beneficiaries requiring outreach, conduct and document communications, respond to beneficiary questions and maintain records demonstrating compliance. Some commenters indicated that these activities could create competing demands during clinical encounters, requiring providers to devote visit time to explaining ACO participation and value-based care concepts rather than focusing on the beneficiary's immediate clinical needs. Commenters also raised concerns that repeated communications on similar materials could contribute to beneficiary confusion rather than improve understanding. Commenters suggested we explore other strategies and work with ACOs to promote beneficiary education and engagement.

While we considered the commenters' concerns when finalizing the follow-up communication requirement in the CY 2023 PFS rule, we adopted it with the expectation that it would improve beneficiary understanding of the Shared Savings Program and give beneficiaries the opportunity to ask questions. Since its implementation, however, we have not seen evidence that the follow-up communication improves beneficiaries' understanding of ACO assignment, value-based care or the benefits of being in an ACO. Although we propose to eliminate the follow-up communication requirement, we remain committed to improving beneficiary education about the Shared Savings Program. We are currently researching additional ways CMS can support beneficiary education, but we do not believe the 180-day follow-up communication requirement is helping achieve that goal. As noted earlier, we recognize that ACOs have developed processes and incurred expenses to meet these requirements. While we believe removing the requirement would relieve an ongoing burden and expense, ACOs are free to

continue to utilize those processes to communicate with beneficiaries if they believe they provide a benefit, as long as such processes are consistent with any other applicable program requirements. We are interested in additional feedback on how to improve beneficiary communications and will continue to work with interested parties to strengthen communications and beneficiary understanding.

To be responsive to interested parties' feedback, prevent potential beneficiary confusion and reduce administrative burden to ACOs and ACO participants, we are proposing to remove the requirement that ACOs must provide a follow up communication as specified in § 425.312(a)(2)(v). Specifically, we propose to remove § 425.312(a)(2)(v) in its entirety.

If finalized, this proposal would be effective beginning January 1, 2027.

We seek comments on this proposal.

10. Request for Information: Specialty Care in the Shared Savings Program

a. Background

We have a goal to grow the number of health care providers and beneficiaries in accountable care relationships. As of January 2025, 53.4 percent of OM beneficiaries were in such a relationship,[339] including through ACOs that participate in the Shared Savings Program and entities participating in CMS Innovation Center ACO models such as ACO REACH.

The Shared Savings Program is central to this strategy: since it was established in 2012, the Shared Savings Program has been associated with improved quality performance, stronger care coordination, better beneficiary experience, and consistent evidence of savings. In 2026, the Shared Savings Program includes 511 ACOs, comprising more than 700,000 providers and organizations and serving over 12.6 million OM beneficiaries. At the same time, nearly 11 million OM beneficiaries are not currently in an accountable care relationship and may be potentially assignable to an ACO. This presents a significant opportunity to expand access to

[339] Centers for Medicare & Medicaid Services. "CMS Moves Closer to Accountable Care Goals with 2025 ACO Initiatives." *CMS*, 15 Jan. 2025, *https://www.cms.gov/newsroom/fact-sheets/cms-moves-closer-accountable-care-goals-2025-aco-initiatives*.

accountable, coordinated care and accelerate progress towards our goal of growing accountable care relationships.

Much of the Shared Savings Program's design, assignment, and accountability are centered around the delivery of primary care services. This structure has supported improvements in population-based care management, outcomes, and efficiency, with 75 percent of the 476 ACOs participating in PY 2024 demonstrating savings while meeting quality of care objectives.[340] Low revenue ACOs (which are typically physician-led ACOs or are comprised of FQHC/RHCs), have consistently outperformed high revenue ACOs in generating savings.[341] High revenue ACOs, which are typically hospital-led, tend to generate smaller savings rates. A low-revenue ACO is usually physician led, where the total Medicare Parts A and B FFS revenue of the ACO participants is less than 35 percent of the total Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries.[342] A high-revenue ACO is generally hospital-based, and the total Medicare Parts A and B FFS revenue of the ACO participants is 35 percent or greater of the total Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries.[343] Low-revenue ACOs often have less ability to control total spending than high-revenue ACOs do. As we pursue OM accountable care goals, we are exploring how to better support the financial performance of our high revenue ACO participants, which are more likely to have a high proportion of high-cost specialists participating in their ACO compared to low revenue participants.

---

[340] Centers for Medicare & Medicaid Services. *Medicare Shared Savings Program Performance Year 2024 Financial and Quality Results*. 29 Sept. 2025, *https://www.cms.gov/files/document/fact-sheet-ssp-py24-financial-quality-results.pdf*.

[341] Centers for Medicare & Medicaid Services. *Medicare Shared Savings Program Accountable Care Organizations: Updated Performance Year 2024 Financial and Quality Results*. 29 Sept. 2025

342 United States, Code of Federal Regulations. "§ 425.20 Definitions." *Electronic Code of Federal Regulations*, Title 42, Chapter IV, Part 425, SubPart A, 2026, *https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-425/subpart-A/section-425.20*. Accessed 18 June 2026.

343 Ibid

Specialty care represented roughly 80 percent of Medicare Part B physician spend in 2024 (as opposed to roughly 20 percent on primary care).[344] CMS reaffirms the central role of primary care in coordinating care; however, we recognize that growth in specialty care has increased the number of specialists involved in beneficiary care. As a result, primary care teams must now coordinate with more specialists than ever before to support the delivery of longitudinal, whole-person care.[345] This also increases the potential for fragmented care delivery to patients, especially those with high-cost and high-need conditions and those receiving long-term care. Accordingly, we seek to strengthen low and high revenue ACOs in incorporating specialists and facilitating care coordination.

Relative to their efforts in primary care, ACOs have had limited direct influence on the type and frequency of specialty care furnished to beneficiaries assigned to an ACO, despite specialists constituting a significant share of participating clinicians. While this varies by ACO type and the role of the specialists, many specialists participating in ACOs remain unaware of their role in the program. They are not consistently engaged in efforts to improve cost and quality for their assigned beneficiaries and are often not held accountable to ACO-related performance targets. Furthermore, existing program data shows high rates of specialty care delivered outside ACO networks, which contributes to fragmented care and limits visibility into the quality, appropriateness, and coordination of specialty services.[346]

Existing literature on specialist engagement and performance in ACOs may inform future directions and opportunities. One study exploring specialist costs in ACOs found that a quarter of ACOs have used cost reduction measures to help determine specialist compensation, however, there was no association between these efforts and cost reduction incentives or specialist

---

[344] Centers for Medicare & Medicaid Services. "Medicare Fee-for-Service Part B Utilization and Expenditures." *CMS*, *https://www.cms.gov/data-research/statistics-trends-reports/medicare-fee-service-parts-b-utilization-reports/medicare-utilization-part-b/expenditures-services-specialty-reports*.

[345] Timmins L, Urato C, Kern LM, Ghosh A, Rich E. Primary Care Redesign and Care Fragmentation Among Medicare Beneficiaries. The American Journal of Managed Care, March 2022, Volume 28, Issue 3.

[346] McWilliams, J. Michael, et al. "Outpatient Care Patterns and Organizational Accountability in Medicare." *JAMA Internal Medicine*, vol. 174, no. 6, 2014, pp. 938–945. *JAMA Network*, *https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1861039*.

performance.[347] Another study suggests that ACOs in which specialists, specifically cardiologists, were included and actively engaged were more likely to have lower spending and utilization.[348] This indicates that there is the potential for cost and quality improvements with enhanced policies that target specialist inclusion in the Shared Savings Program.

As OM beneficiaries increasingly rely on specialty care, it is important to understand the drivers of successful specialty integration and engagement, as well as its barriers. These considerations may differ across ACO types. In low revenue ACOs and outpatient, primary care-focused organizations, primary care teams often coordinate across a broad network of unaffiliated specialists. In contrast, in health system–affiliated organizations, including high revenue ACOs, specialists are more likely to be employed or otherwise closely aligned within a single system, and integration efforts may center on aligning incentives across service lines and advancing system-wide care management approaches. Given the scope of specialty involvement in Medicare spending and the importance of integrated and accountable specialty care to beneficiary outcomes, CMS is seeking public input to inform potential future updates to the Shared Savings Program. These insights may also inform future CMS Innovation Center ACO model features. Responses will assist us in identifying policy options that may promote high quality, coordinated specialty care within the accountable care framework and advance the agency's goals of improving care, promoting efficiency, and ensuring the long-term sustainability of the Medicare program.

b. Solicitation of Public Comments

We are releasing this RFI to gather feedback on policy changes and resources that could improve clinical outcomes and reduce inappropriate Medicare spending through accountable care programs and models. We request feedback on the following:

---

[347] Ganguli, Ishani, et al. "Association between Specialist Compensation and Accountable Care Organization Performance." *Health Services Research*, vol. 55, no. 5, Oct. 2020, pp. 722–728. PubMed, *https://pubmed.ncbi.nlm.nih.gov/32715464/*.

[348] Cohen, Andrew J., et al. "Perspectives From Authors and Editors in the Biomedical Disciplines on Predatory Journals: Survey Study." *Journal of Medical Internet Research*, vol. 21, no. 8, 2019, e13769. PubMed Central, *https://pmc.ncbi.nlm.nih.gov/articles/PMC6750277/*.

- Meaningful engagement;
- CMS-delivered tools and support;
- Attribution or assignment modifications;
- Benchmarking;
- Specialist performance measurement;
- Waiver flexibilities; and
- ACO and provider burden.

Whenever possible, respondents are requested to draw their responses from objective, empirical, and actionable evidence and to cite this evidence within their responses. Where applicable, we encourage respondents to distinguish between experiences in low revenue and high revenue ACOs, given differences in organizational structure, incentives, and approaches to care delivery.

(1) Meaningful Engagement

For the purposes of this request, "meaningful engagement" refers to the extent to which specialists are aware of, aligned with, and actively contributing to an ACO's cost and quality goals. This includes participation in care coordination, adherence to evidence-based care pathways, and responsiveness to financial and non-financial incentives tied to total cost of care.

Specialists represent 65 percent of Shared Savings Program participating physicians and play an increasingly central role in patient care. Between 2000 and 2019, the proportion of beneficiaries seeing five or more physicians increased from 17.5 percent to 30.1 percent.[349] Specialists have become integral to many beneficiaries' care, and their engagement is needed to help meaningfully improve care coordination, reduce unnecessary utilization, and influence high-

[349] Barnett Michael L et al. "Trends in Outpatient Care for Medicare Beneficiaries and Implications for Primary Care, 2000 to 2019." *Annals of Internal Medicine*, vol. 174, no. 12, 2021, pp. 1658–1665, *https://doi.org/10.7326/M21-1523*.

cost clinical decisions. Despite these opportunities, specialist engagement in ACOs remains limited, and there has been no consistent approach to date that explicitly aligns ACO incentives with specialist behavior.

Analyses across the Shared Savings Program and ACO REACH reinforce these findings. Among 101 respondents representing 174 ACOs in the Shared Savings Program and ACO REACH, only 11 percent reported that employed specialists were highly aligned with ACO costs and quality objectives and just 7 percent reported high alignment among contracted specialists.[350] These results indicate areas of opportunity to further integrate specialists into accountable care frameworks. Data from a survey of participating providers in a Michigan ACO support this. Compared to primary care providers (PCPs), specialists reported significantly lower levels of awareness and alignment: 57 percent of specialists do not know they are participating in an ACO (versus 37 percent PCP), 71 percent are not aware of accountability for spending and costs (versus 53 percent PCP), and 75 percent report that the financial bonuses are not large enough to influence their behavior (similar to PCP).[351] These findings demonstrate the potential of expanding education efforts, offering direct incentives, and improving accountability for specialists to advance engagement with ACOs.

Recent trends in physician employment and consolidation have shifted a growing share of specialists into health system-affiliated or other integrated organizational arrangements, rather than independent practice.[352] As a result, approaches to specialty care engagement may vary depending on whether specialists are independent or operating within a health system context. In

---

[350] Mechanic, Robert E., et al. "Accountable Care Organization Initiatives to Improve the Cost and Outcomes of Specialty Care." *The American Journal of Managed Care*, vol. 30, no. 5, May 2024, pp. 237–240, *https://www.ajmc.com/view/accountable-care-organization-initiatives-to-improve-the-cost-and-outcomes-of-specialty-care*.

[351] Markovitz, Adam A., et al. "ACO Awareness and Perceptions Among Specialists Versus Primary Care Physicians: A Survey of a Large Medicare Shared Savings Program." *Journal of General Internal Medicine*, vol. 37, no. 2, 2022, pp. 492–494. *https://doi.org/10.1007/s11606-020-06556-w*.

[352] U.S. Government Accountability Office. *Health Care Consolidation: Published Estimates of the Extent and Effects of Physician Consolidation.* GAO-25-107450, Sept. 2025. *GAO*, *https://www.gao.gov/products/gao-25-107450*.

particular, non-health system ACOs may rely more heavily on contractual or payment-based mechanisms to align incentives and support collaboration with unaffiliated specialists.

To engage specialists, some non-health system organizations may implement sub-capitation ("sub-cap") arrangements, in which ACOs distribute prospective or risk-based payments to specialists tied to defined populations or services. For example, in the forthcoming Long-term Enhanced ACO model (LEAD), the Innovation Center anticipates including an optional component called CMS Administered Risk Arrangements (CARA), which would enable downstream episode-based risk arrangements between ACOs and specialists. Additionally, under the Advanced Payment Option (APO) in ACO REACH, LEAD's predecessor, ACOs can receive and distribute prospective monthly payments for non-primary care services to specialists as defined by their downstream sub-cap arrangement(s). Other Innovation Center models have also sought to improve meaningful specialist engagement by requiring structured arrangements or incentivizing activities through enhanced payment. The Making Care Primary (MCP) model sought to require certain primary care participants to enter Collaborative Care Arrangements (CCAs) with specialists.[353] CCAs help to formalize expectations around collaboration and communication between PCPs and specialists. MCP also created a new Healthcare Common Procedure Coding System (HCPCS) code, the MCP E-consult Code (MEC), which sought to incentivize more frequent and enhanced electronic consults between primary care participants and specialists. Relatedly, the Innovation Center's Ambulatory Specialty Model (ASM) requires that specialist participants enter at least one CCA with a primary care practice, and that the CCA should include elements such as information sharing, referrals, co-management, and transitions in care. These approaches may be particularly relevant in settings where primary care clinicians and specialists are not part of the same organization, as they help to formalize collaboration and accountability across unaffiliated clinicians. Finally, the Advancing Chronic Care with Effective,

[353] MCP wrapped up early on June 30, 2025. See CMS website for more information: *https://www.cms.gov/priorities/innovation/innovation-models/making-care-primary*.

Scalable Solutions (ACCESS) Model offers limited co-management payments to support collaboration with PCPs and other referring clinicians in activities like documenting care-coordination actions, such as medication adjustments or problem-list updates.[354] These activities aim to meaningfully engage specialists and PCPs in care coordination for beneficiaries.

We are seeking feedback on how we could better support meaningful specialist engagement and accountability within the Shared Savings Program.

- Which aspects of the Shared Savings Program's design most influence specialists' ability and willingness to meaningfully participate in accountable care arrangements (for example, data access, attribution/assignment, financial incentives, clinical autonomy)?
- How could the Shared Savings Program better support adoption of care delivery interventions (for example, e-consults, co-management models) to improve primary and specialty care integration? Are there other interventions that should be considered?
- Which incentives (financial, quality-based, or operational) most effectively drive adoption of value-based care interventions? Examples include the use of care coordination codes billed by specialists (for example, MCP), MIPS submission exemption for Qualifying Providers (QPs), and the sub-capitation arrangements between ACOs and specialists (for example, the recently announced CARA in LEAD).[355]
- How does specialist engagement differ across high revenue and low revenue ACOs, including differences in the roles of employed and contracted specialists? What types of specialists are most critical to achieving care coordination and cost and quality goals in each setting, and what strategies have been effective in engaging them?

---

[354] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. *"ACCESS Technical Frequently Asked Questions."* CMS.gov, 2026, *https://www.cms.gov/priorities/innovation/access-technical-frequently-asked-questions#ovw"*.

[355] "LEAD" *Centers for Medicare & Medicaid Services*, U.S. Department of Health and Human Services, *https://www.cms.gov/priorities/innovation/innovation-models/lead.*

- How should engagement strategies be tailored to reflect differences across specialties (for example, procedural specialists versus chronic disease co-managers)?[356]
- Are there specific specialist engagement approaches that are particularly effective for high-need, high-cost populations or beneficiaries receiving long-term care services and supports?
- How can we engage specialists in ways that support physician autonomy while advancing accountability for cost and quality?

(2) CMS-Delivered Tools and Support

ACOs often report that access to actionable data and tools is critical to improving care coordination and driving value-based care.[357] However, gaps remain in both the availability and accessibility of these resources, particularly for driving specialty care accountability and enabling specialist engagement.

One example that was developed in response to ACO feedback is the provision of "shadow bundles" data, which CMS began providing in February 2024 to ACOs participating in the Shared Savings Program and the ACO REACH Model.[358] "Shadow bundles" aggregate claims data for services, supplies, and associated payments into standardized, condition or procedure-specific episodes of care. These episodes are constructed using consistent rules for attributed beneficiaries and include benchmark pricing to support performance comparison and potential shared savings arrangements between a health care provider and an ACO. This CMS-generated dataset offers ACOs actionable insights into specialist care patterns, potentially enabling more informed engagement with specialists. By identifying variations in cost across episodes, ACOs can better understand referral patterns, support high-value care, and design their own episode-based payment initiatives.[359] High-value care in this instance is defined as the

---

[356] Forrest, Christopher B. "A typology of specialists' clinical roles." *Archives of internal medicine* vol. 169,11 (2009): 1062-8. https://doi.org/10.1001/archinternmed.2009.114.
[357] National Association of ACOs. *ACO Drivers for Success*. 2024, https://www.naacos.com/aco-drivers-for-success/
[358] Fowler, Elizabeth, et al. "The CMS Innovation Center's Strategy to Support Person-Centered, Value-Based Specialty Care: 2024 Update." *Health Affairs Forefront*, 2 Apr. 2024.
[359] Congressional Budget Office. *Medicare Accountable Care Organizations: Past Performance and Future Directions*. 2024, *www.cbo.gov/publication/59879*.

appropriate standard of care for a patient with no unnecessary care, complications, or other unnecessary spending. Standardized episode definitions also enhance transparency and allow for more consistent comparisons over time. Ultimately, these insights can help PCPs refer patients to specialists who deliver the highest quality, most cost-effective care. Despite this potential, a 2025 ACO REACH participant survey indicates that 22 percent of ACOs participating in that model use shadow bundle data, highlighting an opportunity to expand uptake and better understand barriers to use, particularly for specialist engagement. Shared Savings Program shadow bundle downloads also declined by 57 percent over the same period, falling from 54 percent in February 2025 and continuing downward in subsequent months.[360]

Effective data use requires adequate infrastructure and analytic capacity, yet many ACOs face significant challenges in collecting, integrating, and analyzing clinical data. Fragmentation across health IT systems further compounds these issues, making it difficult to consolidate and report data consistently. For example, 77 percent of ACOs report that their ACO participants use six or more different electronic health record (EHR) systems, creating substantial interoperability and workflow barriers. These barriers can limit an ACO's ability to invest in and prioritize advanced analytics or data tools needed to support initiatives such as specialist engagement.[361]

Beyond data, ACOs also rely on toolkits and educational resources, some produced by us, that focus on specific topics such as care coordination and care transformation.[362] However, existing resources tend to emphasize primary care transformation and may be less applicable to specialists within ACO models, particularly in low revenue ACOs and outpatient settings. We are interested in understanding how the need and applicability of such resources may differ across low revenue and high revenue ACOs, including those with more integrated health system structures.

---

[360] NORC at the University of Chicago. *2025 ACO REACH Pulse Check Survey*. 2025. Internal report.
[361] "Use of Electronic Health Record Systems in Accountable Care Organizations." *The American Journal of Managed Care*, *www.ajmc.com/view/use-of-electronic-health-record-systems-in-accountable-care-organizations*.
[362] Centers for Medicare & Medicaid Services. *ACO Care Coordination Toolkit*. Mar. 2019. Centers for Medicare & Medicaid Services. *ACO Care Transformation Toolkit*. Jan. 2021.

We seek feedback on how CMS-delivered tools and data could better support specialist engagement and accountability within the Shared Savings Program.

- How is your organization using shadow bundle data or other specialty-specific data?
- If you have had the opportunity to use shadow bundle data and elected not to use it, why not?
- Which data or tools would help ACOs provide meaningful feedback to specialists?
- How could CMS improve specialty care data to better support referrals to specialists based on proven outcomes, low complications, and efficient use of resources?
- How would the CMS-delivered tools and data need to vary to support the needs of low revenue ACOs versus high revenue ACOs?
- What other tools and resources could CMS provide to support specialty integration?

(3) Attribution/Assignment Modifications

In performing claims-based assignment, we determine whether allowed charges for a beneficiary's primary care services (as identified for ACO professionals, including at Electing Teaching Amendment (ETA) hospitals and Method II Critical Access Hospitals (CAHs), and services furnished at an FQHC or RHC) in an ACO are greater than allowed charges for the beneficiary's primary care services in any other ACO, or other individual practitioners, or groups of practitioners identified by Medicare-enrolled billing TINs or CCNs[363] that are not participating in the Shared Savings Program.[364] While this approach appropriately centers around primary care, it can limit opportunities for specialists to be accountable for populations they meaningfully manage, particularly when they often influence total cost of care. We employ the step-wise assignment methodology described in § 425.402 and § 425.404 and a Medicare beneficiary is assigned to an ACO if 1) the beneficiary meets the eligibility criteria under

[363] FQHCs, RHCs, ETA hospitals, and Method II CAHs will be identified on claims by their CCNs.
[364] Refer to § 425.402(b)(3) and (b)(4); § 425.404(b).

§ 425.401(a); and 2) the beneficiary's utilization of primary care services meets the criteria established under the assignment methodology described in § 425.402 and § 425.404.

We have tested specialty models such as the Enhancing Oncology Model (EOM) and Kidney Care Choices (KCC), where beneficiaries are attributed to specialists for specific conditions. EOM attributes condition episodes for beneficiaries with high-risk breast cancer, chronic leukemia, lymphoma, lung cancer, colorectal/small intestine cancer, multiple myeloma, and high-risk prostate cancer to oncologists. KCC attributes beneficiaries with chronic kidney disease stages 4 and 5, end-stage renal disease, and post-kidney transplant patients to nephrologists. The heterogeneous nature of a specialist's role in beneficiary care, which can range from cognitive or procedural consult to co-manager (with primary care) or principal care manager, can make it difficult for specialists to sustain attributed/assigned populations under current rules, even when they can play a central role in managing care.[365] The use of condition-specific HCPCS codes in specialties such as cardiology and ophthalmology could also potentially identify beneficiaries for specialty attribution.

We seek feedback on how specialty-specific attribution methodologies could better support specialist engagement and accountability within the Shared Savings Program.

- How should CMS consider incorporating specialists into beneficiary assignment methodologies, if at all, while ensuring CMS maintains strong primary care relationships?
- Across ACO types, such as low revenue and high revenue ACOs, how can CMS account for care delivered by nurse practitioners (NP) and physician assistants (PA) in assignment methodologies, and what role does NP/PA-led care play in supporting beneficiary attribution, recognizing that section 1899(c)(1) of the Social Security Act requires CMS to assign beneficiaries to a Shared Savings Program ACO based on their utilization of primary care

[365] Forrest, Christopher B. "A typology of specialists' clinical roles." *Archives of internal medicine* vol. 169,11 (2009): 1062-8. https://doi.org/10.1001/archinternmed.2009.114.

services furnished by physicians and, for applicable performance years, primary care services furnished by Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).

- How could the Shared Savings Program assignment methodology better recognize situations where specialists serve as a beneficiary's principal longitudinal care provider?
- How could the Shared Savings Program ACOs enable specialists to share accountability for total cost and quality of care without serving as the primary clinician?
- What design features could support shared accountability between PCPs and specialists for specific conditions and episodes within the Shared Savings Program?

(4) Benchmarking

Another critical element to designing the Shared Savings Program to more appropriately incorporate specialists is the use of benchmarking methodologies tailored to specialty care. Within the Shared Savings Program and Innovation Center ACO models, benchmarks have traditionally been defined as the risk-adjusted, projected total cost of care targets for an ACO's assigned population. These benchmarks serve as the basis for assessing financial performance and determining shared savings or losses. While this population-based approach supports accountability for overall cost and care coordination, it may not fully capture variation in performance at the specialty or condition-specific levels, where significant opportunities for improving efficiency and quality exist.

Expanding benchmarking to more targeted sub-populations or specialty-specific services could provide ACOs with more actionable insights into, and drive improvements in, specialty care delivery. Benchmarking for specialty conditions can be challenging due to the high-cost variability for many conditions overseen by a specialist, for example multiple myeloma, Chronic Obstructive Pulmonary Disease (COPD), and heart failure. However, as clinical scope becomes more narrowly defined, statistical reliability may decrease due to smaller sample sizes, particularly for low-volume, high-cost services. Addressing these methodological challenges would be critical to ensuring that specialty-specific benchmarks are accurate.

We have experience with alternative benchmarking approaches that may inform this work. For example, the Quality Payment Program (QPP), including the Merit-based Incentive Payment System (MIPS), and the Ambulatory Specialty Model incorporate Episode-Based Cost Measures (EBCMs) to assess cost performance at the clinician or group level. EBCMs estimate the total cost of care for a defined clinical episode or condition, rather than for a patient over an entire year. Using Medicare claims data, CMS attributes services to episodes, applies risk adjustment to account for patient complexity, and calculates standardized costs that can be compared across providers and organizations. These episode-based approaches offer a methodologically robust framework for evaluating efficiency in discrete areas of care and may be adaptable for use within ACO models to support specialty engagement. By focusing on specific procedures or conditions, EBCMs can help identify variation in practice patterns, highlight opportunities for improvement, and support more targeted accountability.

In addition to episode-based approaches, certain clinical conditions with more predictable care trajectories may be particularly well-suited for specialty-specific benchmarking. For example, End Stage Renal Disease and cardiology may have sufficient volume and more defined clinical pathways (when appropriately risk adjusted) that could support more stable and reliable cost and quality comparisons at the ACO level. Targeting these types of clinical areas could mitigate some of the challenges associated with low volume and high variability.

We seek feedback on how benchmarking approaches could better support meaningful specialist engagement and accountability.

- What approaches should CMS consider for developing specialty-specific cost benchmarks within the Shared Savings Program? How can CMS mitigate challenges associated with conditions that may have low volumes and/or high-cost variability?
- How could CMS define sub-populations for specialty benchmarking (for example, by chronic condition, procedure type, or specialty service category)? Are there specific sub-populations that lend themselves to specialty benchmarking?

- What risk adjustment factors could CMS incorporate into specialty-specific benchmarks to ensure they reflect patient complexity?
- How could specialty-specific benchmarks interact with existing total cost of care benchmarks in the Shared Savings Program?

(5) Specialty Performance Measures

Quality measurement is central to assessing ACO performance and advancing CMS's goals of improving patient outcomes and promoting high-value care. Quality measures provide critical insight to both CMS and ACOs on how effectively care is being delivered and where opportunities may exist to improve clinical outcomes, patient experience, and safety.

Within the Shared Savings Program, the current quality measurement framework emphasizes the foundational role of primary care in population health management, which aligns with the primary-care based assignment methodology discussed above. As a result, the current Shared Savings Program quality measure set (the Alternative Payment Model (APM) Performance Pathway (APP) Plus measure set under MIPS) focuses on preventive care, chronic disease management, and care coordination activities typically driven by PCPs.

The current primary-care-focused measurement approach may create a gap in assessing the contribution of specialists to beneficiaries' care and ACO performance. This gap may manifest differently across ACO types. In low revenue ACOs, which are more often primary care and physician-led, the existing measure set may more closely align with organizational structure and care delivery models, though it may still underrepresent specialist contributions. In contrast, in high revenue ACOs, where specialists often play a larger role in care delivery and cost drivers, the limited inclusion of specialist-focused quality measures may result in a more pronounced gap in assessing performance across the full continuum of care and may reduce incentives for specialty engagement in quality improvement efforts. Specialty care plays a critical role in the management of acute and chronic conditions and procedural interventions, which can significantly influence both quality outcomes and total cost of care. Without meaningful

inclusion of specialist-focused quality measures, ACOs and CMS may have an incomplete view of performance across the full continuum of care.

This challenge is not unique to the Shared Savings Program. In other CMS programs, such as MIPS, participants have historically had to report on metrics that are more readily reportable or broadly applicable, which tend to be primary care-oriented (for example, screening, preventive services, and management of high-volume chronic conditions such as hypertension and diabetes). To address this, we have established the option to report MIPS Value Pathways (MVPs), which allow providers to report a set of measures more relevant to their specialty. In response to a request for information on MVP reporting for specialists in Shared Savings Program ACOs in the CY 2024 Physician Fee Schedule proposed rule (88 FR 52437), we received feedback in support of the aim to increase specialist participation in ACOs, with some commenters encouraging incentives and flexibility, while others expressed concern that MVPs may increase burden on specialists in ACOs.

Interested parties' feedback has further indicated that specialists may have limited visibility into how their clinical decisions, care patterns, and outcomes contribute to overall ACO performance, particularly when quality measurement and reporting do not reflect their areas of practice. This lack of visibility may reduce opportunities for engagement, alignment, and accountability among specialists participating in ACOs.

We seek feedback on how specialty performance measures could better support meaningful specialist engagement and accountability in the Shared Savings Program, keeping in mind that they may differ between low and high revenue ACOs.

- What considerations should inform how specialist performance is assessed within ACOs and should it differ from how ACOs are currently assessed?
- What specialty-specific performance profiles or feedback mechanisms would drive improvement?

- How could performance measurement approaches support prevention and upstream management by specialists?
- What specialist quality performance information would be of use to ACOs in maximizing care coordination, outcomes, and cost management in their programs? How could CMS incentivize specialists or their ACOs to report on specialist quality performance?
- How can ACOs align financial and non-financial incentives to better reflect specialists' contributions to cost and quality outcomes?
- What are the barriers and burden associated with collecting data from specialists and how can these issues be mitigated?
- Is there an opportunity to tie ACO performance to system-level metrics? Would this remove or increase burden on PCPs and specialists? What potential issues could arise from system-level metrics?
- How could MVPs be leveraged to better support meaningful specialist engagement and accountability in the Shared Savings Program, and in which areas are there opportunities to improve how MVPs could be leveraged? In which contexts, such as low revenue versus high revenue ACOs or different specialty types, have MVPs been most and least effective?

(6) Waiver Flexibilities

Under Section 1899 of the Act, we have the authority to waive certain sections of the Act, as necessary to implement the Shared Savings Program. This waiver authority authorizes us to use trust fund dollars to reduce barriers to care delivery within ACOs, such as to pay participating ACOs for items and services that are not typically covered under Medicare (to include items and services that fall within a Medicare benefit category solely by virtue of waivers of certain requirements issued for purposes of testing the model). These tools may create opportunities for specialists to participate more meaningfully in accountable care by expanding access; reducing burden; and allowing more flexible care delivery, referral, and payment.

One example is the Skilled Nursing Facility (SNF) 3-day rule waiver, which eliminates the requirement for a 3-day inpatient stay prior to a SNF admission. This waiver is highly utilized in many ACOs, with 36 percent of Shared Savings Program ACOs approved for the waiver in 2026.[366] Sixty percent of ACO REACH participants report this waiver is operational as of 2025.[367] Data suggests that when used, it can reduce avoidable inpatient and ED utilization without increasing overall SNF spending.[368] Another example is the diabetic shoe waiver, which in the Primary Care First (PCF) model, allowed NPs/PAs to certify a diabetic shoe prescription. There is no statistical data on waiver uptake, but anecdotal evidence suggests uptake was large and this continues to be a highly requested waiver.

Telehealth flexibilities introduced during the COVID-19 public health emergency are an example of regulatory flexibilities. These policies expanded access to care by allowing beneficiaries to receive telehealth anywhere in the US, permitting all Medicare providers to furnish telehealth services, and paying for audio-only visits when necessary and appropriate. The Shared Savings Program also allows for telehealth flexibilities, which similarly allow certain ACOs in two-sided risk tracks to provide and bill for telehealth services to assigned beneficiaries anywhere in the U.S. Telehealth flexibilities have been widely adopted by many specialists, particularly for consultations and follow-up visits. Data suggests that virtual consultations in a commercial population can reduce expenditures by $195 per person, primarily driven by lower cost of specialist care.[369]

We are seeking feedback on how waivers and regulatory flexibilities can better support specialist engagement and participation in the Shared Savings Program.

---

[366] Shared Savings Program Fast Facts, *https://www.cms.gov/files/document/2026-shared-savings-program-fast-facts.pdf*. January 1, 2026.
[367] NORC at the University of Chicago. *2025 ACO REACH Pulse Check Survey*. 2025. Internal report.
[368] Newman JS, Johnson KS, Meyer TJ, et al. *Implementing the 3-Day Skilled Nursing Facility Waiver: Key Insights.* J Prim Care Community Health. 2026;17. https://doi.org/10.1177/21501319261456960.
[369] "eConsults NORC 2025 ACO REACH Pulse Check Survey Can Lower Costs and Improve Access to Specialty Care." *Mathematica*, *https://www.mathematica.org/news/econsults-can-lower-costs-and-improve-access-to-specialty-care*. Accessed 23 Mar. 2026.

- Which current Shared Savings Program waivers (for example, SNF 3-day rule, telehealth flexibilities) have been most effective in supporting specialty integration? What barriers limit their adoption and how could CMS address them?
- How could CMS modify or expand existing waiver flexibilities to better support specialist-driven care pathways while maintaining beneficiary safety and appropriate utilization?
- What additional waivers should CMS consider to enable specialists to participate in ACOs?
- How should waivers differ by low revenue and high revenue participants?

(7) Burden

Central to CMS's strategic goals is protecting the taxpayer by improving program efficiency and integrity and reducing administrative burden.[370] Burden reduction efforts focus on simplifying program requirements, streamlining oversight, and leveraging automation and data integration so that providers can devote more time to patient care. This includes reducing duplicative or unnecessary data submissions, improving alignment across reporting systems, and enhancing the efficiency of compliance processes. At the same time, we seek to ensure that programs continue to meet their goals to drive improvements in care quality, outcomes, and value.

Our programs, including the Shared Savings Program, rely on robust data reporting, analytics, and administrative infrastructure to support these goals. Participation in these models often requires investments in care coordination, health IT systems, performance measurement, and ongoing operational optimization. While these activities are essential to advancing accountable care, they may also introduce administrative and operational burden for participating organizations.

---

[370] Centers for Medicare & Medicaid Services. "Making America Healthy Again: Innovation for Healthier Lives." *CMS*, *https://www.cms.gov/newsroom/blog/making-america-healthy-again-innovation-healthier-lives*.

Efforts to strengthen specialty integration within ACOs, a key opportunity for improving care coordination and reducing total cost of care, may involve additional activities that require time, resources, and technical capacity.

We are seeking feedback on how to minimize burden when improving specialist engagement and accountability within the Shared Savings Program.

- How can CMS reduce burden associated with specialty-specific quality reporting (for example, aligning measures across programs, leveraging claims-based measures) while maintaining meaningful accountability for specialty care?
- What policy changes could reduce the burden ACOs and specialists face in meeting data-sharing requirements (for example, interoperability)?
- What operational or compliance requirements disproportionately affect smaller or rural specialty practices?
- What flexibilities could CMS introduce to encourage specialist participation or engagement with the Shared Savings Program?
- What flexibilities could CMS introduce to reduce burden with the structure of ACO participation over the current FFS requirements?

H. Changes to the Regulations Associated with the Ambulance Fee Schedule

1. Ambulance Fee Schedule Background

Section 1861(s)(7) of the Act establishes an ambulance service as a Medicare Part B service where the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations. Our regulations relating to coverage for ambulance services are set forth at 42 CFR part 410, subpart B. Since April 1, 2002, payment for ambulance services has been made under the ambulance fee schedule (AFS), which the Secretary established, as required by section 1834(l) of the Act, in 42 CFR part 414, subpart H. Payment for an ambulance service is made at the lesser of the actual billed amount or the AFS amount, which consists of a base rate for the level of service, a separate payment for mileage to the nearest appropriate facility, a geographic adjustment factor (GAF), and other applicable adjustment factors as set forth at section 1834(l) of the Act and § 414.610.

In accordance with section 1834(l)(3) of the Act and § 414.610(f), the AFS rates are adjusted annually based on an inflation factor. (For a discussion about the ambulance inflation factor (AIF), please see CY 2011 PFS final rule (75 FR 73397)). We stated in the CY 2011 PFS final rule that the AIF will be announced by instruction and on the CMS website. AIF transmittals are available on CMS' website*: https://www.cms.gov/medicare/payment/fee-schedules/ambulance/afs-regulations-and-notices* and in the Medicare Claims Processing Manual, Chapter 15, section 20.4). The AFS also incorporates two permanent add-on payments at § 414.610(c)(5)(i) and three temporary add-on payments at § 414.610(c)(1)(ii) and (c)(5)(ii) to the base rate and/or mileage rate.

2. Ambulance Extender Provisions

a. Amendment to Section 1834(l)(13) of the Act

Section 146(a) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110–275, enacted July 15, 2008), amended section 1834(l)(13) of the Act to specify that, effective for ground ambulance services furnished on or after July 1, 2008, and

before January 1, 2010, the ambulance fee schedule amounts for ground ambulance services shall be increased as follows:

- For covered ground ambulance transports that originate in a rural area or in a rural census tract of a metropolitan statistical area, the fee schedule amounts shall be increased by 3 percent.

- For covered ground ambulance transports that do not originate in a rural area or in a rural census tract of a metropolitan statistical area, the fee schedule amounts shall be increased by 2 percent.

The payment add-ons under section 1834(l)(13) of the Act have been extended several times. Most recently, section 6203 of the Consolidated Appropriations Act, 2026 (Pub. L. 119-75, February 3, 2026) amended section 1834(l)(13) of the Act to extend the payment add-ons through December 31, 2027. Thus, these payment add-ons apply to covered ground ambulance transports furnished before January 1, 2028. We are proposing to revise § 414.610(c)(1)(ii) to conform the regulations to this statutory requirement. (For a discussion of past legislation extending section 1834(l)(13) of the Act, please see the CY 2014 PFS final rule with comment period (78 FR 74438 through 74439), the CY 2015 PFS final rule with comment period (79 FR 67743), the CY 2016 PFS final rule with comment period (80 FR 71071 through 71072), the CY 2019 PFS final rule with comment period (83 FR 59681 through 59682), the CY 2024 PFS final rule with comment period (88 FR 79292 through 79293), and the CY 2026 PFS final rule with comment period (90 FR 49837)).

This statutory requirement is self-implementing. A plain reading of the statute requires only a ministerial application of the mandated rate increase and does not require any substantive exercise of discretion on the part of the Secretary.

b. Amendment to Section 1834(l)(12) of the Act

Section 414(c) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) (Pub. L. 108-173, December 8, 2003) added section 1834(l)(12) to the Act,

which specified that, in the case of ground ambulance services furnished on or after July 1, 2004, and before January 1, 2010, for which transportation originates in a qualified rural area (as described in the statute), the Secretary shall provide for a percent increase in the base rate of the fee schedule for such transports. The statute requires this percent increase to be based on the Secretary's estimate of the average cost per trip for such services (not taking into account mileage) in the lowest quartile of all rural county populations as compared to the average cost per trip for such services (not taking into account mileage) in the highest quartile of rural county populations.

Using the methodology specified in the July 1, 2004, interim final rule (69 FR 40288), we determined that this percent increase was equal to 22.6 percent. As required by the MMA, this payment increase was applied to ground ambulance transports that originated in a "qualified rural area," that is, to transports that originated in a rural area comprising the lowest 25th percentile of all rural populations arrayed by population density. For this purpose, rural areas included Goldsmith areas (a type of rural census tract). This rural bonus is sometimes referred to as the "Super Rural Bonus" and the qualified rural areas (also known as "super rural" areas) are identified during the claims process via the use of a data field included in the CMS-supplied ZIP code file.

The Super Rural Bonus under section 1834(l)(12) of the Act has been extended several times. Most recently, section 6203 of the Consolidated Appropriations Act, 2026 (Pub. L. 119-75, February 3, 2026) amended section 1834(l)(12)(A) of the Act to extend this rural bonus through December 31, 2027. Therefore, we are continuing to apply the 22.6 percent rural bonus described in this section (in the same manner as in previous years) to ground ambulance services with dates of service before January 1, 2028, where transportation originates in a qualified rural area.

Accordingly, we are proposing to revise § 414.610(c)(5)(ii) to conform the regulations to this statutory requirement. (For a discussion of past legislation extending section 1834(l)(12) of

the Act, please see the CY 2014 PFS final rule with comment period (78 FR 74439 through 74440), CY 2015 PFS final rule with comment period (79 FR 67743 through 67744), the CY 2016 PFS final rule with comment period (80 FR 71072), the CY 2019 PFS final rule with comment period (83 FR 59682), the CY 2024 PFS final rule with comment period (88 FR 79293), and the CY 2026 PFS final rule with comment period (90 FR 49837 through 49838)).

This statutory provision is self-implementing. It requires an extension of this rural bonus (which was previously established by the Secretary) through December 31, 2027, and does not require any substantive exercise of discretion on the part of the Secretary.

3. Ongoing Data Collection Requirements for the Medicare Ground Ambulance Data Collection System

We expect to address the ongoing data collection requirements for the Medicare Ground Ambulance Data Collection System in the CY 2028 PFS rulemaking to include the Medicare Payment Advisory Commission (MedPAC)'s June 15, 2026, Report to the Congress's findings: https://www.medpac.gov/document/june-2026-report-to-the-congress-medicare-and-the-health-care-delivery-system/.

4. Proposed Changes in Geographic Delineations for Ambulance Payment

Under section 1834(l)(2)(C) of the Act, the Secretary is required to consider appropriate regional and operational differences in establishing the AFS. Historically, the AFS has used the same geographic area designations as the acute care hospital inpatient prospective payment system (IPPS) and other Medicare payment systems to account for appropriate regional (urban and rural differences). The use of consistent geographic standards for Medicare payment provides for consistency across the Medicare program.

The current geographic areas used under the AFS effective CY 2015 are based on OMB standards published on June 28, 2010 (75 FR 37246 through 37252) and Census 2010 Bureau data (OMB Bulletin No. 13-01). For a discussion of OMB's delineation of Core-Based

Statistical Areas (CBSAs) and our implementation of the CBSA definitions under the AFS, we refer readers to the preamble of the CY 2007 AFS proposed rule (71 FR 30358 through 30361), the CY 2007 PFS final rule with comment period (71 FR 69712 through 69716), CY 2015 PFS proposed rule (79 FR 40372 through 40376), CY 2015 PFS final rule with comment period (79 FR 67744 through 67750), CY 2015 PFS final rule correction notice (79 FR 78716 through 78719), CY 2016 PFS proposed rule (80 FR 41788 through 41792), and the CY 2016 PFS final rule with comment period (80 FR 71072 through 71078).

In the July 16, 2021, **Federal Register** (86 FR 37777), OMB finalized a schedule for future updates based on results of the decennial Census updates to commuting patterns from the American Commuting Survey (ACS). In accordance with that schedule, on July 21, 2023, OMB released Bulletin No. 23–01. A copy of OMB Bulletin No. 23–01 may be obtained at: *https:// www.whitehouse.gov/wp-content/ uploads/2023/07/OMB-Bulletin-23-01.pdf.* According to OMB, the delineations reflect the 2020 Standards for Delineating Core Based Statistical Areas (''the 2020 Standards''), which appeared in the **Federal Register** on July 16, 2021 (86 FR 37770 through 37778), and the application of those standards to Census Bureau population and journey-to-work data (that is, 2020 Decennial Census, American Community Survey, and Census Population Estimates Program data).

OMB's 2020 Standards for Delineating Core Based Statistical Areas (86 FR 37778) defines a CBSA as a geographic entity with at least one core of at least 10,000 population, where there are two types of CBSAs. A metropolitan statistical area (MSA) is one type, with populations greater than 50,000 and a micropolitan statistical area (referred to in this discussion as a Micropolitan Area) is the other type as a CBSA associated with at least one core that has a population of at least 10,000 but less than 50,000. Counties that do not qualify for inclusion in a CBSA are deemed "outside of a CBSA."

The July 21, 2023 OMB Bulletin No. 23-01 contains a number of significant changes to the statistical areas in the United States and Puerto Rico. For example, our analysis shows that a

total of 53 counties that were once considered part of a CBSA would be considered to be located outside of a CBSA whereas a total of 54 counties that were located outside of a CBSA would be located in a CBSA under the revised OMB delineations. We believe it is important for the ambulance fee schedule to use the latest labor market area delineations available as soon as reasonably possible in order to maintain a more accurate and up-to-date payment system that reflects the reality of population shifts.

Additionally, in the FY 2025 IPPS final rule with comment period (89 FR 69253), we finalized our proposal to adopt OMB's revised delineations based on OMB bulletin No. 23-01 to delineate areas for purposes of applying the IPPS wage index. Given that ambulance services is a transport benefit where payment is based on the ZIP code of the ambulance point of pickup and in response to industry requests to update the geographic delineations and the statutory requirement at sections 1834(l)(9), (l)(12)(B)(iv), (l)(13)(A)(i), and (l)(14)(C) of the Act that require that we use the most recent version of the Goldsmith Modification to determine rural census tracts within MSAs, we are proposing to update the geographic delineations, consistent with historical practice, rather than proposing to continue to use the current geographic delineations.

We believe it would be appropriate to adopt the same geographic area delineations for use under the AFS as are used under the IPPS and other Medicare payment systems. Thus, we are proposing to make use of the new OMB delineations as described in the July 21, 2023, OMB Bulletin No. 23-01 beginning in CY 2027, along with the geographic areas based on the most version of the Goldsmith Modification, to more accurately identify urban and rural areas for AFS payment purposes. We believe that combining the updated OMB delineations with the Goldsmith Modification's Rural-Urban Commuting Area (RUCA) codes more realistically reflect rural and urban populations, and that the use of such delineations and codes under the AFS would result in more accurate payment. Under the AFS, consistent with our current definitions of urban and rural areas (42 CFR § 414.605), MSAs would continue to be recognized

as urban areas, while Micropolitan Areas and other areas outside MSAs, and rural census tracts within MSAs (as discussed later in this section), would be recognized as rural areas.

In addition to the OMB's statistical area delineations, the current geographic areas used in the AFS are, as just stated, based on the most recent version of the Goldsmith Modification. Sections 1834(l)(9), (l)(12)(B)(iv), (l)(13)(A)(i), and (l)(14)(C) of the Act require that we use the most recent version of the Goldsmith Modification to determine rural census tracts within MSAs. These rural census tracts are considered rural areas under the AFS (see § 414.605). In the CY 2015 PFS final rule with comment period (79 FR 67744 through 67750), we adopted the most recent (at that time) version of the Goldsmith Modification, designated as RUCA codes. RUCA codes use urbanization, population density, and daily commuting data to categorize every census tract in the country. For a discussion about RUCA codes, we refer the reader to the CY 2007 PFS final rule with comment period (71 FR 69714 through 69716), the CY 2015 PFS final rule with comment period (79 FR 67745 and 67746), CY 2015 PFS final rule correction notice (79 FR 78716 through 78719), and the CY 2016 PFS final rule with comment period (80 FR 71073 through 71074).

As stated previously, on July 21, 2023, OMB issued OMB Bulletin No. 23-01, which established revised delineations for Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas, and provided guidance on the use of the delineations of these statistical areas. Several modifications of the RUCA codes were necessary to take into account updated commuting data and the revised OMB delineations. We refer readers to the U.S. Department of Agriculture's Economic Research Service website for a detailed listing of updated RUCA codes found at: *https://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes.aspx.*

The updated RUCA code definitions were introduced on July 31, 2025, and are based on data from the U.S. Bureau of the Census, Department of Commerce, 2020 Census of Population and Housing and the 2017–21 Census Transportation Planning Package (CTPP) special

tabulation for the Department of Transportation and the American Association of State Highway and Transportation Officials. We are proposing to adopt the most recent modifications of the RUCA codes beginning in CY 2027, to recognize levels of rurality in census tracts located in every county across the nation, for purposes of payment under the AFS. If we adopt the most recent RUCA codes, many counties that are designated as urban at the county level based on population would have rural census tracts within them that would be recognized as rural areas through our use of RUCA codes.

The 2020 Primary RUCA codes are as follows:

(1) Metropolitan core: primary commuting flow is within an urban area (UA) of 50,000 or more people (metro UA).

(2) Metropolitan high commuting: primary commuting flow is 30 percent or more to a metro UA.

(3) Metropolitan low commuting: primary commuting flow is 10 percent to 30 percent to a metro UA.

(4) Micropolitan core: primary flow is within an urban area of 10,000 to 49,999 people (micro UA).

(5) Micropolitan high commuting: primary commuting flow is 30 percent or more to a micro UA.

(6) Micropolitan low commuting: primary commuting flow is 10 percent to 30 percent to a micro UA.

(7) Small town core: primary commuting flow is within an urban area of 9,999 or fewer people (small town UA).

(8) Small town high commuting: primary commuting flow is 30 percent or more to a small town UA.

(9) Small town low commuting: primary commuting flow is 10 percent to 30 percent to a small town UA.

(10) Rural areas: primary commuting flow is to a tract outside an UA.

Based on this classification, and consistent with our current policy as set forth in the CY 2015 PFS final rule with comment period (79 FR 67745), we are proposing to designate any census tracts falling at or above RUCA level 4.0 as rural areas for purposes of payment for ambulance services under the AFS. As discussed in the CY 2015 PFS final rule with comment period (79 FR 67745), the Federal Office of Rural Health Policy (formerly the Office of Rural Health Policy) within the Health Resources and Services Administration (HRSA) determines eligibility for its rural grant programs through the use of the RUCA code methodology. Under this methodology, HRSA designates any census tract that falls at RUCA level 4.0 or higher as a rural census tract. In addition to designating any census tracts falling at or above RUCA level 4.0 as rural areas, under the updated RUCA code definitions, HRSA has also designated as rural census tracts those census tracts with RUCA codes 2 or 3 that are at least 400 square miles in area with a population density of no more than 35 people. We refer readers to HRSA's website at: *https://www.hrsa.gov/rural-health/about-us/what-is-rural* for additional information. Consistent with the HRSA guidelines discussed previously and the policy we adopted in the CY 2015 PFS final rule with comment period (79 FR 67750), we are proposing for CY 2027 to designate as rural areas those census tracts that fall at or above RUCA level 4.0. We continue to believe that this HRSA guideline accurately identifies rural census tracts throughout the country, and thus would be appropriate to apply for AFS payment purposes.

Also, consistent with the policy we finalized in the CY 2015 PFS final rule with comment period (79 FR 67749), we would not designate as rural areas those census tracts that fall at RUCA levels 2 or 3 that are at least 400 square miles in area with a population density of no more than 35 people. We have determined that it is not feasible to implement this guideline due to the complexities of identifying these areas at the ZIP code level. We do not have sufficient information available to identify the ZIP codes that fall in these specific census tracts. Also, payment under the AFS is based on the ZIP codes; therefore, if the ZIP code is predominantly

metropolitan but has some rural census tracts, we do not split the ZIP code areas to distinguish further granularity to provide different payments within the same ZIP code. We believe that payment for all ambulance transportation services at the ZIP code level provides for a more consistent and administratively feasible payment system. For example, if we were to pay based on ZIP codes for some areas and counties or census tracts for other areas, there are circumstances where ZIP codes cross county or census tract borders and where counties or census tracts cross ZIP code borders. Such overlaps in geographic designations would complicate our ability to appropriately assign ambulance transportation services to geographic areas for payment under the AFS. Therefore, under the AFS, we would not designate as rural areas those census tracts that fall at RUCA levels 2 or 3 that are at least 400 square miles in area with a population density of no more than 35 people. We invite comments on this proposal.

As we stated in the CY 2015 PFS final rule with comment period (79 FR 67746), the adoption of the most current OMB delineations and the updated RUCA codes would affect whether certain areas are recognized as rural or urban. The distinction between urban and rural is important for ambulance payment purposes because urban and rural transports are paid differently. The determination of whether a transport is urban or rural is based on the point of pick-up for the transport, and thus a transport is paid differently depending on whether the point of pick-up is in an urban or a rural area. During claims processing, geographic designation of urban, rural, or super rural is assigned to each claim for an ambulance transport based on the point of pick-up ZIP code that is indicated on the claim.

Currently, section 1834(l)(12) of the Act (as amended by section 6203 of the Consolidated Appropriations Act, 2026) specifies that, for services furnished during the period July 1, 2004 through December 31, 2027, the payment amount for the ground ambulance base rate is increased by a "percent increase" (Super Rural Bonus) where the ambulance transport originates in a "qualified rural area," which is a rural area that we determine to be in the lowest 25th percentile of all rural populations arrayed by population density (also known as a "super

rural area"). We implement this Super Rural Bonus in § 414.610(c)(5)(ii). Adoption of the revised OMB delineations and the updated RUCA codes would have no negative impact on ambulance transports in super rural areas, as none of the current super rural areas would lose their status due to the revised OMB delineations and the updated RUCA codes.

The adoption of the new OMB delineations and the updated RUCA codes would affect whether transports are eligible for other rural adjustments under the AFS statute and regulations. For ground ambulance transports where the point of pick-up is in a rural area, the mileage rate is increased by 50 percent for each of the first 17 miles (§ 414.610(c)(5)(i)). For air ambulance services where the point of pick-up is in a rural area, the total payment (base rate and mileage rate) is increased by 50 percent (§414.610(c)(5)(i)). Furthermore, under section 1834(l)(13) of the Act (as amended by section 6203 of the Consolidated Appropriations Act, 2026) for ground ambulance transports furnished through December 31, 2027, transports originating in rural areas are paid based on a rate (both base rate and mileage rate) that is 3 percent higher than otherwise is applicable. (See also § 414.610(c)(1)(ii)).

If we adopt OMB's revised delineations and the updated RUCA codes, ambulance providers and suppliers that pick up Medicare beneficiaries in areas that would be Micropolitan or otherwise outside of MSAs based on OMB's revised delineations or in a rural census tract of an MSA based on the updated RUCA codes (but are currently within urban areas) may experience increases in payment for such transports because they may become eligible for the rural adjustment factors discussed previously, while those ambulance providers and suppliers that pick up Medicare beneficiaries in areas that would be urban based on OMB's revised delineations and the updated RUCA codes (but are currently in Micropolitan Areas or otherwise outside of MSAs, or in a rural census tract of an MSA) may experience decreases in payment for such transports because they would no longer be eligible for the rural adjustment factors discussed previously.

The use of the revised OMB delineations and the updated RUCA codes would mean the

recognition of new urban and rural boundaries based on the population migration that occurred over a 10-year period, between 2010 and 2020. As discussed previously in this section, we are proposing to use the updated 2020 RUCA codes to identify rural census tracts within MSAs, such that the census tracts falling at or above RUCA level 4.0 would continue to be designated as rural areas. To determine which ZIP codes are included in each such rural census tract, we are proposing to use the ZIP code approximation file developed by HRSA. This file includes the 2020 RUCA code designation for each ZIP code and can be found at: *https://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes.* If ZIP codes are added over time to the USPS ZIP code file (and thus are not included in the 2020 ZIP code approximation file provided to us by HRSA) or if ZIP codes are revised over time, we would determine the appropriate urban/rural designation for such ZIP code based on any updates provided on the HRSA and OMB websites located at: *https://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes.aspx* and *https:// www.whitehouse.gov/wp-content/uploads/2023/07/OMB-Bulletin-23-01.pdf.*

Based on the April 2026 United States Postal Service (USPS) ZIP code file that we are using in this proposed rule to assess the impacts of the revised geographic designations; there are a total of 42,956 ZIP codes in the U.S. Table B-H1 sets forth an analysis of the number of ZIP codes that changed urban/rural status in each U.S. State and territory using the April 2026 USPS ZIP code file, the revised OMB delineations (OMB Bulletin No. 23-01), and the updated 2020 RUCA codes. Based on this data, the geographic designations for approximately 95.87 percent of ZIP codes would be unchanged by OMB's revised delineations and the updated RUCA codes. As reflected in Table B-H1, more ZIP codes would change from urban to rural (1,172, or 2.73 percent) than rural to urban (602, or 1.40 percent). In general, it is expected that ambulance providers and suppliers in 1,172 ZIP codes within 47 States and Puerto Rico may experience payment increases if we adopt the revised OMB delineations and the updated RUCA codes, as these areas would be redesignated from urban to rural. The State of Maryland would have the

most ZIP codes changing from urban to rural with a total of 49, or 7.78 percent. Ambulance providers and suppliers in 602 ZIP codes within 43 States may experience payment decreases if we adopt the revised OMB delineations and the updated RUCA codes, as these areas would be redesignated from rural to urban. The State of South Carolina would have the most ZIP codes changing from rural to urban (20, or 3.68 percent). Our findings are illustrated in Table B-H1.

TABLE B-H1: ZIP CODES ANALYSIS BASED ON OMB'S REVISED DELINEATIONS AND UPDATED RUCA CODES

State/ Territory*	Total ZIP Codes	Total ZIP Codes Changed Rural to Urban	Percentage of Total ZIP Codes	Total ZIP Codes Changed Urban to Rural	Percentage of Total ZIP Codes	Total ZIP Codes Not Changed	Percentage of Total ZIP Codes Not Changed
AK	276	0	0.00%	0	0.00%	276	100.00%
AL	854	20	2.34%	11	1.29%	823	96.37%
AR	727	4	0.55%	18	2.48%	705	96.97%
AS	1	0	0.00%	0	0.00%	1	100.00%
AZ	571	2	0.35%	8	1.40%	561	98.25%
CA	2730	35	1.28%	93	3.41%	2602	95.31%
CO	677	3	0.44%	22	3.25%	652	96.31%
CT	421	1	0.24%	15	3.56%	405	96.20%
DC	319	1	0.31%	0	0.00%	318	99.69%
DE	99	0	0.00%	6	6.06%	93	93.94%
EK	63	0	0.00%	0	0.00%	63	100.00%
EM	858	10	1.17%	14	1.63%	834	97.20%
FL	1516	23	1.52%	27	1.78%	1466	96.70%
FM	4	0	0.00%	0	0.00%	4	100.00%
GA	1032	5	0.48%	22	2.13%	1005	97.38%
GU	21	0	0.00%	0	0.00%	21	100.00%
HI	143	2	1.40%	0	0.00%	141	98.60%
IA	1080	7	0.65%	11	1.02%	1062	98.33%
ID	335	6	1.79%	10	2.99%	319	95.22%
IL	1630	10	0.61%	86	5.28%	1534	94.11%
IN	1002	16	1.60%	23	2.30%	963	96.11%
KY	1030	25	2.43%	23	2.23%	982	95.34%
LA	739	26	3.52%	23	3.11%	690	93.37%
MA	752	2	0.27%	27	3.59%	723	96.14%
MD	630	0	0.00%	49	7.78%	581	92.22%
ME	505	15	2.97%	14	2.77%	476	94.26%
MH	2	0	0.00%	0	0.00%	2	100.00%
MI	1186	34	2.87%	18	1.52%	1134	95.62%
MN	1044	11	1.05%	10	0.96%	1023	97.99%
MP	3	0	0.00%	0	0.00%	3	100.00%
MS	541	6	1.11%	8	1.48%	527	97.41%
MT	411	1	0.24%	0	0.00%	410	99.76%

State/ Territory*	Total ZIP Codes	Total ZIP Codes Changed Rural to Urban	Percentage of Total ZIP Codes	Total ZIP Codes Changed Urban to Rural	Percentage of Total ZIP Codes	Total ZIP Codes Not Changed	Percentage of Total ZIP Codes Not Changed
NC	1102	25	2.27%	55	4.99%	1022	92.74%
ND	419	12	2.86%	1	0.24%	406	96.90%
NE	632	0	0.00%	4	0.63%	628	99.37%
NH	292	0	0.00%	12	4.11%	280	95.89%
NJ	748	8	1.07%	5	0.67%	735	98.26%
NM	439	0	0.00%	3	0.68%	436	99.32%
NV	258	0	0.00%	3	1.16%	255	98.84%
NY	2247	33	1.47%	73	3.25%	2141	95.28%
OH	1489	42	2.82%	31	2.08%	1416	95.10%
OK	792	24	3.03%	6	0.76%	762	96.21%
OR	500	12	2.40%	15	3.00%	473	94.60%
PA	2245	19	0.85%	157	6.99%	2069	92.16%
PR	178	2	1.12%	12	6.74%	164	92.13%
PW	2	0	0.00%	0	0.00%	2	100.00%
RI	91	0	0.00%	2	2.20%	89	97.80%
SC	544	20	3.68%	21	3.86%	503	92.46%
SD	418	1	0.24%	3	0.72%	414	99.04%
TN	814	19	2.33%	20	2.46%	775	95.21%
TX	2730	60	2.20%	55	2.01%	2615	95.79%
UT	361	3	0.83%	7	1.94%	351	97.23%
VA	1277	16	1.25%	41	3.21%	1220	95.54%
VI	16	0	0.00%	0	0.00%	16	100.00%
VT	309	2	0.65%	0	0.00%	307	99.35%
WA	744	8	1.08%	7	0.94%	729	97.98%
WI	919	12	1.31%	27	2.94%	880	95.76%
WK	712	12	1.69%	5	0.70%	695	97.61%
WM	342	0	0.00%	3	0.88%	339	99.12%
WV	936	7	0.75%	66	7.05%	863	92.20%
WY	198	0	0.00%	0	0.00%	198	100.00%
Totals	**42,956**	**602**	**1.40%**	**1,172**	**2.73%**	**41,182**	**95.87%**

*ZIP code analysis includes U.S. States and Territories (FM—Federated States of Micronesia, GU—Guam, MH—Marshall Islands, MP—Northern Mariana Islands, PW—Palau, AS—American Samoa; VI—Virgin Islands; PR—Puerto Rico). Missouri is divided into east and west regions due to work distribution of the Medicare Administrative Contractors (MACs): EM—East Missouri, WM—West Missouri. Johnson and Wyandotte counties in Kansas were changed as of January 2010 to East Kansas (EK), and the rest of the state is West Kansas (WK).

For more detail on the impact of our proposals, in addition to Table B-H1, the following files are available through the Internet on the Ambulances Services Center website at: *https://www.cms.gov/medicare/coverage/ambulances-services-center*; ZIP Codes By State Changed From Urban To Rural: ZIP Codes By State Changed From Rural To Urban: List of ZIP Codes With RUCA Code Designations: and Complete List of ZIP Codes.

We invite public comments on our proposals to make use of the revised OMB delineations as set forth in OMB's July 21, 2023 bulletin (No. 23-01) and the most recent modifications of the RUCA codes as discussed previously for CY 2027 for purposes of payment under the AFS.

X. Request for Information (RFI) on Duplicate Laboratory Testing, Imaging, and Result Sharing and Interoperability

1. Overview

Diagnostic imaging and laboratory testing are critical to determining a patient's course of treatment. Imaging data and test results are often siloed within the acquiring systems' electronic health record and inaccessible outside of those systems. Treating health care providers often do not even know of the existence of these siloed results. The inaccessibility of laboratory and imaging data due to siloing results in incomplete or delayed care management and duplicative testing, with concomitant increased costs (and in the case of duplicative diagnostic imaging, unnecessary radiation exposure).

2. Purpose of the RFI

We are issuing this RFI to gather input from interested parties — including clinicians, laboratories, imaging health care providers, health systems, payers, health IT developers, and other interested parties — to inform potential actions aimed at addressing the interoperability and duplicate testing concerns described earlier in this section.

3. Potential Mechanisms for Addressing Duplicative Payment

Given the concerns discussed previously in this section resulting from duplicate diagnostic laboratory and image testing, we are exploring various mechanisms for addressing duplicative payment:

- Clarifications to billing instructions to laboratories and imaging centers on parameters of duplicate laboratory or imaging tests;
- Local Medicare Administrative Contractor (MAC) edits that would result in non-payment or reductions in payment as applicable for duplicate laboratory or imaging tests;
- Use of payment integrity levers to recoup payments from health care providers and suppliers who performed duplicate laboratory or imaging tests; and
- Application of frequency limitations to certain tests where clinically appropriate.

We note that frequency limitations are already in use in certain contexts. For example, a Local Coverage Decision (LCD) from a MAC limits testing for Vitamin D levels (L33996 — Vitamin D Assay Testing), providing that once a beneficiary has been shown to be Vitamin D deficient, further testing is medically necessary only to ensure adequate replacement has been accomplished, with annual testing thereafter being appropriate depending on the indication and other mitigating factors. We believe there are likely other diagnostic laboratory tests that should similarly be subject to frequency limitations.

We also recognize that in some cases more frequent testing is clinically justified and we are therefore seeking input not only on which laboratory and imaging tests should be subject to frequency limitations, but also on what exceptions should be permitted to ensure beneficiary access is not inappropriately restricted.

We seek input on how such enforcement actions can be implemented without restricting beneficiary access to necessary care, and specifically how practitioners can communicate clinical justification for repeat testing in specific circumstances — for example, in cases of trauma, stroke, or evolving emergencies where repeat imaging may be clinically appropriate.

- Should CMS consider possible changes to payment policies when diagnostic tests are billed duplicatively; that is, additional imaging or diagnostic laboratory tests for the same condition? For example, is there a time period which an image or laboratory test should automatically be considered "duplicate" and therefore subject to payment consequences? To which kinds of tests or subsets of tests should such policies apply? We welcome responses from both the clinical community as well as payors who have likely addressed or considered these or similar issues related to the payments they make.

4. Laboratory and Imaging Interoperability

Several agencies within HHS have indicated an interest in gaining public input on interoperability for various health programs. Section 4003 of the 21st Century Cures Act (Pub. L. 114-255) amended section 3000 of the PHSA to add a new paragraph (10) to include a

statutory definition of "interoperability." Interoperability is defined to mean, with respect to health information technology, such health information technology that— (A) enables the secure exchange of electronic health information with, and use of electronic health information from, other health information technology without special effort on the part of the user; (B) allows for complete access, exchange, and use of all electronically accessible health information for authorized use under applicable State or Federal law; and (C) does not constitute information blocking as defined in section 3022(a) of the Public Health Service Act.

We view duplicate imaging and laboratory testing as one of several use cases in which the lack of clinical interoperability causes non-trivial beneficiary harm and program integrity concerns. In recognition of that perspective, the broader department, and the Office of the National Coordinator for Health Information Technology (ONC) in particular, adopts standards that facilitate easier exchange of diagnostic clinical information and includes criteria in the ONC Health IT Certification Program that address the certification of health IT to exchange this information. In the January 30, 2026 **Federal Register** (91 FR 4054), ONC published an RFI titled, "Request for Information: Diagnostic Imaging Interoperability Standards and Certification".

The regulatory background section of the January 2026 RFI (91 FR 4055) outlined the following prior efforts:

- Federal efforts to incorporate diagnostic imaging requirements into certification criteria for electronic health record (EHRs) and other health IT systems span more than a decade, marked by a recurring cycle of proposals, reversals, and unresolved interoperability challenges.
- In 2012, the Secretary published the proposed rule titled, "Health Information Technology: Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology, 2014 Edition; Revisions to the Permanent Certification Program for Health Information Technology" (77 FR 13832) (hereinafter " 2014 Edition Proposed Rule"), which proposed an imaging certification criterion (§ 170.314(a)(12)) without requiring the

Digital Imaging and Communications in Medicine (DICOM) standard, while simultaneously requesting public comments on its use (77 FR 13838). The proposed rule also proposed to require EHR technology certified under the View, Download, and Transmit (VDT) certification criterion (§ 170.314(e)(1)) to be capable of enabling images formatted according to the DICOM-formatted images (77 FR 13839 and 13840). However, when the 2014 Edition Final Rule was published later that year (77 FR 54163), the DICOM standard was not adopted, and the image download and transmission requirement was removed from the VDT certification criterion — largely due to complexity and implementation burden raised by commenters (77 FR 54183). Instead, the 2014 Edition Final Rule adopted an "image results" certification criterion that required Health IT Modules certified to that criterion to indicate the availability of patient images and narrative interpretations, accessible either through a direct link within the EHR or a context-sensitive link to an external application (77 FR 54172 and 54173).

Between 2014 and 2024, ONC continued efforts to modernize the VDT imaging related criteria. Public feedback consistently underscored challenges related to standards maturity, uneven implementation across settings, and fragmentation in available technologies. Imaging exchange remains uniquely complex: in addition to narrative reports, large image files, associated metadata, and viewing capabilities must be exchanged in a manner that is performant, secure, and consistent across systems. Information blocking, economic and workflow burdens, and inconsistent conformance to existing standards all continue to affect access to diagnostic imaging across organizational boundaries.

- Responses to other recent RFIs (for example, “Request for Information; Health Technology Ecosystem” which appeared in the May 16, 2025 **Federal Register** (90 FR 21034) (hereinafter “Health Technology Ecosystem RFI”) indicate that the imaging exchange environment remains fragmented and unreliable, with ongoing dependence on CDs and DVDs and limited availability of modern, API-enabled tools that would allow patients and health care providers to access and share images seamlessly. Interested parties have also highlighted privacy

and security considerations that must be accounted for as exchange capabilities evolve. Public feedback highlights support for building on existing standards rather than creating entirely new exchange paradigms.

- Similar patterns are evident in laboratory interoperability, where challenges frequently stem from differing ordering workflows, variations in result reporting practices, local coding conventions, and inconsistent implementation of standards. These issues mirror broader interoperability challenges and reinforce the need for coordinated, standards-based approaches across diagnostic domains.

Other key information received in response to the Health Technology Ecosystem RFI:

- The current system of fragmented patient portals is unworkable.
- A unified, "one-stop shop" for health records is the universal goal.
- API access must go beyond the USCDI data set to the full electronic health information (EHI).
- Existing data access tools are insufficient.

Given what we discussed earlier in this section, we believe there are opportunities to establish or improve interoperability between laboratories and physicians, hospitals, and other care delivery organizations. Specifically, participation in a national interoperability network for exchanging diagnostic imaging and laboratory results in a standardized format remains top of mind for the Department. Such participation would allow physicians, hospitals, laboratories, and other care delivery organizations to more easily access relevant clinical data to prevent the duplicate imaging and testing discussed previously in this section. We are aware that such participation is insufficient. The networks must resolve fundamental technical issues like authentication (for example, are you who you say you are?); authorization (for example, are you allowed to access the data?); and patient matching (for example, what records are associated with the individual in question?). Without a reliable way to match records across systems, even well-connected networks would return incomplete or incorrect results.

We have also considered building on the existing Electronic Notifications Condition of Participation (CoP) at 42 CFR 482.4(d) to require hospitals to participate in a national interoperability network. We believe that the relationship to patient health and safety is clear: timely and accurate information leads to coordinated, safer care and treatment decisions for patients. While we believe a CoP, for Medicare and Medicaid participating hospitals, would be an appropriate mechanism to drive interoperability, we also recognize that unlike other provider types the only statutorily available penalty for noncompliance with the hospital CoPs is termination from the Medicare program, as provided under section 1866(b)(2)(A) and (B) of the Act. We believe this would be overly burdensome. However, we will continue to monitor hospital advances in interoperability and may consider future rulemaking or look to other programs like the Medicare Promoting Interoperability Program or the Hospital Inpatient Quality Reporting program (IQR) or both.

Building upon the RFIs noted previously, we would like to further explore opportunities related to interoperability, specifically for diagnostic laboratory tests and imaging services. The following are questions for which we seek input.

- Because image exchange can involve substantial technical and operational costs, should HHS or CMS consider incentives to support adoption and implementation, and if so, what form should those incentives take?

- Given variability in conformance to existing laboratory and imaging exchange standards, would interested parties find value in expanded conformance testing tools, certification approaches, or implementation guidance?

- How should CMS account for cases in which repeat imaging occurs because prior imaging results were not available for timely, standards-based reuse? Should CMS consider payment, quality, or participation policies that create accountability for the initial imaging provider, furnishing entity, or facility when failure to make results reusable contributes to

avoidable repeat imaging? Are there penalties or disincentives for non-compliance we should consider?

- For laboratory interoperability specifically, what barriers continue to impede exchange despite the availability of established standards, and what policy levers could help address those barriers? Should we consider incentives to support laboratory adoption and implementation of health data standards?

Should CMS establish a minimum data standard for result shareability, for example, a United States Core Data for Interoperability (USCDI+) supplement for imaging and laboratory results, requiring all participating entities to deliver both a structured Fast Healthcare Interoperability Resources (FHIR) R4 Diagnostic Report resource and a human-readable Portable Document Format/Archive (PDF/A) rendition to the ordering health care provider's designated endpoint as a condition of Medicare payment? How should CMS address health care providers who have not yet implemented FHIR-native workflows, especially in rural areas?

IV. Updates to the Quality Payment Program

A. CY 2027 Modifications to the Quality Payment Program Reporting and Data Submission

1. Executive Summary

a. Overview

This section of this proposed rule outlines changes to the Quality Payment Program starting January 1, 2027, except as otherwise noted for specific provisions. We continue to move the Quality Payment Program forward, including focusing more on alignment between the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APM) tracks of participation, alignment with broader CMS initiatives, and new options for clinicians to participate in more meaningful ways. We aim to achieve continuous improvement in the quality of health care services provided to Medicare beneficiaries and other patients through MIPS and Advanced APMs for the CY 2027 performance period/2029 payment year.

Authorized by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114-10, April 16, 2015), the Quality Payment Program is a value-based payment program, by which clinicians are rewarded for providing high-value, high-quality care to their patients in a cost-efficient manner. There are two ways for clinicians who provide services under the Medicare program to participate in the Quality Payment Program: MIPS and Advanced APMs. The statutory requirements for the Quality Payment Program are set forth in section 1848(q) and (r) of the Act for MIPS and section 1833(z) of the Act for Advanced APMs.

For the MIPS participation track, MIPS eligible clinicians (defined at § 414.1305)[371] are subject to a MIPS payment adjustment (positive, neutral, or negative) based on their performance in four performance categories: cost, quality, improvement activities, and Promoting Interoperability. We assess each MIPS eligible clinician's total performance according to

[371] We note that the term MIPS eligible clinician is defined at § 414.1305 as including a group of at least one MIPS eligible clinician billing under a single tax identification number. We refer readers to our policies governing group reporting and scoring under MIPS as set forth at § 414.1310(e).

established performance standards for the applicable measures and activities specified in each of these four performance categories during a performance period to compute a final composite performance score (a "final score" as defined at § 414.1305). In calculating the final score, we must apply different weights for the four performance categories, subject to certain exceptions, as set forth in section 1848(q)(5) of the Act and at § 414.1380. Unless we assign a different scoring weight under these exceptions, for the CY 2027 performance period/2029 MIPS payment year, the scoring weights are as follows: 30 percent for the quality performance category; 30 percent for the cost performance category; 25 percent for the Promoting Interoperability performance category; and 15 percent for the improvement activities performance category.

Once calculated, each MIPS eligible clinician's final score is compared to the performance threshold established in prior rulemaking for that performance period to calculate the MIPS payment adjustment factor as specified in section 1848(q)(6) of the Act, such that the MIPS eligible clinician will receive in the applicable MIPS payment year: (1) a positive adjustment, if their final score exceeds the performance threshold; (2) a neutral adjustment, if their final score meets the performance threshold; or (3) a negative adjustment, if their final score is below the performance threshold. In calculating the MIPS payment adjustment factor for a MIPS eligible clinician, we account for scaling factor and budget neutrality requirements, as further specified in section 1848(q)(6) of the Act. We then apply the MIPS payment adjustment factor to amounts otherwise paid under Medicare Part B for covered professional services for the MIPS eligible clinician for the applicable MIPS payment year and payments for covered professional services are increased, decreased, or not adjusted based on the MIPS eligible clinician's final score relative to the performance threshold.

Section 1848(q) of the Act sets forth other requirements applicable to MIPS, including opportunities for feedback and targeted review and public reporting of MIPS eligible clinicians' performance. Section 1848(r) of the Act sets forth more specific requirements for development of measures for the cost performance category under MIPS.

For the Advanced APM track, if an eligible clinician participates in an Advanced APM and achieves Qualifying APM Participant (QP) or Partial QP status, they are excluded from the MIPS reporting requirements and payment adjustment (though eligible clinicians who are Partial QPs may elect to participate in MIPS and be subject to the MIPS reporting requirements and payment adjustment). In alignment with the application of QPP eligibility determinations, we are proposing to apply QP and Partial QP status to the TIN/NPI under which a clinician achieves QP or Partial QP status. Under current law, eligible clinicians who are QPs for the 2024 performance year/2026 payment year and beyond will receive an increased physician fee schedule update of 0.75 percent qualifying APM conversion factor. We note that, historically, QPs received a lump sum APM Incentive Payment in the corresponding payment year, calculated as a specified percentage of the QP's paid claims for covered professional services from the base year. Only legislation enacted by Congress can make changes to either the enhanced QP conversion factor updates or the APM Incentive Payment.

We plan to continue developing policies for the Quality Payment Program that more effectively reward high-quality of care for patients and increase opportunities for Advanced APM participation. We continue to implement MIPS Value Pathways (MVPs) to allow for a more cohesive participation experience by connecting activities and measures from the four MIPS performance categories that are relevant to a specialty, medical condition, or a particular population.

As we move into the 10th year of the Quality Payment Program, we will be implementing the updates set forth in this section of this proposed rule, encouraging continued improvement in clinicians' performance with each performance year and driving improved quality of health care through payment policy.

b. Summary of Major Proposals

(1) Transforming the Quality Payment Program

The Making America Healthy Again (MAHA) initiative (*https://www.hhs.gov/maha/index.html*) represents a shift from the focus on chronic disease management and moves toward prevention and restoring foundational wellness. This initiative aims to address the root causes of poor health outcomes by reducing chronic disease rates, improving nutrition, promoting preventative care, and increasing transparency in health systems. This vision is supported by aligning policies in MIPS and APMs within the Quality Payment Program with the foundational pillars of MAHA. We are expanding the MVP portfolio to include Diabetic Disease and Hypertension MVPs that address the prevention of chronic illnesses and aim to reduce the incidence and impact of long-term conditions. In alignment with the goal of promoting preventive care and fostering a more proactive and holistic approach to health management, we are proposing new improvement activities under the "Advancing Health and Wellness" subcategory within the improvement activities performance category. The proposed improvement activities integrate concepts that address nutrition, implement lifestyle approaches to disease management, and support patient wellness to ensure a healthier future.

Through the policies described in this proposed rule, we intend to transform and simplify MIPS, promote the use of connected measures and activities, continue rewarding clinicians for providing high value care, and use data-driven information to help all clinicians improve care and engage patients. In accordance with the stated intent, we are proposing the traditional MIPS reporting option would be sunset and that MVPs will be the only reporting option for MIPS beginning with the CY 2029 performance period/2031 MIPS payment year. Traditional MIPS would continue to be an available reporting option until the CY 2029 performance period/2031 MIPS payment year, when sunsetting occurs.

(a) Transforming MIPS: MVP Strategy

MVPs will improve value, reduce burden, and inform patient choice in selecting clinicians. To support our goal of phasing out traditional MIPS and transitioning eligible clinicians to MVP reporting, we are proposing policies supporting MVP only reporting for

MIPS. The MVP reporting option offers aligned measures and activities across quality, cost, improvement activities, and Promoting Interoperability performance categories, focusing on specific specialties, conditions, or patient populations to make reporting more meaningful. Specifically, we propose that beginning in the CY 2029 performance period/2031 MIPS payment year, eligible clinicians participating in MIPS, and not reporting the APM Performance Pathway (APP), would be required to report the measures and activities in a selected MVP for MIPS. We also propose including virtual groups in MVP reporting to ensure all eligible clinicians can report MVPs.

(b) MIPS Value Pathways Development and Maintenance

To continue moving the healthcare community toward value-based, high-quality, safe, and cost-efficient care, we are proposing three new MVPs around the following topics: Diabetic Disease, Hypertension, and Hospitalist.

We are also proposing MVP maintenance updates to our MVP inventory that are aligned with the MVP development criteria and take into consideration feedback from interested parties we have received through the maintenance process. Additionally, we updated all the MVPs to include MIPS core measures. Finally, we are renaming the Rehabilitative Support for Musculoskeletal Care MVP to Rehabilitative Support MVP to better represent the measures and activities included in the MVP.

(c) APM Performance Pathway

We are proposing to align quality measures in the APM Performance Pathway (APP), original quality measure set and the APP Plus quality measure set to reflect our proposed changes to measures specified for the quality performance category as discussed in section IV.A.4.b.2 of this proposed rule.

(d) Fast Healthcare Interoperability Resources (FHIR) Request for Information

We are advancing quality measurement by transitioning existing quality measures and reporting processes to Fast Healthcare Interoperability Resources® (FHIR®)-based digital

reporting options. In this proposed rule, we seek input on the anticipated transition timeline, key milestones, and implementation considerations for FHIR-based quality reporting in the Quality Payment Program and other CMS quality reporting programs.

(e) MIPS Quality Performance Category

For the CY 2027 performance period/2029 MIPS payment year, we are proposing to establish a measure set inventory of 180 MIPS quality measures, of which 177 are available in traditional MIPS and three are available only for utilization in MVPs. Proposed changes to the measure set inventory include 20 measure removals, 10 measure additions for CY 2027, one measure addition for CY 2028, and 43 substantive changes to existing measures.

The proposed measure removals focus on low bar process measures, measures reaching extremely topped-out status or the end of the topped-out measure lifecycle, measures that are duplicative of new or current measures, measures with limited adoption and therefore no benchmark, measures lacking robustness, and measures the steward would no longer maintain. The proposed measure additions focus on measuring patient-reported outcomes and chronic disease management. Proposed substantive changes to existing measures would ensure the measures included in MIPS continue to be meaningful and drive improvements in quality of care.

Beginning with the CY 2027 performance period/2029 MIPS payment year, we are proposing to implement the MIPS core measure designation in traditional MIPS and MVPs. We are also proposing to remove the high priority designation from MIPS quality measures and the MVP inventory. Additionally, we are proposing to no longer use the high priority designation as one of the retention criteria for MIPS quality measures and the MVP inventory.

Furthermore, beginning with the CY 2027 performance period/2029 MIPS payment year, we propose removing the current quality measure data submission requirement of one outcome (or one high priority measure if an outcome measure is not available) for traditional MIPS and MVP reporting and replacing it with the requirement that eligible clinicians must report at least

one MIPS core measure (or, if an applicable MIPS core measure is not available, report one other MIPS non-core measure). We are also proposing that if a MIPS eligible clinician does not have an available and applicable MIPS core measure, they must attest during the data submission period that a MIPS core measure is not available and applicable for them to report. The clinician would then be required to choose another measure to report instead of the MIPS core measure.

Also, we are proposing that clinicians in small practices would be exempt from the proposed MIPS core measure requirement and would not need to submit an attestation if a MIPS core measure is not available and applicable to them.

Lastly, we are proposing to expand the definition of the collection type to include Medicare Electronic Clinical Quality Measures for Accountable Care Organizations Participating in the Medicare Shared Savings Program (Medicare eCQMs); establish the data submission criteria for Medicare eCQMs; and establish the data completeness criteria for Medicare eCQMs.

(f) MIPS Cost Performance Category

We are proposing to update the operational list of care episodes and patient condition groups and codes to reflect coding changes identified through our annual maintenance process for MIPS cost measures.

(g) MIPS Improvement Activities Performance Category

We are proposing the following updates to the MIPS Improvement Activity Inventory beginning with the CY 2027 performance period/2029 MIPS payment year. First, we are proposing to add six new improvement activities into two subcategories: (1) Care Coordination and (2) Advancing Health and Wellness, our newest subcategory. Second, we propose modifying five existing improvement activities currently specified for the performance category. Third, we propose to remove eleven improvement activities currently specified for the performance category.

(h) MIPS Promoting Interoperability Performance Category

We are proposing the following policies:

● Starting with the CY 2026 performance period/2028 MIPS payment year, we are proposing to remove the ONC Direct Review attestation and the ONC-Authorized Certification Bodies (ACB) Surveillance attestation.

● Starting with the CY 2027 performance period/2029 MIPS payment year, we are proposing to:

++ Modify the definition of Certified Electronic Health Record Technology (CEHRT) to align with the applicable Office of the National Coordinator for Health Information Technology's (ONC) proposals to remove certain certification criteria from the ONC Health IT Certification Program as outlined in the Health Data, Technology, and Interoperability: Office of the Assistant Secretary for Technology Policy (ASTP)/ONC Deregulatory Actions to Unleash Prosperity (HTI-5) proposed rule;

++ Modify the Electronic Prior Authorization measure by updating the measure description, and for the CY 2027 performance period, changing the measure from being a required measure to being an optional measure; and

++ Remove the Security Risk Analysis measure.

● Starting with the CY 2028 performance period/2030 MIPS payment year, we are proposing to:

++ Modify the Electronic Prior Authorization measure by updating the measure description to account for additional requirements pertaining to the measure, and changing the measure to being a required measure; and

++ Add a new measure, Electronic Prior Authorization for Prescription Drugs, as a required measure under the Health Information Exchange objective.

(i) MIPS Scoring

We are proposing scoring policies consistent with the proposed MIPS core measure requirement for MIPS eligible clinicians beginning in the CY 2027 performance period/2029 MIPS payment year. Specifically, we propose to assign zero measure achievement points for one

quality measure for clinicians reporting data under traditional MIPS and MVP reporting, if they do not submit a MIPS core measure and do not attest during data submission that they do not have an available and applicable MIPS core measure.

We are seeking feedback on the proposed list of topped out measures impacted by limited measure choice in specialty measure sets and MVPs to be subject to the defined topped out measure benchmark for the CY 2027 performance period/2029 MIPS payment year. We propose to modify the publishing location of topped out measures impacted by limited measure choice and scored according to the defined topped out benchmark. We also propose to apply the defined topped out benchmark for MIPS core measures that are topped out for 2 or more consecutive years. Additionally, we seek feedback in a request for information (RFI) on the future direction of MVP scoring policies.

Lastly, we are proposing the following modifications: The benchmarking methodology for the Medicare CQMs collection type by extending the use of flat benchmarks; establishment of a flat benchmarking methodology for the proposed Medicare eCQMs collection type; and modification of the Electronic Prior Authorization measure from a required measure to an optional measure worth 10 bonus points under the MIPS Promoting Interoperability performance category for the CY 2027 performance period/2029 MIPS payment year.

(j) Third Party Intermediaries

In this proposed rule, we seek to update our requirements for third-party intermediaries related to the conditions for approval of Qualified Clinical Data Registries (QCDRs) and qualified registries, remove the additional requirements for health IT vendors, and revise our remedial action and termination policies. At a high level, we are proposing the following:

- Clarify that the additional requirements for health IT vendors no longer apply beginning with the CY 2025 performance period/2027 MIPS payment year, as health IT vendors are no longer permitted to submit MIPS data as a third-party intermediary starting in that year;
- Make minor revisions to the audit requirements;

- Modify our policy so that third-party intermediaries that do not submit data for 1 year would be terminated;

- Revise existing policies to specify a QCDR or a qualified registry must be able to submit to CMS data for at least six quality measures including at least one MIPS core measure to align with the proposed removal of high priority designation from MIPS quality measures and the MIPS core measure reporting requirements in section IV.A.4.d.(1)(c) of this proposed rule; and

(k) Calculating MIPS Final Score

In this proposed rule, we propose that beginning with the CY 2027 performance period/2029 MIPS payment year we will use whatever data is most current and reliable to determine if an individual MIPS eligible clinician is located in an area that has been identified as being affected by an extreme and uncontrollable circumstance (EUC). We also propose to adjust the deadline by which clinicians would be able to submit reweighting requests for the quality, improvement activities, and Promoting Interoperability performance categories due to scenarios where a third-party intermediary did not submit data on their behalf in accordance with the applicable data submission deadlines. Specifically, we propose that beginning with the CY 2025 performance period/2027 MIPS payment year, MIPS eligible clinicians would be able to submit reweighting requests on or before December 31st of the year preceding the relevant MIPS payment year.

(l) Public Reporting

The public reporting section of this proposed rule contains a policy proposal and RFI for improvements to the CMS Compare Tools hosted by the U.S. Department of Health and Human Services (HHS) available on clinician profile pages at *https://www.medicare.gov/care-compare/* and in the Medicare Provider Data Catalog available at *https://data.cms.gov/provider-data/topics/doctors-clinicians*.

We propose to remove the requirement preventing public reporting of any performance data reported through an MVP on new improvement activity or Promoting Interoperability (PI) measure, objective, or activity during the first year in which it is included in such MVP. Under the removal of this requirement, performance information for new improvement activities and PI measures would be publicly reported on CMS Compare Tools during the first year in which the measures and activities are included in the program, regardless of reporting option.

We are also soliciting feedback on improvements to the current star rating assignment methodology for quality measure scores collected under the administrative claims collection type. With more information, we can determine whether an alternative methodology for star rating assignments is more appropriate for administrative claims quality measures prior to the public reporting of these scores on clinicians' profile pages on the Medicare.gov Compare Tool.

(2) Advanced APM Proposals

We are proposing to modify the application of the QP and partial QP status at § 414.1425 to ensure that only TINs participating in Advanced APMs receive additional incentive payments, both the APM Incentive Payment and the qualifying APM conversion factor.

We are proposing to clarify language at § 414.1425(c)(5) pertaining to when QP status is lost as a result of an APM Entity terminating participation from an Advanced APM.

We are proposing that for certain Alternative Payment Models where a participation list is not practicable that they would not provide a participation list for as a MIPS APM or APM participation for QPP purposes.

We are proposing to modify the conditions by which we award credit for Improvement Activities specified at § 414.1355 to ensure that participants receive credit.

We are proposing to modify the thresholds established at § 414.1430 in accordance with the Consolidated Appropriations Act, 2026.

2. Definitions

At § 414.1305, we are proposing to revise definitions of the following terms:

- APM Incentive Payment
- Collection type
- High priority measure
- MVP Participant
- Participation List

These terms and definitions are discussed in detail in the relevant sections of this proposed rule.

3. *Transforming MIPS: MIPS Value Pathway (MVP) Strategy*

We play a leading role in transitioning the Federal health care system from Original Medicare payment toward value-based payment, incentivizing higher quality of care over higher quantity of care. MIPS aims to drive value through the collection, assessment, and public reporting of data that informs and rewards the delivery of high-value care. We continue to focus on transforming health care delivery, driving higher value care, and increasing alignment with other CMS programs and initiatives to reduce burden. We intend to continue our efforts to align the Quality Payment Program with the broader aims of CMS to ensure patients receive the care they want and deserve by promoting prevention, wellness, and chronic disease management. We are guided by the CMS National Quality Strategy[372] which focuses on achieving the best outcomes and safest care across the full care journey through innovation and collaboration. We are implementing meaningful improvements designed to strengthen healthcare delivery and advance patient outcomes. Through these efforts, we strive to create a healthcare system that not only responds to chronic disease but works proactively to prevent it.

In the CY 2022 PFS proposed rule and CY 2025 PFS final rule, we stated our intent to transform MIPS and obtain more meaningful, comparable performance data, and drive higher value care through MVPs (86 FR 39356 and 89 FR 98346) and that we intended to propose a full transition to MVP reporting along with the Alternative Payment Model (APM) Performance Pathway (APP) reporting to support movement towards value-based payment (86 FR 65394 through 65396, 87 FR 70034, and 89 FR 98346). As noted in the CY 2025 PFS proposed rule (89 FR 62012), robust MVP availability and clinician coverage would be a precursor to sunsetting traditional MIPS. Through this proposed rule and future rulemaking, we acknowledge that we will need to develop policies to support MVP reporting for all MIPS eligible clinicians by the CY 2029 performance period/2031 MIPS payment year. We will continue engaging with

[372] *https://www.cms.gov/medicare/quality/meaningful-measures-initiative/cms-quality-strategy*.

specialty societies to identify gaps and opportunities, and leveraging additional policy options, as needed.

In this section, we are proposing to phase out traditional MIPS reporting for MIPS eligible clinicians not participating in the APP and are proposing to sunset traditional MIPS reporting beginning with the CY 2029 performance period/2031 MIPS payment year. The MVP reporting option offers aligned measures and activities across quality, cost, improvement activities, and Promoting Interoperability performance categories. MVPs focus on specific specialties, conditions, or patient populations to make reporting more meaningful. With increased MIPS eligible clinicians reporting MVPs, MVP comparative performance data may become valuable to patients and caregivers in evaluating clinician performance and making choices about their care. We are proposing that MIPS eligible clinicians participating in MIPS and not the APP, would be required to report the measures and activities in the selected MVP beginning in the CY 2029 performance period/2031 MIPS payment year. We also propose to include virtual groups in MVP reporting to ensure all MIPS eligible clinicians can report MVPs.

a. Overview

In the CY 2022 PFS final rule, we finalized the MVP reporting option for MIPS eligible clinicians beginning in the CY 2023 performance period/2025 MIPS payment year to serve as an additional reporting option (86 FR 65391 through 65394). Currently there are three reporting options: MVPs, traditional MIPS, and the APP. We noted that we created the MVP reporting pathway to improve value, reduce burden, and inform patient choice in selecting clinicians. We also stated the MVP framework will move MIPS forward on the path to value by offering a reporting option that connects measures and activities across MIPS performance categories, better informing and empowering patients to make decisions about their healthcare, and by helping clinicians to achieve better outcomes using robust and accessible healthcare data and interoperability (86 FR 65392).

We intend to propose to transform MIPS through a full transition to MVP reporting to allow reporting of both MVPs and the APP to support movement towards value-based payment. If the proposal to phase out traditional MIPS reporting for MIPS eligible clinicians not participating in the APP is finalized, there would be two reporting options in the Quality Payment Program: MVPs and the APP. The transition from clinicians selecting from a large inventory of measures and activities in traditional MIPS to reporting more clinically relevant measures and activities in MVPs represents a necessary progression in MIPS if we are to achieve our intended goals of connecting measures and activities across MIPS and providing meaningful data to inform and empower patients to make decisions about their healthcare. We introduced the MVP reporting pathway in the CY 2020 PFS final rule (84 FR 62946). In the CY 2021 PFS final rule, we established MVP Guiding Principles (85 FR 84845 through 84849). In the CY 2022 PFS final rule, we finalized that MVP scoring policies would align with traditional MIPS unless exceptions were noted (86 FR 65419 through 65422). In the CY 2022 PFS proposed rule, we requested feedback on the potential sunset of traditional MIPS as a reporting option beginning with the CY 2028 performance period/2030 MIPS payment year (86 FR 65396). In the CY 2023 PFS final rule, we indicated our intention that MVPs would be the only pathway for participation in MIPS in the future (87 FR 70035). We have made continued and substantial progress in developing an MVP inventory offering clinicians the ability to report an MVP with clinically relevant measures. As discussed in section IV.A.4.a.(1) of this proposed rule, we previously finalized 27 MVPs and are proposing three additional MVPs for the CY 2027 performance period/2029 MIPS payment year. If the three newly proposed MVPs are finalized, our MVP inventory would increase to 30, potentially resulting in coverage of approximately 98 percent of specialties for MIPS eligible clinicians based upon self-reported specialty designations data and MVP topic. Please see section IV.A.4.a.(1) of this proposed rule for more information on MVP development. Phasing out traditional MIPS reporting and full implementation of MVPs for MIPS eligible clinicians not participating in the APP will move MIPS away from a fragmented

reporting approach toward a more meaningful, specialty-aligned framework. Further, MVPs will continue to advance the overall goals of the Quality Payment Program of aligning quality and payment, fostering accountability, and improving care and outcomes for people served by Medicare.

b. Background on Full MVP Implementation

The MVP framework was introduced in the CY 2020 PFS final rule (84 FR 62946 through 62948). In the CY 2022 PFS proposed rule, we noted our intent to sunset traditional MIPS in a future performance period and solicited public comments on: 1) the length of time MVP reporting should be voluntary; 2) the timing for when we should fully implement MVPs; and 3) sunsetting the traditional MIPS reporting option (86 FR 39356). Responding interested parties supported MVP goals and a transparent, gradual transition to MVPs with voluntary MVP reporting, with adequate time to prepare for reporting an MVP (86 FR 65391 through 65396). In the CY 2022 PFS final rule, we finalized that voluntary reporting of MVPs would start in the CY 2023 performance period/2025 MIPS payment year. Additionally, we stated that we considered input from interested parties who encouraged implementation of MVPs through a gradual process that allows MVP participants and third-party intermediaries time to adapt to changes in policy, requirements, and programming updates that would need to occur in technology systems (86 FR 65394 to 65396).

In the CY 2025 PFS proposed rule, we issued a Request for Information (RFI) on the development of a timeline for the full transition to MVPs. We sought feedback on clinician readiness for MVP reporting and MIPS policies needed to sunset traditional MIPS to allow for full MVP implementation in the CY 2029 performance period/2031 MIPS payment year (89 FR 62011 and 62012). We noted full implementation of MVPs represents an evolution in MIPS towards value-based payment using meaningful sets of measures and activities reported by clinicians, including specialists. We stated MVPs would reduce the complexity of reporting burden associated with MIPS inventory of measures and activities through a targeted set of

measures and activities that relate to specialties or conditions, aligning quality and cost measures, improvement activities, and a foundational layer of Promoting Interoperability measures and population health measures. We also noted that full implementation of MVPs would allow for closer comparisons of the performance of clinicians within the same specialty submitting an MVP and would provide improved data for patients.

In response to the RFIs that sought feedback on full MVP implementation, interested parties provided many comments regarding activities and policies that may support full MVP adoption. One key concern they noted was the limited ability of clinicians to choose the quality measures to report within an MVP. We recognize that full MVP implementation may limit the choice of measures and activities compared to those currently afforded by policies in traditional MIPS. However, MVPs include a set of clinically relevant measures and activities that provide an opportunity for MIPS performance data to better reflect clinicians' scope of care.

With the full implementation of MVPs, clinicians not reporting the APP would be able to select an MVP relevant to their scope of care and further choose the quality measures and improvement activities within the selected MVP that reflect the care provided. Widescale adoption of MVPs, using a standardized connected set of measures and activities for a specialty or medical condition, may generate important and meaningful information for patients to be able to compare the performance of clinicians on the same or similar sets of measures. Additionally, we refer readers to section IV.A.4.d.(1)(c)(i) of this proposed rule for details on the proposed MIPS core measure requirement for traditional MIPS and MVP reporting. The proposed MIPS core measure requirement would further clarify how MVPs would emphasize and increase reporting on select quality measures that are most important to clinicians and patients and reflect the care that is central to an applicable specialty, medical condition, or episode of care. Interested parties indicated that full implementation of MVPs requires the ability of all specialties to participate. In the CY 2026 PFS final rule, we finalized six new MVPs and updated 21 previously finalized MVPs. MVPs were developed and added to create a comprehensive

inventory based on MVP clinical issues and targeted specialties/subspecialties (90 FR 49847). We refer readers to section IV.A.4.a.(1) of this proposed rule regarding the three new proposed MVPs for the CY 2027 performance period/2029 MIPS payment year.

In response to the RFIs that sought feedback on full MVP implementation (89 FR 62011 through 62016), some interested parties voiced concerns that full implementation of MVPs and subgroup policies would result in increased reporting burden. The commenters also expressed concern about the subgroup reporting requirement for multispecialty groups reporting an MVP beginning in the CY 2026 performance period/2028 MIPS payment year. As further discussed in this paragraph, we have modified our MVP and subgroup reporting policies to address some of these concerns. Our current MVP and subgroup reporting policies are aligned with the goal for full MVP implementation and would encourage increased participation from specialists. As we have greater MVP adoption and subgroup reporting, we anticipate specialist reporting through MVPs would increase the amount of performance data available to patients when selecting a clinician (89 FR 62012). In the CY 2022 PFS final rule (86 FR 65397), we finalized the subgroup reporting option for clinicians participating in MVP reporting. We noted that the intent of the subgroup reporting policies is to move away from large multispecialty groups reporting on the same set of measures, which may not be relevant or meaningful to all specialists that participate within a multispecialty group. In addition, subgroup reporting addresses feedback from interested parties over the prior years that large multispecialty groups tend to submit data that is not necessarily representative of all the clinicians that make up that group. To address concerns from interested parties on the MVP subgroup reporting burden, we finalized policies in the CY 2026 PFS final rule (90 FR 49842 through 49846) allowing a group practice to self-attest and identify the need to divide into subgroups based on the scope of care provided by clinicians in their group. We will continue to monitor subgroup participation in MVP reporting to determine potential policy changes in the future as we transition to full MVP implementation for MIPS eligible clinicians not participating in the APP .

Historically, we have received feedback from MIPS eligible clinicians in small group practices, defined at § 414.1305 as a TIN consisting of 15 or fewer eligible clinicians during the MIPS determination period, about the lack of adequate resources to successfully meet MIPS reporting requirements. To provide flexibility and to prevent additional burden for small groups we finalized a policy to maintain the MVP group reporting option for small practices, without the need for small practices to form subgroups (90 FR 49842 to 49843). We also note that MVP policies continue to offer the same scoring flexibilities for small group practices available to small group practices reporting traditional MIPS finalized at § 414.1380(b)(1) (86 FR 65419 through 65422). We refer readers to sections IV.A.4.d.(1)(c)(iii)(C) and IV.B.1.b.(2) of this proposed rule for details on the proposed exemption of small practices from the MIPS core measure reporting requirements and proposed scoring flexibilities for small practices.

Additionally, we will continue to monitor the subgroup reporting burden of larger group practices to determine if additional flexibilities are needed in the future for multispecialty groups that are not small practices to participate as subgroups. We believe the potential increase in the reporting burden for larger groups to divide into subgroups is outweighed by the benefit of additional information clinicians and patients will receive through increased specialist reporting data (86 FR 65393 and 65394).

Finally, interested parties were interested in how scoring rules may work with full MVP implementation for clinicians with limited measure choices. MVP scoring policies, which rely on traditional MIPS scoring policies finalized at § 414.1380(b)(1), were established in the CY 2023 PFS final rule. More recently, in response to the RFI (89 FR 62011 through 62016) interested party feedback voiced concerns about quality measures within MVPs that cannot be scored for reasons beyond the clinician's control, such as measures without benchmarks, and the potential for some topped out measures to have a scoring cap. As noted previously, the existing scoring policies established in traditional MIPS specific to small group practices and the scoring policies related to measures without benchmarks, measures that do not meet case minimum, and

measures that do not meet data completeness requirements also apply to MVP scoring (86 FR 65419 through 65420). We acknowledge concerns from clinicians with limited choice of measures and, in the CY 2026 PFS final rule, we finalized expansion of our approach for identifying measures impacted by limited choice and subject to topped-out measure benchmarks would extend to MVPs (90 FR 49903 through 49908). Additionally, we refer readers to section IV.B.1.b.(3) of this proposed rule for proposals on the scoring of topped out measures included in MVPs, to address concerns that interested parties raised with respect to those clinicians with limited measure choice and scoring caps for topped out measures. We will continue to evaluate the performance of clinicians impacted by limited measure choice as the program evolves and may refine the topped out scoring policies as needed in the future. Commenters responding to the RFI also requested that we develop scoring policies to ensure scoring between MVPs is equitable. We agree that ensuring scoring between MVPs is equitable is an important goal of MVP reporting. Therefore, we have solicited feedback on the future direction of MVP scoring in an RFI in section IV.B.1.e. of this proposed rule.

c. Proposal to Update Timeline for Full MVP Implementation

As discussed previously in section IV.A.3.a. of this proposed rule, MVP reporting became available for clinicians beginning in the CY 2023 performance period/2025 MIPS payment year (86 FR 65394 to 65396). In previous PFS rules, we have stated our intention to fully transition to MVPs and to sunset traditional MIPS (85 FR 50279 and 50284, 86 FR 65394 through 65396). We are concerned that continuing to maintain the traditional MIPS reporting option may impede MVP adoption for eligible clinicians. Additionally, it may cause slow adoption which may delay the intended benefits of MVPs, including simplification of MIPS and improving comparable clinician performance data that helps to drive value and inform clinician selection by patients. In addition, the availability of two MIPS reporting options, MVPs and traditional MIPS, creates challenges for developing and refining MVP policies over time due to limited MVP reporting resulting from continued clinician reliance on the traditional MIPS

reporting option. However, in establishing the sunset date we are also cognizant of the need to provide ample time for clinicians to prepare for full MVP reporting. Therefore, we propose to phase out traditional MIPS reporting for MIPS eligible clinicians not participating in the APP beginning in the CY 2029 performance year/2031 MIPS payment year. Transitioning to MVP implementation alongside the option to participate through the APP would support efforts to transform MIPS for clinicians and patients who rely on program performance information. We note that traditional MIPS reporting will be available to clinicians through the CY 2028 performance period/2030 MIPS payment year. This proposed timeline will have provided a period of 6 years for voluntary MVP reporting, allowing clinicians time to engage in the development of the MVP inventory, update their systems and work processes to prepare for MVP reporting, and gain experience with MVP reporting. Clinicians would continue to be able to report through either traditional MIPS or via MVPs through the CY 2028 performance year/2030 MIPS payment year.

We currently believe that the CY 2029 performance year/2031 MIPS payment year would be an appropriate timeline for full implementation of MVPs. Since the current and proposed inventory of MVPs listed in section Appendix 2 of this proposed rule offers the opportunity for approximately 98 percent of MIPS eligible clinicians based on self-reported specialty designations and MVP topic to report through an MVP, we anticipate that nearly all MIPS eligible clinicians will be able to choose an applicable MVP. As discussed in section IV.A.4.a.(1) of this proposed rule, we continue developing new MVPs that are relevant and meaningful for MIPS eligible clinicians. We intend to explore a range of strategies for transitioning to full MVP reporting, including, but not limited to, proposing additional MVPs. We recognize that clinicians may currently lack applicable measures and may not have an applicable MVP or may be unable to report a sufficient number of measures in an MVP. However, for subspecialists without many applicable and available measures in the MIPS measure inventory, we are on track to developing reporting options or exploring alternatives to

reporting MVPs by CY 2029. For example, we could consider developing a process for clinicians to indicate at the time of MVP registration that no available MVP in the MVP inventory includes applicable and available measures and activities. Alternatively, we could consider expanding measure denominators as applicable to strengthen specialty coverage for clinicians with limited applicable measures. We could also consider policies that allow us to review available and applicable measures for clinicians in the selected MVP to reduce the denominator of the quality performance category to score the quality performance category with fewer than four measures. Delaying the timeline for full implementation of MVPs would not result in a significantly greater availability of MVPs for the remaining specialists who currently lack applicable measures, since the MVPs are built on the measures and activities available in the current traditional MIPS measure inventory. With the majority of specialists having available MVPs, policies for clinicians with few quality measures, and 6 years of availability of MVPs we believe we should move forward with full implementation of MVPs.

Beginning in the CY 2029 performance period/2031 MIPS payment year, we propose that all MIPS eligible clinicians, with the exception of clinicians reporting through the APP, would report through an MVP. Specifically, we propose to add under § 414.1365(a)(2) that beginning in the CY 2029 performance period/2031 MIPS payment year, except for clinicians reporting under the APM performance pathway pursuant to § 414.1367, all MIPS eligible clinicians must report through an MVP.

We request public comment on this proposal.

d. Proposal to Include Virtual Groups in MVP Reporting

Section 1848(q)(5)(I) of the Act establishes the use of voluntary virtual groups for certain assessment purposes. The statute requires the establishment and implementation of a process that allows an individual MIPS eligible clinician or a group consisting of not more than 10 MIPS eligible clinicians to elect to form a virtual group with at least one other such individual MIPS eligible clinician for a performance period. As determined in statute, individual MIPS eligible

clinicians and groups forming virtual groups are required to make such election prior to the start of the applicable performance period under MIPS and cannot change their election during the performance period.

In the CY 2022 PFS final rule (86 FR 65394), we finalized a delay in the availability of MVP reporting for virtual groups. We noted that there are several considerations, such as implementation burden for interested parties and us, value of MVP reporting for these clinicians versus burden, scoring policies, and other issues that must be addressed prior to allowing clinicians in virtual groups to participate in MVP reporting. Therefore, we did not include virtual groups in the previously finalized definition of an MVP participant at § 414.1305 (86 FR 65392 through 65394). However, to comply with the statute, full implementation of MVPs must include a pathway for virtual groups to participate. For this reason, we propose to allow virtual groups to participate in MVP reporting beginning in the CY 2029 performance period/2031 MIPS payment year, aligning with the proposed timeline for full MVP implementation in section IV.A.3.c. of this proposed rule. This approach would allow time for us to further refine participation criteria and address potential barriers for virtual groups to participate in MVP reporting.

To include virtual groups in MVP reporting, we propose to revise the definition of an MVP participant at § 414.1305 to provide that, beginning in the CY 2029 performance period/2031 MIPS payment year, MVP participant means an individual MIPS eligible clinician, single specialty group, multispecialty group that meets the requirements of a small practice, virtual group, subgroup, or APM Entity that is assessed on an MVP in accordance with § 414.1365 for all MIPS performance categories. As we update the definition of an MVP participant to include virtual groups, we are interested in feedback from virtual groups about any concerns they have regarding MVP reporting.

We considered including virtual groups in MVP reporting beginning in the CY 2028 performance period/2030 MIPS payment year. We recognize that we would need to evaluate additional related policies before including virtual groups in MVP reporting. Under the current

policy at § 414.1365(b), MVP participants must register during the performance period. We recognize that the inclusion of virtual groups in MVP reporting would therefore require these groups to register for MVP reporting, which would be an addition to the existing registration requirement to form a virtual group prior to the performance period. We are exploring options to mitigate the need for virtual groups to register a second time for MVP reporting. Additionally, we note that even with the proposed inclusion of virtual groups in MVP reporting, clinicians in virtual groups would be unable to participate as subgroups because the definition of a subgroup at § 414.1305 is limited to clinicians within a single TIN and therefore excludes virtual groups, which, by definition, are composed of clinicians across two or more TINs. Under § 414.1305, a subgroup is a subset of a group that includes at least one MIPS eligible clinician and is identified by the group TIN, a subgroup identifier, and each eligible clinician's NPI.

We request public comment on this proposal.

4. QPP Reporting and Data Submission

a. CY 2027 MVP Development and Maintenance

(1) Development of New MIPS Value Pathways (MVPs)

The development of MVPs is informed by the framework established in prior rulemaking (85 FR 84849 through 84856). In the CY 2023 PFS final rule (87 FR 70035 through 70037), we expanded the MVP development process to provide interested parties more opportunities to submit feedback on new candidate MVPs prior to the notice and comment rulemaking process. Consistent with these policies, we posted three MVP candidates for interested parties to review and provide feedback for consideration in this proposed rule. We refer readers to the Quality Payment Program website to review public feedback for each 2027 MVP candidate (*https://qpp.cms.gov/mips/candidate-feedback*).

In alignment with the MVP development process (85 FR 84849 through 84856; 87 FR 70035 through 70037) and feedback received from interested parties, we are proposing to adopt three new MVPs:

- Diabetic Disease;
- Hospitalist; and
- Hypertension.

We aim to continue developing new MVPs that are relevant and meaningful for MIPS eligible clinicians. The Diabetic Disease and Hypertension MVPs are specifically designed to address the prevention of chronic illnesses by including measures and activities aimed at reducing the incidence and impact of long-term conditions. Disease-specific MVPs allow for more targeted interventions, improved measurement accuracy, and support clinicians in delivering evidence-based care for high-risk populations. We refer readers to Appendix 3: MVP Inventory, in this proposed rule for a detailed description of each proposed new MVP.

We continue to encourage interested parties to utilize our established pre-rulemaking processes to develop and submit candidate quality and cost measures relevant to their specialty.

Furthermore, we continue to develop MVPs based on needs and priorities, as described in the MVP Needs and Priorities document (*https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1803/MIPS%20Value%20Pathways%20(MVPs)%20Development%20Resources.zip)*.

(2) MVP Maintenance Updates to Previously Finalized MVPs

Beginning with the CY 2022 PFS final rule (86 FR 65998 through 66031) and continuing through the CY 2026 PFS final rule (90 FR 50376 through 50405), we have expanded the MVP inventory to include the following 27 MVPs:

- Adopting Best Practices and Promoting Patient Safety within Emergency Medicine;
- Advancing Cancer Care;
- Advancing Care for Heart Disease;
- Advancing Rheumatology Patient Care;
- Complete Ophthalmologic Care;
- Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes;
- Dermatological Care;
- Diagnostic Radiology;
- Focusing on Women's Health;
- Gastroenterology Care;
- Improving Care for Lower Extremity Joint Repair;
- Interventional Radiology;
- Neuropsychology;
- Optimizing Chronic Disease Management;
- Optimal Care for Kidney Health;
- Pathology;
- Patient Safety and Support of Positive Experiences with Anesthesia;
- Podiatry; and

- Prevention and Treatment of Infectious Disorders Including Hepatitis C and Human Immunodeficiency Virus (HIV);
- Pulmonology Care;
- Quality Care for Patients with Neurological Conditions MVP;
- Quality Care for the Treatment of Ear, Nose, and Throat Disorders;
- Quality Care in Mental Health and Substance Use Disorder; and
- Rehabilitative Support for Musculoskeletal Care;
- Surgical Care;
- Value in Primary Care; and
- Vascular Surgery.

In this proposed rule, we are proposing modifications to 23 previously finalized MVPs with the addition and removal of measures and improvement activities based on the MVP development criteria (85 FR 84849 through 84854). Through these modifications, we can expand upon clinical concepts, advance health and wellness, address maintenance requests from interested parties, and remove measures and activities that would either be replaced by more robust measures or activities or are being proposed for removal from their respective MIPS inventory. We are also proposing to rename the Rehabilitative Support for Musculoskeletal Care MVP to Rehabilitative Support MVP to better reflect the measures and activities it includes.

Additionally, we are proposing modifications to all 27 previously finalized MVPs in alignment with the proposed implementation of MIPS core measures. In section IV.A.4.d.(1) of this proposed rule, we propose modifications to the current MVP quality reporting requirements at § 414.1365 to replace the current requirement for an outcome/high priority measure with one MIPS core measure included in the MVP. We revised the format of the MVP tables in Appendix 3: MVP Inventory of this proposed rule to include MIPS core measures for each previously finalized MVP. We also added a MIPS core measure table to the newly proposed MVPs. We

refer readers to sections IV.A.4.d.(1) and IV.B.1.b. of this proposed rule where we discuss the proposed policies for MIPS core measures.

We refer readers to Appendix 3: MVP Inventory of this proposed rule for the proposed modifications and detailed descriptions to the previously finalized MVPs and the newly proposed MVPs.

We request public comment on these proposals.

b. APM Performance Pathway (APP)

(1) Overview

In the CY 2021 PFS final rule (85 FR 84859 through 84866), we finalized the APM Performance Pathway (APP) at § 414.1367 beginning with the CY 2021 performance period/CY 2023 MIPS payment year. The APP was designed as a reporting and scoring pathway available only to MIPS eligible clinicians identified on the Participation List or Affiliated Practitioner List of an APM Entity participating in a MIPS APM as defined in § 414.1305 (MIPS APM participants) (§ 414.1367(a)). The APP provides a predictable and consistent MIPS reporting option to reduce reporting burden for, and encourage continued APM participation by, these clinicians. We also established in the APP for Shared Savings Program ACOs providing that, beginning with the Shared Savings Program performance year 2021 (CY 2021 performance period/CY 2023 MIPS payment year), ACOs were required to report quality data for purposes of the Shared Savings Program via the APP (42 CFR 425.512(a)(3); 85 FR 84722).

In that same rule, we finalized a quality measure set (85 FR 84860 and 84861) for purposes of quality performance category scoring for the APP. For those MIPS eligible clinicians, groups, or APM Entities for whom a given measure is unavailable due to the size of the available patient population or who are otherwise unable to meet the minimum case threshold for a measure, we established that such measure would be removed from the quality performance category score for such MIPS eligible clinician, group, or APM Entity (85 FR 84861).

In the CY 2025 PFS final rule (89 FR 98562), we finalized a second, optional quality measure set within the APP, called the APP Plus quality measure set, to align with the Universal Foundation measure set. The measure set for CY 2026 performance year includes the current APP quality measures and two additional quality measures from the Adult Universal Foundation measure set. As discussed in the CY 2025 PFS final rule, we intended to incrementally add the remaining three Adult Universal Foundation measures by the CY 2028 performance period/2030 MIPS payment year. We also finalized a 1-year delay to the CY 2026 performance year/CY 2027

MIPS payment year in the incorporation of the Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (Quality ID: 484) measure.

Further, for MIPS eligible clinicians, groups, and APM Entities reporting through the APP, we established in the CY 2021 PFS final rule (85 FR 84907) that we would not apply the quality measure scoring cap at § 414.1380(b)(1)(iv) in the event that a measure in the APP quality measure set is determined to be topped out. Because the APP quality measure set is fixed, we noted that it would not be appropriate to limit the maximum quality performance category score available to APP reporters. Should an APP quality measure be determined to be topped out, we would at that time consider amending the APP quality measure set through future rulemaking, if appropriate.

In the CY 2024 PFS final rule (88 FR 79329), we established the Medicare Clinical Quality Measures for Accountable Care Organizations Participating in the Medicare Shared Savings Program (Medicare CQMs) collection type in the APP quality measure set and finalized that the Medicare CQMs collection type would be available to only ACOs participating in the Shared Savings Program.

In the CY 2026 PFS final rule (90 FR 49849 through 49856) we updated quality measures in the original quality measure set and the APP Plus quality measure set, to reflect measures updates specified for the quality performance category.

(2) Updates to Quality Measures in the APP and APP Plus Quality Measure Set

In the CY 2021 PFS final rule, we adopted the original APP quality measure set (85 FR 84860 and 84861). In the CY 2025 PFS final rule, we finalized a phased approach to establish the APP Plus quality measure set over 4 years (89 FR 62024), including by incorporating into the APP Plus quality measure set the measures from the original APP quality measure set.

In the CY 2025 PFS final rule, we finalized a phased approach to establish the APP Plus quality measure set over 4 years (89 FR 62024). As finalized, the APP Plus quality measure set consisted of all the measures that were within the APP quality measure set (five Adult Universal Foundation measures and a separate quality measure) plus one additional measure from the Adult Universal Foundation measure set, with the intention of incrementally incorporating the remaining measures from the Adult Universal Foundation measure set by the CY 2028 performance year/CY 2030 MIPS payment year. We finalized this incremental approach in part to allow for both the eCQM and, for Shared Savings Program ACOs, Medicare CQMs collection types to be developed and become available.

Because the APP is a feature within MIPS and therefore the quality measures used within the APP and APP Plus quality measure sets are all MIPS measures, any proposed updates we apply to MIPS measures also are incorporated into the APP and APP Plus quality measure sets, and proposed here accordingly. As discussed in Table Group D, in Appendix 1, of this proposed rule, we are proposing to adopt measure specification changes to the following measures that are part of the APP and APP Plus quality measure sets:

- Diabetes: Glycemic Status Assessment Greater Than 9% (Quality ID: 001) (eCQMs collection type)
- Preventive Care and Screening: Screening for Depression and Follow-up Plan (Quality ID: 134)
- Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups (Quality ID: 479)

In addition, we are proposing the removal of the following measures that, under the policies finalized in the CY 2025 PFS final rule (89 FR 98369 through 98371) are scheduled to be added to the APP Plus quality measure set for the CY 2027 performance period and for the CY 2028 performance period or the performance period that is 1 year after the eCQM specification becomes available, whichever is later, respectively:

- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment measures (Quality ID: 305)
- Adult Immunization Status (Quality ID: 493)

We are proposing the removal of these two measures from the APP Plus quality measure set due to operational issues impacting the development of the collection types that were finalized in the CY 2025 PFS final rule for these two measures. Our proposal would address concerns expressed by ACOs with increasing the number of measures in the APP Plus quality measure set each year. ACOs have suggested maintaining a stable measure set as they transition to digital quality measurement. In the CY 2026 PFS dQM RFI, many commenters recommended that we maintain the APP Plus quality measure set as finalized without adding new measures to preserve resources for the transition to digital quality measurement and to consider challenges ACOs face in data aggregations for eCQM/MIPS CQM/Medicare CQM reporting (90 FR 49856).

These changes have been reflected in Tables C-BC2. Table C-BC2 also reflects the proposed creation of the new Medicare eCQMs collection type for Shared Savings Program ACOs reporting the APP Plus Quality measure set for performance year 2027 and subsequent performance years, as discussed in section XXX and Table Group D and DD, in Appendix 1, of this proposed rule.

TABLE C-BC1: APM PERFORMANCE PATHWAY QUALITY MEASURE SET BEGINNING WITH THE CY 2026 PERFORMANCE PERIOD/2028 MIPS PAYMENT

YEAR AND SUBSEQUENT PERFORMANCE PERIODS/MIPS PAYMENT YEARS

#	Measure Title	Collection Type	Submitter Type	Measure Type
001	Diabetes: Glycemic Status Assessment Greater Than 9%	eCQM/MIPS CQM/Part B Claims (all APP reporters)	MIPS Eligible Clinician Representative of a Practice APM Entity Third Party Intermediary	Intermediate Outcome
134	Preventive Care and Screening: Screening for Depression and Follow-up Plan	eCQM/MIPS CQM/Part B Claims (all APP reporters)	MIPS Eligible Clinician Representative of a Practice APM Entity Third Party Intermediary	Process
236	Controlling High Blood Pressure	eCQM/MIPS CQM/Part B Claims (all APP reporters)	MIPS Eligible Clinician Representative of a Practice APM Entity Third Party Intermediary	Intermediate Outcome
321	CAHPS for MIPS	CAHPS for MIPS Survey	Third Party Intermediary	Patient Engagement/ Experience
479	Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups	Administrative Claims	N/A	Outcome
484	Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	Administrative Claims	N/A	Outcome

TABLE C-BC2: APP PLUS QUALITY MEASURE SET FOR THE CY 2027 PERFORMANCE PERIOD/CY 2029 MIPS PAYMENT YEAR AND SUBSEQUENT PERFORMANCE PERIODS/MIPS PAYMENT YEARS

QUALITY #	MEASURE TITLE	COLLECTION TYPE	SUBMITTER TYPE	MEASURE TYPE
001	Diabetes: Glycemic Status Assessment Greater Than 9%	eCQM/MIPS CQM/Part B Claims (all APP reporters) Medicare CQM/Medicare eCQM (SSP ACOs only)	MIPS Eligible Clinician Representative of a Practice APM Entity Third Party Intermediary	Intermediate Outcome
112	Breast Cancer Screening	eCQM/MIPS CQM/Part B Claims (all APP reporters) Medicare CQM/Medicare eCQM (SSP ACOs only)	MIPS Eligible Clinician Representative of a Practice APM Entity Third Party Intermediary	Process
113	Colorectal Cancer Screening	eCQM/MIPS CQM/Part B Claims (all APP reporters) Medicare CQM /Medicare eCQM (SSP ACOs only)	MIPS Eligible Clinician Representative of a Practice APM Entity Third Party Intermediary	Process
134	Preventive Care and Screening: Screening for Depression and Follow-up Plan	eCQM/MIPS CQM/Part B Claims (all APP reporters) Medicare CQM/Medicare eCQM (SSP ACOs only)	MIPS Eligible Clinician Representative of a Practice APM Entity Third Party Intermediary	Process
236	Controlling High Blood Pressure	eCQM/MIPS CQM/Part B Claims (all APP reporters) Medicare CQM/Medicare eCQM (SSP ACOs only)	MIPS Eligible Clinician Representative of a Practice APM Entity Third Party Intermediary	Intermediate Outcome
321	CAHPS for MIPS	CAHPS for MIPS Survey	Third Party Intermediary	Patient Engagement/Experience
479	Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups	Administrative Claims	N/A	Outcome
484	Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	Administrative Claims	N/A	Outcome

c. Fast Healthcare Interoperability Resources®-Based Digital Quality Measurement in the Quality Payment Program and Other CMS Quality Programs - Request for Information

(1) Background

We are advancing quality measurement by transitioning existing quality measures and reporting processes to Fast Healthcare Interoperability Resources® (FHIR®)-based digital approaches. Digital quality measures[1] (dQMs) use standardized, interoperable digital data from multiple sources, including electronic health records (EHRs), to enable more comprehensive and timely assessment of care while reducing reporting burden. We continue to collaborate with Federal partners to advance health information technology and digital quality measurement policy, interoperability standards, and quality measurement infrastructure to support the transition to FHIR-based digital quality reporting. The establishment of the United States Core Data for Interoperability (USCDI)+ Quality Version 1 (V1), which identifies a common set of quality-related data elements to support more consistent and reusable data for quality measurement across programs, was released in 2026.[2] FHIR-based implementation guides and tools are also being developed to enable end-to-end FHIR-based digital quality measurement.[3] The 2026 US Quality Core Implementation Guide version 0.5.0 provides guidance for implementing USCDI+ Quality in FHIR to support consistent, interoperable representation and exchange of quality data for quality measurement and reporting programs.[4] The Data Exchange for Quality Measures (DEQM) FHIR implementation guide provides guidance on how FHIR-

---

[1] Read more about the dQM transition in the Electronic Clinical Quality Improvement (eCQI) Resource Center here: *https://ecqi.healthit.gov/dqm/about-dqms*.

[2] Additional information on USCDI+ Quality Version 1, including the list of quality data elements and related implementation materials, is available at https://uscdiplus.healthit.gov/uscdiplus?id=uscdi_record&table=x_g_sshh_uscdi_domain&sys_id=7ddf78228745b95098e5edb90cbb3525&view=sp#:~:text=of%20quality%20measures.-,Quality%20V1,-The%20USCDI%2B%20Quality. The January 2026 announcement of the release of USCDI+ Quality Version 1 is available at https://uscdiplus.healthit.gov/uscdiplus/en/announcing-the-release-of-uscdi-quality-version-1-january-2026?id=kb_article&table=kb_knowledge&sys_id=9ee9383c87f6fe108edc42e50cbb350b.

[3] For example, see the eCQI Resource Center description of the FHIR Quality Measure Implementation Guide at https://ecqi.healthit.gov/tool/hl7-quality-measure-ig.

[4] See the eCQI Resource Center description of the US Quality Core Implementation Guide (https://ecqi.healthit.gov/qi-core/about) and version 0.5.0 of the 2026 US Quality Core Implementation Guide (http://fhir.org/guides/onc/us-quality-core/ImplementationGuide/fhir.onc.us-quality-core).

based quality data can be reported and exchanged between providers, intermediaries, and payers.[5] Also available is the Measure Authoring Development Integrated Environment (MADiE), a software tool that enables creation and testing of eCQMs and FHIR-based dQMs within a single application, supporting modernized CMS quality measurement and reporting workflows.[6] Finally, the FHIR dQM specifications are also available.[7] Collectively, these developments are intended to provide a foundation for FHIR-based digital quality measurement and reporting. To further these goals, we seek public comment on the timeline for transitioning to FHIR-based quality measurement.

(2) Transition to FHIR-based quality measurement in the Quality Payment Program and other CMS clinician and hospital quality programs

The Quality Payment Program and other CMS clinician and hospital quality programs use clinical quality measures (CQMs) and electronic clinical quality measures (eCQMs), with current eCQM reporting supported through Quality Reporting Document Architecture (QRDA) files. We previously sought input on dQMs, including eCQMs, and FHIR-based quality measurement and reporting in multiple Medicare payment rules[8] and now seek input on a transition timeline, key milestones, and implementation considerations for FHIR-based quality reporting in the Quality Payment Program and other CMS clinician and hospital quality programs.

Subject to future notice and comment rulemaking, we are developing a phased transition to FHIR-based digital quality reporting for applicable measures that balances modernization

---

[5] Additional information about the DEQM implementation guide is available at the eCQI Resource Center description: https://ecqi.healthit.gov/tool/deqm-ig.

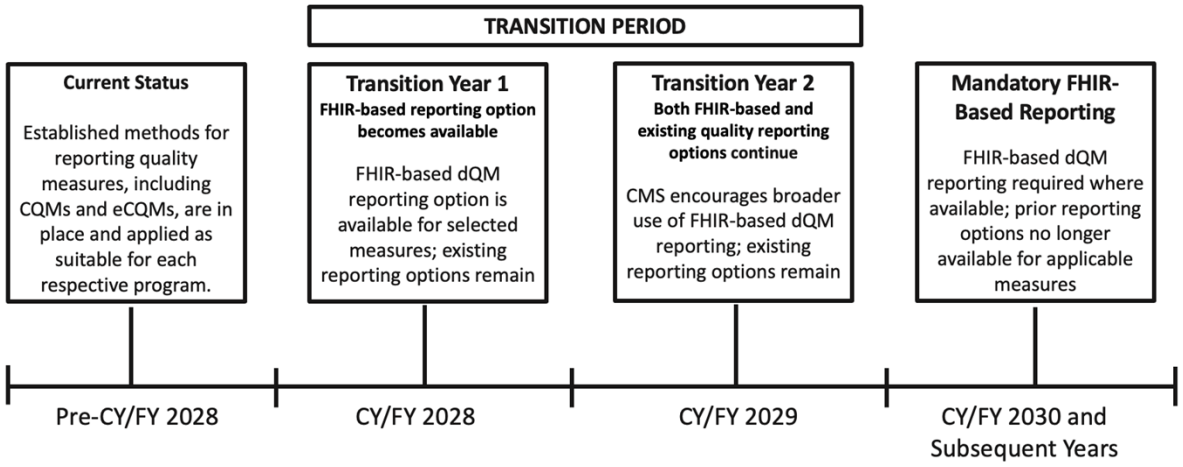
[6] Additional information on MADiE is available at https://www.emeasuretool.cms.gov/.

[7] See *CMS* https://ecqi.healthit.gov/sites/default/files/CMSdQMStrategicRoadmap_032822.pdfdigital quality measurement specifications at .

[8] We have previously issued RFIs on digital quality measurement and FHIR-based reporting in multiple Medicare payment rules, including several Physician Fee Schedule (PFS) rules, such as CY 2022 PFS final rule (86 FR 65377 through 65382), CY 2023 PFS proposed rule (87 FR 46259 through 46262), and CY 2026 PFS final rule (90 FR 49855 through 49856). Additional requests for comment include the Health Technology Ecosystem RFI (90 FR 21034) and the Public Comment Period for Draft CMS FHIR® Digital Quality Measures (dQMs) request for comment available at https://ecqi.healthit.gov/now-open-public-comment-period-draft-cms-fhir%C2%AE-digital-quality-measures-dqms.

goals with practical implementation considerations. Under this approach, for example, in the Quality Payment Program, we would introduce a 2-year transition period beginning with the CY 2028 performance period/2030 MIPS payment year during which existing quality collection types for CQMs and eCQMs, including eCQM reporting via QRDA files, would continue to be available while FHIR-based dQM options are introduced for selected measures, including both new and existing measures. Following this transition period, FHIR-based reporting would be required for those applicable measures that were available as FHIR-based dQM collection types during the transition period, beginning with the CY 2030 performance period/2032 MIPS payment year. An example of this timeline is illustrated in Figure C-C1.

Figure C-C1: TIMELINE FOR TRANSITION TO FHIR-BASED QUALITY REPORTING IN CMS QUALITY REPORTING PROGRAMS*



*We note that more specific adoption timelines may vary by measure and program based on feasibility, implementation complexity, and readiness of interested parties. Existing quality collection types for CQMs and eCQMs may include the following, as applicable by program: MIPS CQMs, Medicare CQMs, eCQM reporting via QRDA files, and proposed Medicare eCQMs. An additional timeline, titled "Transition Timeline for FHIR-based Digital Quality Measurement and Reporting," is also available on the QPP Resource Library at for more context.

We anticipate that the transition would begin with a limited set of measures for which FHIR-based digital specifications are available initially and would expand over time as technical infrastructure and implementation experience grow. Specific timelines for adopting FHIR-based digital quality reporting may need to vary by measure and program based on feasibility, implementation complexity, and program-specific requirements or reporting structures. We recognize that clear expectations and sufficient lead time are essential for successful implementation. Program-specific considerations for the Medicare Shared Savings Program

(Shared Savings Program) are discussed in section IV.A.4.c.(3). In addition, we note that CMS Innovation Center models may have separate requirements and timelines related to FHIR-based digital quality measurement and reporting. We recognize resource constraints, and reporting burden may differ significantly for solo practitioners, small practices and provider facilities, and other practices and provider facilities in rural or underserved areas, and that these differences may warrant additional flexibilities or support.

TABLE C-C1: IMPLEMENTATION TIMELINE AND MILESTONES FOR TRANSITION TO FHIR-BASED DIGITAL QUALITY MEASUREMENT

Phase	Timeframe	Implementation Focus
Transition Period with FHIR-Based Reporting Options (Year 1)	CY and FY 2028*	Initial availability of FHIR-based digital quality measure (dQM) reporting option for selected measures, while existing quality reporting options for clinical quality measures (CQMs) and electronic clinical quality measures (eCQMs)** remain available for applicable measures and programs.
Transition Period with FHIR-Based Reporting Options (Year 2)	CY and FY 2029*	Continued availability of FHIR-based dQM reporting options for selected measures alongside existing quality reporting options for CQMs and eCQMs**, with CMS encouraging broader use of FHIR-based reporting.
Mandatory FHIR-Based Reporting	CY and FY 2030 and subsequent years*	FHIR-based dQM reporting required for measures that have been transitioned to FHIR-based digital quality specifications, with prior CQM and eCQM reporting options no longer available for those transitioned measures. Existing CQM and eCQM reporting options** would continue to be available for measures that have not yet transitioned to FHIR-based dQM reporting, as applicable under program-specific policies.

*Timeframes shown may correspond to performance periods, program years, reporting periods, or other CMS quality program-specific timeframes, as applicable. For example, CMS quality programs operate under both timings including CY and FY.
**Existing quality collection types for CQMs and eCQMs may include the following, as applicable by program: MIPS CQMs, Medicare CQMs, eCQM reporting via Quality Reporting Document Architecture (QRDA) files, and proposed Medicare eCQMs.

We invite public comment on the phased timeline, which we anticipate will start with a transition period with FHIR-based reporting options available alongside existing quality reporting options for the CY/FY 2028 and CY/FY 2029 performance periods, respectively. This transition period would then be followed by required FHIR-based reporting for applicable measures beginning with the CY 2030 performance period/2032 MIPS payment year.

● **Transition Approach and Design:** What factors should be considered in determining the structure of the 2-year transition period, during which FHIR-based reporting options and

existing electronic quality reporting options for CQMs and eCQMs would be available concurrently? What are the scoring implications that CMS must consider during the transition period, when multiple reporting options are available? How should CMS approach data submission criteria, completeness, and other regulatory elements around quality measurement during the transition period?

● **Factors Affecting Readiness for FHIR-Based Reporting:** How does readiness for adopting FHIR-based quality measurement and reporting vary across different practice types, organizational settings, and supporting health IT entities (for example, EHR vendors, Qualified Clinical Data Registries (QCDRs), qualified registries, and other intermediaries)? What are the primary barriers and facilitators to adoption (for example, access to technology, workforce capacity, resources)? Specifically, what can be done to support technology readiness, testing needs, and measure availability? What strategies, technical assistance, policies, and scoring approaches would be most effective in helping reporting entities transition to FHIR-based reporting? In particular, how do these factors differ for solo practitioners, small practices and provider facilities, and other practices and provider facilities in rural or underserved areas, and what specific types of technical assistance, shared services, or policy flexibilities would be most helpful for these practices to successfully participate in FHIR-based quality reporting? We invite comment on existing clinician capabilities to begin the transition to FHIR-based quality reporting, challenges in using these approaches, and insights from early implementation that may inform future FHIR-based quality reporting activities.

● **General Solicitation of Comments:** We welcome comments on any additional issues, opportunities, or considerations related to the transition to FHIR-based digital quality measurement for the Quality Payment Program and other CMS clinician and hospital quality programs for topics not specifically addressed earlier in this section.

(3) Additional Considerations for Shared Savings Program transition to FHIR-based quality measurement

As finalized in the CY 2025 PFS final rule, Shared Savings Program ACOs are required to report the Alternative Payment Model (APM) Performance Pathway (APP) Plus quality measure set beginning with the 2025 performance year (89 FR 98105).

We are seeking input from interested parties, ahead of future policy decisions, on a phased transition to FHIR-based digital quality reporting for applicable measures[9] under which we would introduce a 2-year transition period beginning with the 2028 performance period. During the transition period, existing quality reporting options[10] for Shared Savings Program ACOs would continue to be available while FHIR-based dQM options are introduced for selected measures. For the Shared Savings Program, the transition to FHIR-based dQMs builds upon the existing eCQM reporting infrastructure used for the APP Plus quality measure set (including APP/APP Plus measure alignment and current electronic reporting approaches) while introducing FHIR-based specifications for dQMs and related software tools, such as the Measure Authoring Development Integrated Environment (MADiE), so that Shared Savings Program ACOs would have a feasible pathway to adopt FHIR-based quality measurement. Following this transition period, FHIR-based reporting would be required for those applicable measures that were available as FHIR-based dQM reporting options during the transition period, beginning with the 2030 performance period. For example, Shared Savings Program ACOs would need to be prepared, by the 2030 performance period, to report each applicable APP Plus measure via FHIR-based digital quality reporting where a FHIR-based dQM specification exists for that measure. For APP Plus measures that do not have FHIR-based dQM specifications following the transition period, Shared Savings Program ACOs would continue to use applicable existing reporting mechanisms (for example, MIPS CQMs, Medicare CQMs, eCQM reporting via QRDA files, and proposed Medicare eCQMs) until FHIR-based dQM options are developed and

[9] For Shared Savings Program ACOs, applicable measures include the five current eCQMs and proposed Medicare eCQMs in the APP Plus quality measure set.

[10] Existing quality reporting options for Shared Savings Program ACOS would include MIPS CQMs, Medicare CQMs, eCQM reporting via Quality Reporting Document Architecture (QRDA) files, and proposed Medicare eCQMs.

adopted through future rulemaking. We recognize that clear expectations and sufficient lead time are essential for successful implementation, so we are clearly stating our planned timeline to avoid confusion among participants, in particular Shared Savings Program ACOs which, due to their organizational complexity, may require a longer lead time than MIPS reporting clinical groups.

As noted in section III.G.4.b.(2) of this proposed rule, we are also pursuing proposals in the Shared Savings Program to encourage the use of other pathways for using FHIR-enabled capabilities in certified health IT to support quality measurement reporting by ACOs and demonstrate use of CEHRT. This approach would offer another avenue for ACOs to gain experience with supporting quality measurement reporting using FHIR in anticipation of the transition to dQMs.

We invite public feedback on the phased timeline which starts with a 2-year transition period followed by required FHIR-based reporting for applicable measures.

- **Request for Information**: In addition to the questions included in section IV.A.4.of this proposed rule, we request public input on the technical assistance needed by organizations and on whether support and informational needs may differ for entities with more complex reporting environments, such as multi-taxpayer identification number (multi-TIN) ACOs, APM Entities, or providers operating across multiple EHR systems.

d. MIPS Performance Category Measures and Activities

(1) Quality Performance Category

(a) Background

Section 1848(q)(1)(A)(i) and (ii) of the Act requires the Secretary to develop a methodology for assessing the total performance of each MIPS eligible clinician according to certain specified performance standards and, using such methodology, to provide for a final score for each MIPS eligible clinician. Section 1848(q)(2)(A)(i) of the Act provides that the Secretary must use the quality performance category in determining each MIPS eligible clinician's final score, and section 1848(q)(2)(B)(i) of the Act describes the measures that must be specified under the quality performance category.

We refer readers to §§ 414.1330 through 414.1340 and the CY 2017 and CY 2018 Quality Payment Program final rules (81 FR 77097 through 77162 and 82 FR 53626 through 53641, respectively), and the CY 2019 through CY 2026 PFS final rules (83 FR 59754 through 59765, 84 FR 63949 through 62959, 85 FR 84866 through 84877, 86 FR 65431 through 65445, 87 FR 70047 through 70055, 88 FR 79329 through 79338, and 89 FR 98381 through 98390, and 90 FR 49856 through 49859, respectively) for a description of previously established policies and the statutory basis for policies regarding the quality performance category. In this proposed rule, we are proposing to:

- Amend the definition of the term “collection type” to include the Medicare Electronic Clinical Quality Measures for Accountable Care Organizations Participating in the Medicare Shared Savings Program (Medicare eCQMs).
- Implement the MIPS core measure designations for quality measures in traditional MIPS and MVPs.
- Remove the high priority designation from MIPS quality measures.
- Remove the high priority designation from quality measure retention consideration.

- Replace the requirement to report a high priority measure with the requirement to report a MIPS core measure; and require an attestation process for cases in which a MIPS core measure is not available and applicable.

- Exempt clinicians in small practices from the MIPS core measure requirement and the attestation process.

- Amend the quality performance category data submission criteria at § 414.1335 and § 414.1365 to require MIPS core measure reporting with an attestation process.

- Amend the data submission criteria for the Medicare CQMs collection type.

- Establish the data submission criteria for the Medicare eCQMs collection type.

- Amend the data completeness criteria for the Medicare CQMs collection type.

- Establish data completeness criteria for the Medicare eCQMs collection type.

- Modify the MIPS quality measure set as described in Appendix 1 of this proposed rule, including the addition of new measures, updates to specialty sets, removal of existing measures, and substantive changes to existing measures.

(b) Proposal to Update Definition of Collection Type

With the proposed establishment of a new collection type, the Medicare Electronic Clinical Quality Measures for Accountable Care Organizations (ACOs) Participating in the Medicare Shared Savings Program (Medicare eCQMs) specific to the APM Performance Pathway (APP) as described in section XXX of this proposed rule, we are proposing to amend the definition of the term "collection type" to include Medicare eCQMs to account for the new collection type available only to Medicare Shared Savings Program ACOs meeting the reporting requirements of the APP. Specifically, starting with the CY 2027 performance period/2029 MIPS payment year, we are proposing to amend the definition of the term "collection type" in § 414.1305 to mean a set of quality measures with comparable specifications and data completeness criteria, as applicable, including, but not limited to: Electronic clinical quality measures (eCQMs); MIPS clinical quality measures (MIPS CQMs); Qualified Clinical Data

Registry (QCDR) measures; Medicare Part B claims measures; CMS Web Interface measures (except as provided in paragraph (1) of this definition, for the CY 2017 through CY 2022 performance periods/2019 through 2024 MIPS payment years); the CAHPS for MIPS survey measure; administrative claims measures; Medicare Clinical Quality Measures for Accountable Care Organizations Participating in the Medicare Shared Savings Program (Medicare CQMs); and Medicare Electronic Clinical Quality Measures for Accountable Care Organizations Participating in the Medicare Shared Savings Program (Medicare eCQMs).

We request public comment on this proposal.

(c) Proposals to Modify Quality Data Submission Criteria

(i) Proposal to Designate MIPS Core Measures

In the CY 2026 PFS proposed rule (90 FR 32702), we published a Core Elements Request for Information (RFI) soliciting feedback on how to encourage MVP reporting on key quality measures, or "core" measures, that reflect the essential components of care. One goal of MIPS reporting, particularly with the transition to MVPs, is to provide patients with comparative clinician performance data so they can make the most informed decisions about their care. The number of MIPS quality measures available for clinicians to choose from in traditional MIPS reduces the standardization of performance data. While MVPs reduce the number of quality measures for clinicians to choose from, MVPs still provide a degree of measure choice that may not produce sufficient comparative performance data on standardized measures to support patient choice of care. In the Core Elements RFI in the CY 2026 PFS proposed rule (90 FR 37021 and 37022), we sought feedback on a potential reporting requirement in which clinicians reporting an MVP would be required to select and report one quality measure from a subset of "core" quality measures in each MVP, which would count as one of the four quality measures required in MVP reporting. MVP reporting requirements for the other performance categories would be unchanged. MIPS core measures would be limited to measures that are most reflective of the care that is unique to each MVP's specialty or medical condition. In response to the Core

Elements RFI in the CY 2026 PFS proposed rule (90 FR 32702), commenters shared concerns that MIPS core measures may not be applicable to their scope of care and that a MIPS core measure reporting requirement could add complexity to MVP reporting. We have taken this commenter feedback into consideration in our proposal of the MIPS core measures policy and in our proposed modifications to the quality performance category data submission criteria for traditional MIPS and MVPs.

One of the goals of implementing MIPS core measures is to provide patients with comparative clinician performance data. This would enable patients to make better assessments of the quality of care provided by requiring clinicians within a given specialty to report on a narrower group of measures. This would also emphasize and increase reporting on select quality measures that we believe are the most reflective of the care central to an applicable specialty, medical condition, or episode of care. In developing the MIPS core measure policy, we evaluated several alternative approaches. First, when considering how to procure more robust comparative performance data, we considered mandating clinicians reporting an MVP be required to report the same MIPS quality measure. This approach was not consistent with section 1848(q)(2)(D)(i) of the Act, nor did it achieve intended policy goals of generating more comparative clinician performance data on key quality measures, since what matters most for high-quality care in one specialty may differ from another. Additionally, cross-cutting quality measures, while applicable to the majority of MIPS eligible clinicians, may not be applicable to all, especially bearing in mind subgroup reporting. Expanding upon this idea, we also examined the possibility of a uniform subset of quality measures that would be consistent across all MVPs, and from which clinicians would be required to report one to two quality measures. While having the same subset of measures provides better coverage of the variety of scopes of care provided by MIPS eligible clinicians, we remain concerned that a uniform subset of quality measures would not sufficiently account for the variety of MIPS eligible clinicians' scopes of care while meaningfully assessing quality performance.

In focusing on the goal of providing patients and clinicians with "comparative performance data," particularly among clinicians practicing within the same clinical specialty or providing care to patients with a specific medical condition, we considered whether to use existing population health measures or to develop new administrative claims-based measures. While these approaches would allow for automatic capture of data, there are still constraints in applicability across MIPS eligible clinicians in addition to resources and feasibility. Given these findings, we determined that the most prudent way to capture meaningful comparative data and provide patients with better insight into the quality of care provided was to create a curated set of core quality measures for each MVP. The proposed list of MIPS core measures was selected because we determined these measures were most reflective of the care central to a clinical specialty or medical condition and would be the measures that the MIPS eligible clinician would be required to report from within that MVP.

For each MVP, we propose to select the MIPS core measures from the list of MIPS quality measures already assigned to the MVP because the quality measures within each MVP are the measures that are clinically relevant to the MVP's specialty or medical condition, and the proposed MIPS core measures are intended to be most reflective of the care that is central to the MVP's specialty or medical condition. The selection process focused on existing MIPS quality measures and quality measures proposed for the CY 2027 performance period/2029 MIPS payment year.

From this list, we then propose to select a minimum of three MIPS core measures per MVP. We may designate more than three MIPS core measures within an MVP if we determine more than three measures must be selected to reflect the care central to the subspecialties within that MVP.

Selection of the MIPS core measures would be based on the following factors:

- Whether the measure is an outcome-based measure;

- Measure collection type availability and the clinician's ability to meet reporting requirements to the extent practicable. Qualified Clinical Data Registry (QCDR) measures were not considered for MIPS core measure selection to ensure MIPS core measures are broadly available and accessible for all eligible clinicians;

- Measure adoption and current and historic performance rates for each measure, to be in alignment with section 1848(q)(3) of the Act which states that the Secretary shall consider historical performance standards and opportunity for continued improvement in establishing performance standards; and

- Whether the measure is most reflective of the care that is central to the clinical focus of the selected MVP, represents best practices essential to the MVP's specialty or medical condition, or addresses important areas for improving care.

We propose that the MIPS core measure designation would apply to quality measures in both traditional MIPS and MVPs. Establishing a set of unified key quality measures across both reporting pathways promotes alignment, reduced reporting complexity for clinicians reporting both traditional MIPS and MVPs and is operationally feasible. While the proposed MIPS core measures were selected from MVPs, the proposed MIPS core measure inventory would include over 70 quality measures. We believe these measures represent key aspects of care across a variety of specialties and medical conditions. The proposed MIPS core measures inventory also overlaps with the MIPS quality measures currently designated as high priority measures. Given the proposed removal of high priority designation for MIPS quality measures, the MIPS core measure inventory would not only support reporting within MVPs but would also be applicable to clinicians reporting via traditional MIPS. Additionally, it would provide sufficient data for benchmarking for the MIPS core measures once we phase out traditional MIPS reporting and transition to full implementation of MVP reporting, as proposed in section IV.A.3.c. of this proposed rule.

As detailed in section IV.A.4.d.(1)(c)(iii)(B) of this proposed rule, we are proposing that clinicians reporting through the traditional MIPS reporting option would select from the complete inventory of available MIPS core measures for the performance period. Whereas clinicians reporting through the MVP reporting option would select the applicable MIPS core measures from the core measures identified within their chosen MVP. As discussed in section IV.A.4.a.(2) of this proposed rule, we propose to revise the format of the MVP tables in Appendix 3: MVP Inventory of this proposed rule to include MIPS core measures for each previously finalized MVP. We also added a MIPS core measure table to the newly proposed MVPs. Further, we propose, beginning with the CY 2027 performance period/2029 MIPS payment year, to establish a MIPS core measure designation applicable to selected quality measures contained in the MIPS quality measure inventory and the MVP inventory found in the Appendices of this proposed rule.

We request public comment on these proposals.

(ii) Proposal to Remove High Priority Measure Designation and High Priority Quality Measure Retention Consideration

In the CY 2019 PFS final rule (83 FR 59761), we finalized that beginning with the CY 2019 performance period/2021 MIPS payment year, the term "high priority measure" is defined at § 414.1305 as an outcome (including intermediate-outcome and patient-reported outcome), appropriate use, patient safety, efficiency, patient experience, care coordination, or opioid-related quality measure. In the CY 2023 PFS final rule (87 FR 70047 through 70049), we finalized an amended definition of the term "high priority measure" to include quality measurement pertaining to health equity. In the CY 2026 PFS final rule (90 FR 49857), we finalized at § 414.1305 an amended definition of the term "high priority measure" to mean an outcome (including intermediate-outcome and patient-reported outcome), appropriate use, patient safety, efficiency, patient experience, care coordination, or opioid-related quality measure, beginning with the CY 2026 performance period/2028 MIPS payment year.

In the CY 2017 Quality Payment Program final rule (81 FR 77558 through 77785) and subsequent Quality Payment Program and PFS rules (82 FR 53965 through 54174, 83 FR 60097 through 60285, 84 FR 63205 through 63513, 85 FR 85045 through 85368, 86 FR 65686 through 65968, 87 FR 70250 through 70633, 88 FR 79556 through 79964, 89 FR 98599 through 98957, and 90 FR 50036 through 50353), we designated certain quality measures as high priority in the MIPS quality measure inventory found in the Appendices of the rules for the applicable performance period to allow MIPS eligible clinicians to easily identify which measures meet the definition of a high priority measure at § 414.1305 and satisfy the reporting requirement. Additionally, in the CY 2022 PFS final rule (86 FR 65998 through 66031) and subsequent PFS rules we designated high priority quality measures in the MVP inventory found in the Appendices. The Explore Measures and Activities Tool on the QPP website (*https://qpp.cms.gov/reporting-requirements/measures-activities/explore*) also indicates which quality measures are designated as high priority in traditional MIPS and MVP reporting.

Given the proposed implementation of the MIPS core measure designation in section IV.A.4.d.(1)(c)(i) of this proposed rule, which identifies a subset of measures that reflect the essential components of care specific to a given specialty, medical condition, or episode of care, we are proposing to remove the high priority designation from MIPS quality measure inventory and the MVP inventory. The proposed MIPS core measures intend to increase reporting on select quality measures that are most reflective of the care central to a particular specialty, medical condition or episode of care, while providing patients with more comparative clinician performance data. We considered maintaining the high priority designation since many of the proposed MIPS core measures are high priority measures. However, the high priority designation does not appropriately capture a measure's relevance to a specific clinical specialty, medical condition or episode of care. We identify and designate quality measures that reflect agency-wide priorities as high priority in our programs through myriad ways such as using the MIPS high priority definition, developing the Universal Foundation, and implementing the Core

Quality Measures Collaborative (CQMC). However, the proposed MIPS core measure designations specifically represent key quality measures that reflect the measure's relevance to a specific clinical specialty, medical condition or episode of care for clinicians and patients for each MVP and essential best practices to the MVP's clinical topic. The significant overlap in the proposed MIPS core measures with the MIPS high priority measures means we would still largely capture agency-wide priorities but with a greater emphasis on supporting intended MIPS policy goals of providing robust quality measure data relevant to the scope of care for a specialty or medical condition. Additionally, maintaining the high priority measure designation could add complexity and confusion for clinicians given the overlap of the existing high priority measures and the proposed MIPS core measures. While we acknowledge the overlap in intended goals for high priority measures and MIPS core measures, we anticipate that the proposed MIPS core measures, with a selection emphasis on outcome-based measures, would provide a more targeted set of measures, focused on more meaningful improvement in the quality of care related to each MVP specialty or medical condition. Therefore, to implement the proposed MIPS core measure designation as described in section IV.A.4.d.(1)(c)(i) of this proposed rule, we are proposing to remove the high priority designation from the MIPS quality measure and the MVP inventory in Appendices 1 and 3 of this proposed rule.

Additionally, in the CY 2019 PFS final rule (83 FR 59765) at § 414.1330(c)(2), we revised the approach to remove quality measures to include considerations for retaining MIPS quality measures that otherwise meet the criteria for removal, including "whether the MIPS quality measure is designated as high priority or not." To align with the proposed removal of high priority designation from MIPS quality measures, we would no longer include the use of a high priority measure designation as one of the considerations for retaining a MIPS quality measure. Therefore, we propose to update the existing quality measure retention consideration at § 414.1330(c)(2)(iv) to state that we would consider whether the quality measure is designated as high priority or not through the CY 2026 performance period/2028 MIPS payment year.

We request public comment on these proposals.

(iii) Proposal to Implement Data Submission Requirement for MIPS Core Measures

(A) Background

In the CY 2017 Quality Payment Program final rule (81 FR 77114), we finalized at § 414.1335(a)(1) that for the performance period, a MIPS eligible clinician will report at least six measures including at least one outcome measure. If an applicable outcome measure is not available, a MIPS eligible clinician will be required to report a high priority measure instead. Additionally, in the CY 2022 PFS final rule (86 FR 65412), we finalized at § 414.1365(c)(1), that except as provided in paragraph § 414.1365(c)(1)(i), an MVP participant must select and report, if applicable, 4 quality measures, including 1 outcome measure (or, if an outcome measure is not available, 1 high priority measure), included in the MVP, excluding the population health measure required under paragraph (c)(4)(ii). We were concerned that small practices do not have the same resources to meet the quality reporting requirement of four measures if the MVP does not include four Medicare Part B claims measures. Therefore, we finalized at § 414.1365(c)(1)(i) that paragraph § 414.1365(c)(1) does not apply to a small practice that reports on an MVP that includes fewer than four Medicare Part B claims measures, provided that the small practice reports each such measure that is applicable.

(B) Proposal for MIPS Core Measure Data Submission Requirements with Self-Attestation

In conjunction with the proposed removal of the high priority designation for MIPS quality measures, and the proposed new designation of MIPS core measures beginning with the CY 2027 performance period/2029 MIPS payment year, we are proposing to remove the current quality measure data submission requirement of one outcome measure (or, if an outcome measure is not available, one high priority measure) for traditional MIPS and MVPs and replace the requirement with a MIPS core measure data submission requirement to emphasize the reporting on the proposed MIPS core measures. The requirement to report an outcome measure (or, if an outcome measure is not available, one high priority measure) would no longer be

necessary, as the goals of that policy would be met by the proposed MIPS core measure reporting requirement, since the proposed MIPS core measure selection process considers outcome-based measures and measures that are integral in driving positive patient outcomes. Specifically, we are proposing that MIPS eligible clinicians reporting via traditional MIPS must submit data on at least six measures, including at least one MIPS core measure. Clinicians reporting a specialty measure set in traditional MIPS must report at least six measures and choose an applicable MIPS core measure, if available, within that specialty measure set. If the set contains fewer than six measures or fewer than six measures within the set apply, they must report on each measure that is applicable. Additionally, to be consistent with the existing reporting requirements for clinicians reporting a specialty measure set, as finalized in the CY 2017 Quality Payment Program final rule (81 FR 77114), if a specialty measure set does not contain a MIPS core measure, clinicians must still report on at least six measures within the specialty set. If the specialty set does not contain a MIPS core measure and contains fewer than six measures, or fewer than six measures within the set apply, they must report on each measure that is applicable within the specialty measure set. An MVP participant must select and report, if applicable, four quality measures, including at least one MIPS core measure. We note that clinicians submitting data for the quality performance category in traditional MIPS reporting would choose an applicable MIPS core measure from the full inventory of available MIPS core measures for the performance period. Clinicians reporting an MVP would choose the applicable MIPS core measures from those available in the selected MVP. Each MVP would include a minimum of three MIPS core measures for a clinician to select from. MVPs that encompass multiple specialties or subspecialties may include more than three MIPS core measures to ensure comprehensive coverage for the variety of clinicians reporting that MVP.

Since the proposed MIPS core measures were identified to reflect the care most central to a clinician specialty, medical condition, or episode of care within each MVP for clinicians and patients, we anticipate that clinicians could report the proposed MIPS core measures in the

selected MVP. We acknowledge that due to the variety of clinician practices, specialties, and subspecialties reporting each MVP, there may be instances in which a clinician does not have an available and applicable MIPS core measure due to the limited inventory of the proposed MIPS core measures. If an individual eligible clinician, group, subgroup, or APM Entity does not have an available and applicable MIPS core measure that meets the numerator and denominator criteria as specified in the MIPS quality measure inventory for the applicable performance period, either in traditional MIPS or MVP reporting, we propose to establish a MIPS core measure self-attestation process. Under this process, the clinician would be required in good faith to attest during the data submission period that there was not an available and applicable MIPS core measure for them to report. The clinician would then be required to choose another measure to report in place of the MIPS core measure. A clinician reporting via traditional MIPS could report any other applicable quality measure in the MIPS quality measure inventory. In MVP reporting, a clinician could report any other quality measure in the selected MVP. There may be instances in which a clinician attested to not having an applicable and available MIPS core measure, but new information or changing circumstances later made it so that the clinician does have an applicable and available MIPS core measure to report. To account for these cases, we would allow a clinician to attest that they do not have an applicable and available MIPS core measure and then submit a MIPS core measure. We refer readers to section IV.B.1.b.(1) for our proposals for scoring MIPS core measures. While we considered requiring clinicians without an available and applicable MIPS core measure to report an outcome or high priority measure, we determined that such a requirement would increase complexity for clinicians and would be unnecessary given that MVPs are already a collection of the key quality measures for a specialty, medical condition, or episode of care. We would not penalize a MIPS eligible clinician who provides a self-attestation to not having a MIPS core measure to report. We note that we may monitor attestations received for the MIPS core measure requirement and may, in future years, conduct random reviews to verify that there were no available and applicable MIPS core

measures for reporting. We refer readers to section IV.B.1.b.(1) of this proposed rule for details on the proposed scoring policies for MIPS core measures.

For traditional MIPS reporting, we propose at § 414.1335(a)(1)(i) that beginning in the CY 2027 performance period/2029 MIPS payment year, MIPS eligible clinicians, except as provided in paragraphs (a)(1)(ii) and (a)(1)(iii) of this section, submits data on at least six quality measures, including at least one MIPS core measure. If there is not an available and applicable MIPS core measure, a MIPS eligible clinician must attest to not having an available and applicable MIPS core measure and submit data on a separate MIPS quality measure. If fewer than six measures apply, then the MIPS eligible clinician, group, virtual group, or APM Entity must report on each measure that is applicable.

Additionally, we propose at § 414.1335(a)(1)(ii) that beginning in the CY 2027 performance period/2029 MIPS payment year, except as provided in paragraph (a)(1)(iii) of this section, a MIPS eligible clinician that reports on a specialty or subspecialty measure set, as designated in the MIPS final list of quality measures established by CMS through rulemaking, must submit data on at least six measures within that set, including at least one MIPS core measure. If there is not an available and applicable MIPS core measure, a MIPS eligible clinician must attest to not having an available and applicable MIPS core measure and submit data on a separate MIPS quality measure within that set. If the set contains fewer than six measures or if fewer than six measures within the set apply to the MIPS eligible clinician, report on each measure that is applicable.

For MVP reporting, we propose at § 414.1365(c)(1) that, beginning in the CY 2027 performance period/2029 MIPS payment year, except as provided in paragraphs (c)(1)(i) and (c)(1)(ii) of this section, an MVP participant must select and report, if applicable, four quality measures, including one MIPS core measure available in the MVP, excluding the population health measure required under paragraph (c)(4)(ii). If there is not an available and applicable

MIPS core measure, an MVP participant must attest to not having an available and applicable MIPS core measure and submit data on a separate MIPS quality measure within the MVP.

We request public comment on these proposals.

(C) Proposal to Exempt Small Practices from MIPS Core Measure Reporting Requirement

We recognize that clinicians in small practices often face challenges in successfully participating in MIPS and MVP reporting due to limited financial, administrative, and health IT resources, when compared to medium and large practices. Historically, we have received feedback from small practices expressing concerns that meeting the MIPS reporting requirements can be challenging due to the limited resources of small practices, and we have implemented policies in MIPS to support clinicians in small practices to address these concerns. For example, in the CY 2022 PFS final rule (86 FR 65412), we finalized at § 414.1365(c)(1)(i) that the requirement to report four quality measures in an MVP does not apply to small practice clinicians reporting under the Medicare Part B claims collection type when the selected MVP contains fewer than four Medicare Part B claims-based quality measures. In addition, in MVPs, small practices reporting via Medicare Part B claims measures are currently exempt from the outcome/high priority reporting requirement if the MVP does not contain at least four Medicare Part B claims measures.

We considered several policy options for small practices with respect to reporting MIPS core measures. Initially, we considered whether to align the reporting requirements for small practices with the proposed MIPS core measure reporting requirements for clinicians in medium and large practices participating in traditional MIPS and MVP reporting. However, we anticipate that clinicians in small practices may continue to experience challenges with meeting the proposed MIPS core measure reporting requirement due to limited resources, difficulty reaching the case minimum requirement, and the limited inventory of proposed MIPS core measures, particularly the limited inventory of proposed MIPS core measures available via the Medicare Part B claims collection type, which is only available to small practices. While we also

considered exempting small practices from the proposed MIPS core measure reporting requirement only if the selected MVP does not contain at least one MIPS core measure available via the Medicare Part B claims collection type, we remained concerned that such a policy would further limit measure choice for clinicians in small practices and could lead to confusion and unfairness if some MVPs contained Medicare Part B claims MIPS core measures and other MVPs did not. In recognition of these ongoing challenges, and to streamline reporting requirements for small practices while continuing to support clinicians in small practices, we want to provide flexibilities for clinicians in small practices to successfully report the MIPS quality performance category. Therefore, in both traditional MIPS and MVP reporting, we propose that small practices, as defined under § 414.1305, be exempt from the MIPS core measure data submission requirement. Under this proposal, clinicians in small practices would continue to report six quality measures for traditional MIPS or four quality measures as currently required for MVPs. It is important to note that while small practices are not required to report a MIPS core measure, they may choose to do so on a voluntary basis.

Specifically, we propose at § 414.1335(a)(1)(iii) that beginning with the CY 2027 performance period/2029 MIPS payment year, MIPS eligible clinicians in small practices are not required to submit at least one MIPS core measure or attest to not having an available and applicable MIPS core measure. MIPS eligible clinicians in small practices must submit data on at least six measures, if applicable. Additionally, we propose at § 414.1365(c)(1)(ii) that beginning with the CY 2027 performance period/2029 MIPS payment year, an MVP participant that meets the requirements of a small practice is not required to submit at least one MIPS core measure or attest to not having an available and applicable MIPS core measure. Except as provided in paragraph (c)(1)(i) of this section, an MVP participant that meets the requirements of a small practice must select and report, if applicable, at least four quality measures included in the MVP, excluding the population health measure required under paragraph (c)(4)(ii) of this section.

We request public comment on these proposals.

(iv) Proposal to Modify Data Submission Criteria for Medicare CQMs

In this proposed rule, we are proposing an amendment to the data submission criteria for the Medicare CQMs collection type in § 414.1335(a)(4) by including the availability of Medicare CQMs within the APP Plus measure set, as applicable. Specifically, in § 414.1335(a)(4)(i), we are proposing that the data submission criteria pertaining to Medicare CQMs would be met by a MIPS eligible clinician, group, and APM Entity reporting on the Medicare CQMs (reporting quality data on beneficiaries eligible for Medicare CQMs as defined at § 425.20) within the APP measure set or APP Plus measure set (as applicable) and administering the CAHPS for MIPS Survey as required under the APP.

We are including the availability of Medicare CQMs under the APP Plus measure set to provide various options that would assist Medicare Shared Savings Program ACOs with reporting quality data and transition to the adoption of digital quality measures (dQMs). We encourage Medicare Shared Savings Program ACOs to evaluate all quality reporting options to determine which collection type is most appropriate based on their unique composition and technical infrastructure.

We request public comment on this proposal.

(v) Proposal to Implement Data Submission Criteria for Medicare eCQMs

In this proposed rule, we are proposing to establish the data submission criteria for the Medicare eCQMs collection type (as proposed under the APP in section III.G.3.d.(3) of this proposed rule) in § 414.1335(a)(5). Specifically, in § 414.1335(a)(5)(i), we are proposing that the data submission criteria pertaining to Medicare eCQMs would be met by a MIPS eligible clinician, group, and APM Entity reporting on the Medicare eCQMs (reporting quality data on beneficiaries eligible for Medicare eCQMs as defined at § 425.20) within the APP Plus measure set (as applicable) and administering the CAHPS for MIPS Survey as required under the APP.

Medicare eCQMs would serve to address concerns discussed in section III.G.3.d.(1) of this proposed rule by defining a population of beneficiaries that exists within the all payer/all

patient eCQM specifications and tethering that population to a Medicare Shared Savings Program ACO's assigned beneficiary population. Medicare Shared Savings Program ACOs have noted challenges with quality data reporting as their list of eligible beneficiaries has often contained beneficiaries for whom the Medicare Shared Savings Program ACO is unable to identify a primary care relationship. Specifically, Medicare eCQMs would address the concern raised by Medicare Shared Savings Program ACOs with a higher proportion of specialty practices and/or multiple EHRs, the broader all payer/all patient eligible population would capture beneficiaries with no primary care relationship to the Medicare Shared Savings Program ACO. Medicare eCQMs would provide an additional optional collection type for reporting quality data and assist with the transition and adoption of dQMs. Also, we anticipate in future years when FHIR-based reporting becomes mandatory that Medicare Shared Savings Program ACOs would be able to continue to use the FHIR-based digital specifications to report only on their assigned beneficiary population. We encourage Medicare Shared Savings Program ACOs to evaluate all quality reporting options to determine which collection type is most appropriate based on their unique composition and technical infrastructure.

We request public comment on this proposal.

(d) Proposal to Modify Data Completeness Criteria

(i) Proposal to Modify Data Completeness Criteria for Medicare CQMs

As described in section III.G.3.c. of this proposed rule, we are extending the availability of the Medicare CQMs collection type and anticipating the sunsetting of the Medicare CQMs collection type starting with the CY 2030 performance period/2032 MIPS payment year when FHIR-based reporting becomes mandatory. We are proposing an amendment to the data completeness criteria for the Medicare CQMs collection type in § 414.1340(d)(1) by modifying the duration of availability for the Medicare CQMs collection type as a means for meeting data completeness criteria requirements, which would eliminate the specific duration of availability (from the CY 2024 performance period/2026 MIPS payment year to the CY 2028 performance

period/2030 MIPS payment year) and extend the duration of the availability of the Medicare CQMs collection type. Such modification would extend the availability of the Medicare CQMs collection type for meeting the data completeness criteria threshold requirements under the APP until CMS identifies the sunsetting of the Medicare CQMs collection type in future rulemaking.

Specifically, in § 414.1340(d), respectively, we are proposing the following modification to the data completeness criteria threshold pertaining to the Medicare CQMs collection type:

At paragraph (d)(1), starting with the CY 2024 performance period/2026 MIPS payment year, an APM Entity, specifically a Medicare Shared Savings Program ACO that meets the reporting requirements under the APP, submitting quality measure data on Medicare CQMs must submit data on at least 75 percent of the APM Entity's applicable beneficiaries eligible for the Medicare CQM, as proposed to be defined at § 425.20, who meet the measure's denominator criteria.

We request public comment on this proposal.

(ii) Proposal to Implement Data Completeness Criteria for Medicare eCQMs

As we propose to establish a new collection type, Medicare eCQMs specific to the APP as described in section III.G.3.d.(3) of this proposed rule, we are also proposing to establish the data completeness criteria threshold for the Medicare eCQMs collection type. Specifically, in § 414.1340(e), respectively, we are proposing the following data completeness criteria threshold pertaining to the Medicare eCQMs collection type:

At paragraph (e)(1), starting with the CY 2027 performance period/2029 MIPS payment year, an APM Entity, specifically a Medicare Shared Savings Program ACO that meets the reporting requirements under the APP, submitting quality measure data on Medicare eCQMs must submit data on at least 75 percent of the APM Entity's applicable beneficiaries eligible for the Medicare eCQM, as proposed to be defined at § 425.20, who meet the measure's denominator criteria.

Also, for the data completeness criteria pertaining to the quality performance category, we are proposing a technical amendment to recognize the former paragraph (e) as new paragraph (f) due to the proposal to establish the data completeness criteria for the new collection type, Medicare eCQM, in § 414.1340(e) as discussed in the following XXX section of this proposed rule.

We request public comment on this proposal.

(e) Addition of New Quality Measures

(i) Pre-Rulemaking Process

Prior to introducing a new MIPS quality measure in a proposed rule, we receive public input on measures through the pre-rulemaking process (referred to as the Pre-Rulemaking Measure Review (PRMR)) established in accordance with section 1890A of the Act. Although section 1848(q)(2)(D)(viii) of the Act provides that the pre-rulemaking process under section 1890A of the Act is not required to apply to the selection of MIPS quality measures, we have found that the pre-rulemaking process provides a comprehensive review of measures from multi-stakeholder workgroups and have accordingly elected for such measures to be reviewed utilizing the PRMR process (87 FR 70048). Under the established PRMR process (additional information regarding the PRMR process is available at *https://p4qm.org/PRMR*), CMS has contracted with a Consensus-Based Entity (CBE), which is responsible for convening a multi-stakeholder panel comprised of clinicians, patients, measure experts, and health information technology specialists to provide input on measures CMS is considering for use in Medicare.

The PRMR process begins with CMS's publication of measures under consideration for use in Medicare (the Measures Under Consideration (MUC) List). Each measure on the MUC List is reviewed by one of several committees convened by the CBE for the purpose of providing multi-stakeholder input to the Secretary. The PRMR process includes opportunities for public comments through a 21-day public comment period, as well as public listening sessions. The CBE posts the compiled comments and listening session inputs received during the public

comment period and the listening sessions within 5 days of the close of the public comment period. More details regarding the PRMR process may be found in the PQM Guidebook of Policies and Procedures for Pre-Rulemaking Measure Review and Measure Set Review (available at *https://p4qm.org/sites/default/files/2025-07/OP2-PRMR-MSR-Final-Multi-Stakeholder-Group-Guidebook-of-Policies-and-Procedures-508_1.pdf*).

Per the PQM Guidebook, the final vote of the multistakeholder committee convened by the CBE may result in the following disposition of a measure: The committee recommends that this measure be added to the CMS program or the committee does not recommend that this measure be added to the CMS program. A "does not recommend" voting result signals continued disagreement among the committee despite being presented with perspectives from public comments and committee member feedback and discussion and highlights the multi-faceted assessments of quality measures. There may be cases in which the CBE does not recommend a measure to move forward to the rulemaking process and eventual implementation but we go forth with proposing a measure. We note that section 1848(q)(2)(D)(iii)(v)(III) of the Act does not preclude the Secretary from proposing and implementing measures that are not endorsed by a CBE as long as the measure is evidence-based.

Quality measures considered for potential implementation in MIPS starting with CY 2027 performance period/2029 MIPS payment year were informed, in part, by the measures included on the 2025 MUC List (available at *https://mmshub.cms.gov/sites/default/files/2025-MUC-List.xlsx*). We refer readers to Table Group A of Appendix 1: MIPS Quality Measures of this proposed rule for detailed descriptions of the new MIPS quality measures proposed. We note that we are advancing quality measurement by transitioning existing quality measures and reporting processes to Fast Healthcare Interoperability Resources® (FHIR®)-based digital approaches. We refer readers to section IV.A.4.c. of this proposed rule, where we seek input on the anticipated transition timeline, key milestones, and implementation considerations for FHIR-based quality reporting.

(ii) Removal of Quality Measures

In the CY 2025 PFS final rule, we codified previously established criteria for the removal of MIPS quality measures from the MIPS quality measure inventory at § 414.1330. In the CY 2017 Quality Payment Program final rule (81 FR 77136 through 77137), we established the following criteria for measure removal to include: If the Secretary determines that the MIPS quality measure is no longer meaningful, such as MIPS quality measures that are topped out; and, if a measure steward is no longer able to maintain the quality measure. In the CY 2019 PFS final rule (83 FR 59763), we expanded the criteria for measure removal to include MIPS quality measures that reached an extremely topped-out status (for example, a measure with an average mean performance within the 98th to 100th percentile range). The MIPS quality measure may be proposed for removal in the next rulemaking cycle, regardless of whether or not it is in the midst of the topped-out measure lifecycle, due to the extremely high and unvarying performance where meaningful distinctions and improvement in performance can no longer be made, after taking into account any other relevant factors.

Also, in the CY 2019 PFS final rule (83 FR 59764), we established other criteria for measure removal, specifically MIPS quality measures that are: duplicative; not maintained or updated to reflect current clinical guidelines, which are not reflective of a clinician's scope of practice; and low-bar, standard of care process measures. As described in the CY 2019 PFS final rule (83 FR 59765), we established an approach to incrementally remove process measures where prior to removal, consideration will be given to, but will not be limited to, the following:

- Whether the removal of the process measure impacts the number of measures available for a specific specialty.

- Whether the MIPS quality measure addresses a priority area highlighted in the Measure Development Plan: *https://www.cms.gov/medicare/quality/value-based-programs/quality-payment-program/measure-development*.

- Whether the MIPS quality measure promotes positive outcomes in patients.

- Considerations and evaluation of the measure's performance data.
- Whether the MIPS quality measure is designated as high priority or not.
- Whether the MIPS quality measure has reached extremely topped-out status within the 98th to 100th percentile range, due to the extremely high and unvarying performance where meaningful distinctions and improvement in performance can no longer be made.

In the CY 2020 PFS final rule (84 FR 62958 through 62959), we expanded the criteria for measure removal to include MIPS quality measures that do not meet case minimum and reporting volumes required for benchmarking after being in the program for 2 consecutive CY performance periods and are not available for MIPS quality reporting by or on behalf of all MIPS eligible clinicians. For MIPS quality measures that do not meet case minimum and reporting volumes required for benchmarking after being in the program for 2 consecutive CY performance periods, we noted that we will factor in other considerations (such as, but not limited to, the robustness of the measure; whether it addresses a measurement gap; if the measure is a patient-reported outcome; and consideration of the MIPS quality measure in developing MVPs) prior to determining whether to remove the MIPS quality measure. We refer readers to section IV.A.4.d.(1)(c)(ii) of this proposed rule for our proposals regarding removing references to the high priority measure designation from MIPS quality measures and MIPS quality measure retention consideration.

(iii) Inventory of Quality Measures

Section 1848(q)(2)(D)(i) of the Act requires the Secretary, through notice and comment rulemaking, to establish an annual final list of quality measures from which MIPS eligible clinicians may choose for the purpose of assessment under MIPS. Section 1848(q)(2)(D)(i)(II) of the Act requires that the Secretary annually update the list by removing measures from the list, as appropriate; adding new measures to the list, as appropriate; and determining whether measures that have undergone substantive changes should be included on the updated list.

Previously finalized MIPS quality measures can be found in the CY 2017 and CY 2018 Quality Payment Program final rules (81 FR 77558 through 77816 and 82 FR 53966 through 54174, respectively), and the CY 2019 through CY 2026 PFS final rules (83 FR 60097 through 60285, 84 FR 63205 through 63513, 85 FR 85045 through 85369, 86 FR 65687 through 65968, 87 FR 70250 through 70633, 88 FR 79556 through 79964, 89 FR 98599 through 98957, and 90 FR 50036 through 50353, respectively). We are proposing changes to the MIPS quality measure inventory, as outlined in Appendix 1 of this proposed rule, including the following: the addition of new measures; updates to specialty sets (that is, creation of new specialty sets; addition and/or removal of measures; and substantive changes to existing measures within specialty sets, as appropriate); removal of existing measures; and substantive changes to existing measures. For the CY 2027 performance period/2029 MIPS payment year, we are proposing an inventory of 180 MIPS quality measures.

The new MIPS quality measures that we are proposing to include in MIPS for the CY 2027 performance period/2029 MIPS payment year and future years can be found in Table Group A of Appendix 1 of this proposed rule. For the CY 2027 performance period/2029 MIPS payment year, we are proposing 10 new MIPS quality measures, which include measures focused on patient-reported outcomes and chronic disease management.

On January 14, 2026, we solicited recommendations for potential new specialty measure sets or revisions to existing specialty measure sets for the CY 2027 performance period/2029 MIPS payment year.[376] The recommendations we received were based on the MIPS quality measures finalized in the CY 2026 PFS final rule and the 2025 MUC List. The recommendations include the addition or removal of current MIPS quality measures from existing specialty sets, and/or the creation of new specialty sets. All specialty set recommendations submitted for

[376] Message to the Quality Payment Program listserv on January 14, 2026, entitled "The Centers for Medicare & Medicaid Services (CMS) is Soliciting Interested Party Recommendations for Potential Consideration of New Specialty Measure Sets and/or Revisions to the Existing Specialty Measure Sets for the 2027 Performance Year of the Merit-based Incentive Payment System (MIPS)."

consideration were assessed and vetted, and as a result, the recommendations that we agree with are proposed in this proposed rule.

We are proposing modifications to existing specialty sets as described in Table Group B of Appendix 1 of this proposed rule. Modifications to specialty sets include the addition of new measures and/or existing measures within the MIPS quality measure inventory, removal of measures, and/or substantive changes to previously finalized measures. Specialty and subspecialty sets are not inclusive of every specialty or subspecialty. We develop and maintain specialty measure sets to assist MIPS eligible clinicians with selecting quality measures that are most relevant to their scope of practice.

In addition to establishing new individual MIPS quality measures and modifying existing specialty sets as described in Tables Group A and Group B of Appendix 1 of this proposed rule, we refer readers to Table Group C of Appendix 1 of this proposed rule for a list of MIPS quality measures proposed for removal and detailed discussion of our rationale for each measure. Of the 20 MIPS quality measures proposed for removal, two MIPS quality measures are extremely topped out, four MIPS quality measures have reached the end of the topped-out lifecycle, three MIPS quality measures are no longer being maintained by the measure steward, eight MIPS quality measures are duplicative of new or current measures, one MIPS quality measure has limited adoption and therefore no benchmark, one MIPS quality measure is a low bar process measure, and one MIPS quality measure lacks robustness. The proposal to remove the MIPS quality measures described in Table Group C of Appendix 1 of this proposed rule would lead to a more parsimonious inventory of meaningful, robust measures in the program.

Further, in Appendix 1 of this proposed rule, we are proposing substantive changes to 43 MIPS quality measures, which can be found in Table Group D and Table Group DD of Appendices of this proposed rule. Of the proposed substantive changes to the 43 MIPS quality measures, two MIPS quality measures are only available for use in relevant MVPs, which can be found in Table Group DD of Appendix 1 of this proposed rule. We have previously established

criteria that would apply when we are considering making substantive changes to a quality measure (81 FR 77137 and 86 FR 65441 through 65442). On an annual basis, we review the established MIPS quality measure inventory to consider updates to the measures. Possible updates to measures may be minor or substantive. The proposed inventory of 180 MIPS quality measures for the CY 2027 performance period/2029 MIPS payment year includes 177 MIPS quality measure available for utilization in traditional MIPS and MVPs, and 3 MIPS quality measures available only for utilization in MVPs (as finalized in the CY 2024 PFS final rule (88 FR 79897 through 77902)).

In summary, in the CY 2027 PFS proposed rule, we are proposing to modify the quality performance category measure inventory to include a set of 180 MIPS quality measures for the CY 2027 performance period/2029 MIPS payment year, which includes the following:

- Implementation of 10 new MIPS quality measures including measures focused on patient-reported outcomes and chronic disease management;
- Removal of 20 MIPS quality measures: Two MIPS quality measures that are extremely topped out, four MIPS quality measures that have reached the end of the topped-out measure lifecycle, three MIPS quality measures that are no longer being maintained by the measure steward, eight MIPS quality measures that are duplicative of new or current measures, one MIPS quality measure that has limited adoption and therefore no benchmark, one MIPS quality measure that is a low bar process measure, and one MIPS quality measure lacking robustness, and;
- Substantive changes to 43 current MIPS quality measures.

We refer readers to Table Groups A through DD of Appendix 1 of this proposed rule for a summary of the new measures proposed, the measures proposed for removal, and the substantive changes proposed as well as specialty set changes proposed.

We request public comment on these proposals.

(2) Cost Performance Category

(a) Background

Section 1848(q)(2)(A)(ii) of the Act includes resource use as a performance category under MIPS. We refer to this performance category as the cost performance category. As required by sections 1848(q)(2) and (5) of the Act, the four performance categories of MIPS are used in determining the MIPS final score for each MIPS eligible clinician. In general, MIPS eligible clinicians are evaluated under all four of the MIPS performance categories, including the cost performance category.

Section 1848(q)(2)(B)(ii) of the Act provides that, for the cost performance category, the measurement of resource use (that is, cost) for such period must be in accordance with section 1848(p)(3) of the Act, using the methodology under section 1848(r) of the Act as appropriate, and, as feasible and applicable, accounting for the cost of drugs under Medicare Part D. Section 1848(p)(3) of the Act provides that costs shall be evaluated, to the extent practicable, based on a composite of appropriate measures of costs established by the Secretary that eliminate the effect of geographic adjustments in payment rates, and take into account risk factors (such as socioeconomic and demographic characteristics, ethnicity, and health status of individuals) and other factors determined appropriate by the Secretary. Section 1848(r) of the Act specifies a series of steps and activities for the Secretary to undertake to involve physicians, practitioners, and other interested parties in enhancing the infrastructure for cost measurement, including for purposes of MIPS and Advanced APMs under section 1833(z) of the Act. Specifically, section 1848(r)(2)(H) of the Act provides that, not later than November 1 of each year (beginning with 2018), the Secretary shall, through rulemaking, make revisions to the operational lists of care episode and patient condition codes as the Secretary determines may be appropriate.

We are proposing the following update to the cost performance category beginning with the CY 2027 performance period/2029 MIPS payment year:

- Update the operational list of care episode and patient condition groups and codes to reflect changes to service and diagnosis codes that define care episodes and patient condition groups, as identified through the annual maintenance of episode-based measures.

For a description of the statutory authority for and existing policies pertaining to the cost performance category, we refer readers to §§ 414.1350 and 414.1380(b)(2) and the CY 2017 Quality Payment Program final rule (81 FR 77162 through 77177), CY 2018 Quality Payment Program final rule (82 FR 53641 through 53648), CY 2019 PFS final rule (83 FR 59765 through 59776), CY 2020 PFS final rule (84 FR 62959 through 62979), CY 2021 PFS final rule (85 FR 84877 through 84881), CY 2022 PFS final rule (86 FR 65445 through 65461), CY 2023 PFS final rule (87 FR 70055 through 70057), CY 2024 PFS final rule (88 FR 79339 through 79349), CY 2025 PFS final rule (89 FR 98390 through 98408), and CY 2026 PFS final rule (90 FR 49859 through 49864).

More details on the proposal in this section, which we invite comments on, are provided in section IV.A.4.d.(2)(b) through section IV.A.4.d.(2)(d) of this proposed rule.

(b) Selection of Cost Measures

In accordance with our statutory authority as described in section IV.A.4.d.(2)(a) of this proposed rule and our regulation at § 414.1350(a), we specify cost measures for a performance period to assess the performance of MIPS eligible clinicians on the cost performance category.

We consider adoption of cost measures to capture new clinical areas, which furthers our goals to transition from traditional MIPS to MVPs and expands the Medicare spending that is captured by the cost performance category assessment. MVPs require the inclusion of at least one cost measure, so adoption of cost measures for new clinical areas allows us to create new MVPs for clinical areas that do not yet have MVPs or to increase the amount of applicable cost measures in existing MVPs. Additionally, adopting cost measures that assess new clinical areas moves us closer towards the statutory goal of covering 50 percent of costs under Medicare Parts A and B, as specified under section 1848(r)(2)(D)(i)(I) of the Act.

In the CY 2022 PFS final rule (86 FR 65455 through 65459), we established common standards for potential episode-based measures to ensure consistency across episode-based measures being considered for potential use in MIPS. Specifically, the CY 2022 PFS final rule requires that any episode-based measure for the cost performance category include the following: (1) episode definition based on trigger codes that determine the patient cohort; (2) attribution; (3) service assignment; (4) exclusions; and (5) risk adjustment.

Additionally, in the CY 2025 PFS final rule (89 FR 98405), we codified criteria that must be met for a cost measure to be removed from the MIPS cost measure inventory at § 414.1350. Under the criteria, we may remove a cost measure from MIPS based on one or more of the following factors; provided, however, that we may retain a cost measure that meets one or more of the following factors if we determine the benefit of retaining the measure outweighs the benefit of removing it.

- It is not feasible to implement the measure specifications.
- A measure steward is no longer able to maintain the cost measure.
- The implementation costs or negative unintended consequences associated with a cost measure outweigh the benefit of its continued use in the MIPS cost performance category.
- The measure specifications do not reflect current clinical practice or guidelines.
- The availability of a more applicable measure, including a measure that applies across settings, applies across populations, or is more proximal in time to desired patient outcomes for the particular topic.

We are not proposing to adopt any new measures for the CY 2027 performance period/2029 MIPS payment year. We are also not proposing to remove any measures for the CY 2027 performance period/2029 MIPS payment year.

(c) Inventory of Cost Measures

As discussed previously, we specify cost measures for a performance period to assess the performance of MIPS eligible clinicians on the cost performance category. There are currently

35 cost measures in the cost performance category for the CY 2026 performance period/2028 MIPS payment year, comprising 33 episode-based measures covering a range of conditions and procedures and 2 population-based measures. Previously finalized MIPS cost measures can be found in the CY 2018 Quality Payment Program final rule (82 FR 53641 through 53648), CY 2019 PFS final rule (83 FR 59765 through 59776), CY 2020 PFS final rule (84 FR 62959 through 62979), CY 2021 PFS final rule (85 FR 84877 through 84881), CY 2022 PFS final rule (86 FR 65445 through 65461), CY 2023 PFS final rule (87 FR 70055 through 70057), CY 2024 PFS final rule (88 FR 79339 through 79349), and CY 2025 PFS final rule (89 FR 98390 through 98408). We refer readers to the CY 2026 PFS proposed rule (90 FR 32718 through 32719) for more context on how we establish the inventory of cost measures, including the pre-rulemaking requirements.

We are neither proposing any new MIPS cost measures nor proposing to remove any MIPS cost measures for the CY 2027 performance period/2029 MIPS payment year. We are also not proposing substantive changes to any existing MIPS cost measures for the CY 2027 performance period/2029 MIPS payment year.

(d) Proposal to Update the Operational List of Care Episode and Patient Condition Groups and Codes

Generally, to calculate MIPS eligible clinicians' performance on cost measures, we use codes from claims data to identify and apply the applicable cost measure's specifications, which govern the attribution, scope, and calculation of the cost measure. We are proposing to revise the operational list of care episode and patient condition groups and codes to reflect coding changes that are identified during the annual measure maintenance of implemented cost measures. This section of this proposed rule provides context on the statutory requirements for care episode and patient condition groups and proposes changes to the operational list.

Section 1848(r) of the Act specifies a series of steps and activities for the Secretary to undertake to involve physicians, practitioners, and other interested parties in enhancing the

infrastructure for cost measurement, including for purposes of MIPS and Advanced APMs under section 1833(z) of the Act. Section 1848(r)(2) of the Act requires the development of care episode and patient condition groups, and classification codes for such groups, and provides for care episode and patient condition groups to account for a target of an estimated one-half of expenditures under Medicare Parts A and B (with this target increasing over time as appropriate). Sections 1848(r)(2)(E) through (G) of the Act require the Secretary to post on the CMS website a draft list of care episode and patient condition groups and codes for solicitation of input from interested parties, and subsequently, post an operational list of such groups and codes. Section 1848(r)(2)(H) of the Act requires that not later than November 1 of each year (beginning with 2018), the Secretary shall, through rulemaking, revise the operational list of care episode and patient condition codes as the Secretary determines may be appropriate, and that these revisions may be based on experience, new information developed under section 1848(n)(9)(A) of the Act, and input from physician specialty societies and other interested parties.

For more information about past revisions to the operational list that we made as we developed, proposed, and finalized episode-based measures, we refer readers to the CY 2023 PFS final rule (87 FR 70056 and 70057), CY 2024 PFS final rule (88 FR 79348), and CY 2025 PFS final rule (89 FR 98404). Prior operational lists are available at the QPP Cost Measure Information page at *https://www.cms.gov/medicare/quality/value-based-programs/cost-measures/about*.

In accordance with section 1848(r)(2)(H) of the Act, we are proposing to revise the operational list beginning with the CY 2027 performance period/2029 MIPS payment year to reflect changes to codes used to identify existing care episode and patient condition groups, based on new information gathered during annual maintenance of MIPS cost measures. We conduct annual maintenance for measures implemented in MIPS to ensure that the codes used for the measure specifications remain up to date. For example, we may update the service or diagnosis codes associated with a cost measure's specifications to retain the intent of the measure

when these codes are changed in, added to, or deleted from the applicable code sets. During our annual maintenance review process for MIPS cost measures, we work with the measure developer to identify non-substantive changes to service and diagnosis codes that should be reflected in the operational list of care episode and patient condition groups so that, to the extent feasible, there is alignment between the operational list and measure specifications. More information on the annual maintenance process is available at the CMS Measures Management System (MMS) page at *https://mmshub.cms.gov/measure-lifecycle/measure-use/maintenance/annual-update*.

Our proposed revisions to the operational list are available for review on our QPP Cost Measure Information page at *https://www.cms.gov/medicare/quality/value-based-programs/cost-measures/about.* We seek interested party feedback on the service and diagnosis codes used in MIPS care episode and patient condition groups to inform any non-substantive changes to the operational list in tandem with CMS's annual maintenance efforts for the CY 2027 performance period/2029 MIPS payment year.

We request public comment on this proposal.

(3) Improvement Activities Performance Category

(a) Background

Section 1848(q)(2)(A)(iii) of the Act includes clinical practice improvement activities as a performance category under MIPS. We refer to this performance category as the improvement activities performance category. As required by section 1848(q)(2) and (5) of the Act, the four performance categories of MIPS are used in determining the MIPS final score for each MIPS eligible clinician. In general, MIPS eligible clinicians are evaluated under all four of the MIPS performance categories, including the improvement activities performance category.

Section 1848(q)(2)(C)(v)(III) defines the term "clinical practice improvement activities" as activities that relevant eligible professional organizations and other relevant stakeholders identify as improving clinical practice or care delivery and that the Secretary determines, when effectively executed, is likely to result in improved outcomes.

Section 1848(q)(2)(B)(iii) of the Act provides that, for the improvement activities category, the Secretary shall specify subcategories of clinical practice improvement activities, including at least six subcategories as specified in section 1848(q)(2)(B)(iii)(I) through (VI) of the Act. These statutorily enumerated subcategories are: (1) expanded practice access (such as same day appointments for urgent needs and afterhours access to clinician advice); (2) population management (such as monitoring health conditions of individuals to provide timely health care interventions or participation in a qualified clinical data registry); (3) care coordination (such as timely communication of test results, timely exchange of clinical information to patients and other providers, and use of remote monitoring or telehealth); (4) beneficiary engagement (such as the establishment of care plans for individuals with complex care needs, beneficiary self-management assessment and training, and using shared decision-making mechanisms); (5) patient safety and practice assessment (such as through use of clinical or surgical checklists and practice assessments related to maintaining certification); and (6)

participation in an alternative payment model, as defined in section 1833(z)(3)(C) of the Act (section 1848(q)(2)(B)(iii)(I) through (VI) of the Act).

For previous discussions on the general background of the improvement activities performance category, we refer readers to the CY 2017 Quality Payment Program final rule (81 FR 77177 and 77178), the CY 2018 Quality Payment Program final rule (82 FR 53648 through 53661), the CY 2019 Physician Fee Schedule (PFS) final rule (83 FR 59776 and 59777), the CY 2020 PFS final rule (84 FR 62980 through 62990), CY 2021 PFS final rule (85 FR 84881 through 84886), the CY 2022 PFS final rule (86 FR 65462 through 65466), the CY 2023 PFS final rule (87 FR 70057 through 70061), the CY 2024 PFS final rule (88 FR 79350 and 88 FR 79351), CY 2025 PFS final rule (89 FR 98408 through 98413), and CY 2026 PFS final rule (90 FR 49846 through 49868). We also refer readers to § 414.1305 for the relevant definitions of improvement activities and attestation, § 414.1320 for standards establishing the performance period, § 414.1325 for the data submission requirements, § 414.1355 for standards related to the improvement activity performance category generally, § 414.1360 for data submission criteria for the improvement activity performance category, and § 414.1380(b)(3) for improvement activities performance category scoring.

We are proposing various updates to the Improvement Activities Inventory (the Inventory) beginning with the CY 2027 performance period/2029 MIPS payment year, as described further in section IV.A.4.d.(3)(b)(ii) of this proposed rule. First, we propose adding six new improvement activities in two performance categories: (1) Care Coordination and (2) Advancing Health and Wellness, our newest subcategory. Second, we propose modifying five existing improvement activities currently specified for the performance category. Third, we propose removing 11 improvement activities currently specified for the performance category.

(b) Improvement Activities Inventory

(i) Annual Call for Activities Background

In the CY 2017 Quality Payment Program final rule (81 FR 77190), for the first year of MIPS, we implemented the initial Inventory consisting of approximately 95 activities (81 FR 77817 through 77831). We took several steps to ensure the Inventory was inclusive of activities aligned with statutory and program requirements. As part of this process, we conducted numerous interviews with high performing organizations of all sizes and conducted an environmental scan to identify existing models, activities, or measures that met all or part of the improvement activities performance category.

Beginning with the CY 2018 performance period/2020 MIPS payment year (82 FR 53656 through 53659), we introduced an informal process for interested parties to submit new improvement activities or modifications for our consideration and potential inclusion in the comprehensive Inventory. In the CY 2018 Quality Payment Program final rule (82 FR 53656 through 53659), beginning with the CY 2019 performance period/2021 MIPS payment year, we finalized a formal Annual Call for Activities process for the addition of possible new activities and for possible modifications to current activities in the Inventory. This process requires interested parties to submit a nomination form similar to the one we used for the CY 2018 performance period/2020 MIPS payment year (82 FR 53656 through 53659). In order to submit a request for a new activity or a modification to an existing activity, the interested party must submit a nomination form (OMB control # 0938–1314) available at https://qpp.cms.gov/resources/resource-library during the Annual Call for Activities.

(ii) Proposals to Update the Improvement Activities Inventory

In the CY 2018 Quality Payment Program final rule (82 FR 53660), we finalized that we would establish improvement activities through notice-and-comment rulemaking. For our previously finalized Improvement Activities Inventories, we refer readers to Table H in the CY 2017 Quality Payment Program final rule (81 FR 77817) Appendix, Tables F and G in the CY 2018 Quality Payment Program final rule (82 FR 54175 through 54229) Appendix, Tables A and B in the CY 2019 PFS final rule (83 FR 60286 through 60303) Appendix 2, Tables A, B, and C

in the CY 2020 PFS final rule (84 FR 63514 through 63538) Appendix 2, Tables A, B, and C in the CY 2021 PFS final rule (85 FR 85370 through 85377) Appendix 2, Tables A, B, and C in the CY 2022 PFS final rule (86 FR 65969 through 65997) Appendix 2, Tables A, B, and C in the CY 2023 PFS final rule (87 FR 70633 through 70650) Appendix 2, Tables A, B, and C in the CY 2024 PFS final rule (88 FR 79965 and 88 FR 79977) Appendix 2, Tables A, B, and C in the CY 2025 PFS final rule (89 FR 98958 through 98971) Appendix 2, and Tables A, B, and C in the CY 2026 PFS final rule (90 FR 50354 through 50369) Appendix 2. We also refer readers to the Quality Payment Program website at https://qpp.cms.gov/ and the Explore Measures and Activities tool at https://qpp.cms.gov/reporting-requirements/measures-activities/explore?tab=improvementActivities&py=2026for a complete list of the current improvement activities.

(iii) Proposals to Adopt New Improvement Activities

We propose adding six new improvement activities beginning with the CY 2027 performance period/2029 MIPS payment year. We propose that IA_CC_XX (Use of Data to Improve Practice Workflows) and IA_CC_XX (Understand and Improve Diagnostic Performance) be included in the Care Coordination subcategory. We propose that IA_AHW_XX (Systematic Screening and Intervention for Nutrition and other Health-Impacting, Non-Clinical Issues), IA_AHW_XX (Advance Care Planning Conversations to Support Patient Wellness and Care Preferences), IA_AHW_XX (Clinician Use of Artificial Intelligence (AI) to Improve Patient Care), and IA_AHW_XX (Lifestyle Approaches to Diabetes Remediation) would be included in the Advancing Health and Wellness subcategory.

The first new improvement activity, IA_CC_XX, titled “Use of Data to Improve Practice Workflows”, would allow MIPS-eligible clinicians to improve integration of evidence-based guidelines into care by developing and refining clinical pathways and workflows. If gaps are identified through data, clinicians would update and implement changes, monitor adoption and outcomes, and reassess performance regularly.

The second new improvement activity, IA_CC_XX, titled "Understand and Improve Diagnostic Performance", supports clinicians in improving patient safety by reducing diagnostic safety events and miscommunication through standardized processes for tracking discrepancies, near-misses, and data accuracy. If issues are identified, teams would conduct root-cause analyses, implement corrective actions such as workflow changes or training, and monitor performance regularly to ensure improvement.

The third new improvement activity, IA_AHW_XX, titled "Systematic Screening and Intervention for Nutrition and other Health-Impacting, Non-Clinical Issues", would allow MIPS-eligible clinicians to implement standardized screening tools for nutrition, housing, transportation, and financial strain within clinical workflows. If needs are identified, clinicians would initiate referrals to appropriate community resources, track follow-up and resolution, and reassess screening processes and outcomes regularly to improve effectiveness.The fourth new improvement activity, IA_AHW_XX, titled "Advance Care Planning Conversations to Support Patient Wellness and Care Preferences", would allow MIPS-eligible clinicians to engage patients and caregivers in advance care planning and end-of-life discussions using structured communication tools while documenting goals of care, symptom management, and patient priorities. If care preferences or needs change, clinicians would update care preferences, coordinate across specialties, and reassess regularly to ensure alignment with the patient's goals and clinical status.

The fifth new activity, IA_AHW_XX, titled "Clinician Use of Artificial Intelligence (AI) to Improve Patient Care", would allow MIPS-eligible clinicians to implement and participate in organizational initiatives that improve patient care through the responsible and transparent use of artificial intelligence (AI) in clinical and operational workflows. Clinicians would establish policies for evaluating and monitoring AI tools or participate in developing and refining AI-enabled resources, such as predictive analytics, clinical decision support, and risk-stratification

models, to improve patient outcomes, care-team efficiency, and population health management. Examples may include using AI tools to summarize medical literature for clinical decision-making, assist with documentation (e.g., AI-generated notes with clinician review), support population health management by identifying care gaps, determine patient eligibility for clinical trials, or generate draft responses to patient questions for clinician review.

The sixth new activity, IA_AHW_XX, titled "Lifestyle Approaches to Diabetes Remediation", engages clinicians in delivering structured, evidence-based lifestyle interventions for diabetes management, addressing nutrition, physical activity, sleep, stress, and behavior change through programs such as; Lifestyle Empowerment Approach for Diabetes Remission (LEADR) or the Diabetes Self-Management Education and Support (DSMES). Clinicians provide education and coaching, track patient progress, and adjust interventions as needed to improve health outcomes.

See Table F-B1 in Appendix 2 for more information regarding each of these proposed new improvement activities.

We are seeking public comments on our proposals to add each of these activities to the Inventory beginning with the CY 2027 performance period/2029 MIPS payment year.

(iv) Proposals to Modify Existing Improvement Activities

We are proposing to modify five existing improvement activities beginning with the CY 2027 performance period/2029 MIPS payment year. First, IA_BMH_4 "Depression screening", IA_CC_8 "Implementation of documentation improvements for practice/process improvements", IA_CC_9 "Implementation of practices/processes for developing regular individual care plans", and IA_PM_4 "Glycemic management services" will be combined with elements of similar improvement activities in the Inventory to make their descriptions more robust. IA_BMH_4, will be combined with elements from IA_BMH_5 "Major depressive disorder (MDD) prevention and treatment interventions". The proposed description modification involves clinicians using a coordinated, team-based approach to screen for depression, assess suicide risk, and provide

evidence-based follow-up care, with ongoing monitoring and documentation to support safe, effective management of patients.

IA_CC_8 , will be combined with elements from IA_CC_10 “Care transition documentation practice improvements”, IA_CC_11 “Care transition standard operational improvements”, and IA_CC_12 “Care coordination agreements that promote improvements in patient tracking across settings”. The proposed description modification promotes proactive, patient-centered care coordination across all settings by improving communication, tracking referrals and transitions, and documenting actions to ensure continuity, reduce fragmentation, and support better outcomes.

IA_CC_9 will be combined with elements from IA_BE_15 “Engagement of Patients, Family, and Caregivers in Developing a Plan of Care”. The proposed description modification highlights creating and regularly updating individualized care plans for at-risk patients in collaboration with the patient and their family or caregivers. It emphasizes aligning care with the patient’s goals, priorities, and desired outcomes while ensuring clear communication and shared understanding.

IA_PM_4, will be combined with elements from IA_PM_19 “Glycemic Screening Services” and IA_PM_20 “Glycemic Referring Services”. The proposed description modification requires clinicians to attest to screening for abnormal blood glucose, referring eligible patients to prevention programs, and setting individualized glycemic goals that are regularly reassessed. Documentation must meet 60 percent in the first year and 75 percent thereafter, including patients treated for at least 90 days.

Second, IA_PSPA_16 “Use decision support—ideally platform-agnostic, interoperable clinical decision support (CDS) tools, including AI-enabled predictive decision-support interventions—and standardized treatment protocols to manage workflow on the care team to meet patient needs,” would be modified to explicitly incorporate AI-enabled decision support and strengthen oversight requirements, including monitoring, root cause analysis, and mitigation

of AI-related risks. The proposed description modification specifies that MIPS-eligible clinicians use interoperable, AI-enabled clinical decision support tools to guide care-team workflows and support evidence-based, patient-centered care, while also implementing safeguards for safe use, ongoing monitoring, and evaluation of tool performance and patient safety.

See Table F-B2 in Appendix 2 for more information regarding each of these proposed modifications to existing improvement activities.

We are seeking public comments on our proposals to modify each of these activities currently specified for the Inventory beginning with the CY 2027 performance period/2029 MIPS payment year.

(v) Proposals to Remove Existing Improvement Activities

Additionally, we are proposing to remove eleven previously finalized improvement activities beginning with the CY 2027 performance period/2029 MIPS payment year: IA_BMH_5 "MDD prevention and treatment interventions", IA_CC_10 "Care transition documentation practice improvements", IA_CC_11 "Care transition standard operational improvements", IA_CC_12 "Care coordination agreements that promote improvements in patient tracking across settings", IA_PSPA_2 "Participation in MOC Part IV", IA_CC_16 "Primary Care Physician and Behavioral Health Bilateral Electronic Exchange of Information for Shared Patients", IA_BE_15 "Engagement of Patients, Family, and Caregivers in Developing a Plan of Care", IA_PM_19 "Glycemic Screening Services", IA_PM_20 "Glycemic Referring Services", IA_EPA_4 "Additional improvements in access as a result of QIN/QIO TA", and IA_PM_2 "Anticoagulant management improvements". We are proposing removal of these specific improvement activities in accordance with our activity removal policy set forth at § 414.1355(d). Specifically, we propose to remove each of these eleven improvement activities under Removal Factor(s) 1 or 7, which provides that we may remove an improvement activity if we determine it is duplicative of another activity (§ 414.1355(d)(1)) or the activity is obsolete (§ 414.1355(d)(7)).

Our proposal to remove IA_BMH_5, IA_CC_10, IA_CC_11, IA_CC_12, IA_BE_15, IA_PM_19, and IA_PM_20 would align with Removal Factor 1, as these activities are similar to other improvement activities in the Inventory and can be considered duplicative. Additionally, our proposal to remove IA_PSPA_2, IA_CC_16, IA_EPA_4, and IA_PM_2 would align with Removal Factor 7, as the activities are no longer relevant or useful in current clinical practice or policy and can be considered obsolete. See Table F-B3 in Appendix 2 for more information regarding our proposals to remove each of these existing improvement activities.

We are seeking public comments on our proposals to remove each of these activities from the improvement activities performance category beginning with the CY 2027 performance period/2029 MIPS payment year.

(4) MIPS Promoting Interoperability Performance Category

(a) Background

Section 1848(q)(2)(A)(iv) of the Act includes the meaningful use of certified electronic health record (EHR) technology (CEHRT) as a performance category under MIPS. We refer to this performance category as the MIPS Promoting Interoperability performance category (formerly the advancing care information performance category).

Section 1848(q)(2)(B)(iv) of the Act provides that the requirements established under section 1848(o)(2) of the Act for determining whether a MIPS eligible clinician is a meaningful EHR user also applies to our assessment of a MIPS eligible clinician's performance on measures and activities with respect to the MIPS Promoting Interoperability performance category. Section 1848(o)(2)(D) of the Act generally provides that the requirements for being a meaningful EHR user under section 1848(o)(2) continue to apply for purposes of MIPS.

Under section 1848(o)(2)(A) of the Act, a MIPS eligible clinician must meet three requirements related to the meaningful use of CEHRT during a performance period for a MIPS payment year. Specifically, under section 1848(o)(2)(A) of the Act, the MIPS eligible clinician must: (1) Demonstrate to the satisfaction of the Secretary the use of CEHRT in a meaningful manner, which shall include the use of electronic prescribing as determined to be appropriate by the Secretary; (2) Demonstrate to the satisfaction of the Secretary that their CEHRT is connected in a manner that provides, in accordance with law and standards applicable to the exchange of information, for electronic exchange of health information to improve the quality of care, such as promoting care coordination, and demonstrates (through a process specified by the Secretary), that they have not knowingly and willfully taken action (such as to disable functionality) to limit or restrict the compatibility or interoperability of the CEHRT; and (3) Use CEHRT to submit information on clinical quality measures and such other measures as selected by the Secretary.

For previously established policies regarding the MIPS Promoting Interoperability performance category, we refer readers to §§ 414.1305 (includes definitions pertaining to the

MIPS Promoting Interoperability performance category), 414.1375 (MIPS Promoting Interoperability performance category provisions), and 414.1380(b)(4) (includes scoring provisions pertaining to the MIPS Promoting Interoperability performance category); and the CY 2017 Quality Payment Program final rule (81 FR 77199 through 77245), CY 2018 Quality Payment Program final rule (82 FR 53663 through 53688), CY 2019 PFS final rule (83 FR 59785 through 59820), CY 2020 PFS final rule (84 FR 62991 through 63006), CY 2021 PFS final rule (85 FR 84886 through 84895), CY 2022 PFS final rule (86 FR 65466 through 65490), CY 2023 PFS final rule (87 FR 70060 through 70087), CY 2024 PFS final rule (88 FR 79308 through 79312 and 79351 through 79365), the 21st Century Cures Act: Establishment of Disincentives for Health Care Providers That Have Committed Information Blocking final rule (89 FR 54662 through 54718), CY 2025 PFS final rule (89 FR 98414 through 98427), and CY 2026 PFS final rule (90 FR 49868 through 49902).

In this proposed rule, we are proposing to--

● Update the definition of CEHRT to align with ONC Health IT Certification Program proposed updates relevant to the MIPS Promoting Interoperability performance category;

● Remove the ONC Direct Review and ONC-Authorized Certification Bodies (ACB) Surveillance attestations;

● Remove the Security Risk Analysis measure;

● Add an Electronic Prior Authorization for Prescription Drugs measure; and

● Update the previously adopted Electronic Prior Authorization measure.

(b) Proposal to Modify the Definition of Certified Electronic Health Record Technology in the MIPS Promoting Interoperability Performance Category

(i) Background

In accordance with § 414.1375(b)(1), to earn a performance category score for the MIPS Promoting Interoperability performance category, a MIPS eligible clinician must be a meaningful EHR user for MIPS and use CEHRT during the performance period, as both terms

are defined in § 414.1305. In the CY 2025 PFS final rule, we discussed previously finalized modifications related to the CEHRT definition for the Quality Payment Program, including for the MIPS Promoting Interoperability performance category at § 414.1305 (89 FR 98414 and 98415). Currently, we define CEHRT, for purposes of MIPS, as EHR technology (which could include multiple technologies) certified under the Office of National Coordinator for Health Information Technology's (ONC) Health Information Technology (IT) Certification Program that meets the Base EHR definition at 45 CFR 170.102 and certified as meeting additional ONC health IT certification criteria as adopted and updated in 45 CFR 170.315 as enumerated in paragraph (2)(i) of the CEHRT definition at § 414.1305, including as necessary to report on applicable measures specified for the MIPS Promoting Interoperability performance category. In section IV.A.4.d.(4)(g)(iv) of this proposed rule, Table C-G 8 outlines the measures for the MIPS Promoting Interoperability performance category for the CY 2027 performance period/2029 MIPS payment year and the associated ONC health IT certification criteria set forth at 45 CFR 170.315 impacting the definition of CEHRT, as applicable as of the publication date of this proposed rule.

In the Health Data, Technology, and Interoperability: ASTP/ONC Deregulatory Actions to Unleash Prosperity proposed rule (90 FR 60970) (HTI-5 proposed rule) published in the **Federal Register** on December 29, 2025, ONC[377] proposed a wide-ranging set of updates to the ONC Health IT Certification Program. The HTI-5 proposed rule focuses on deregulatory actions in 45 CFR part 170 (Health Information Technology Standards, Implementation Specifications, and Certification Criteria and Certification Programs for Health Information Technology) and 45 CFR part 171 (Information Blocking). The HTI-5 proposed rule seeks to reduce burden, offer flexibility to developers and providers, and support innovation through the removal and revision

[377] ASTP/ONC is now referred to as ONC, pursuant to a notice published in the **Federal Register** on April 1, 2026 (91 FR 16204). Although at the time of specific references noted herein, ONC was either referenced as ASTP/ONC or as ONC; for clarity, all references in this proposed rule are noted as ONC.

of certain certification criteria and regulatory provisions. The following summarizes proposals in the HTI-5 proposed rule that are relevant to MIPS eligible clinicians.

In the HTI-5 proposed rule, ONC identified 34 certification criteria for removal and 7 certification criteria for revision. ONC stated that removing or revising these criteria would reduce burden and costs for health IT developers and clinicians, partly due to the decreased necessity to maintain ongoing conformance with certification requirements (90 FR 60973).

Table C-G 1 of this proposed rule summarizes the potential impacts the proposed removal and revisions of the ONC health IT certification criteria may have on MIPS eligible clinicians reporting the MIPS Promoting Interoperability performance category. Table C-G 1 of this proposed rule describes how the criteria subject to HTI-5 proposals are incorporated into the definition of CEHRT in § 414.1305. In addition to the ONC health IT certification criteria included in the definition of CEHRT in § 414.1305, the definition includes EHR technology certified under the ONC Health IT Certification Program that meets the Base EHR definition at 45 CFR 170.102 and technology certified to the health IT criteria necessary to report on applicable measures specified for the MIPS Promoting Interoperability performance category.

TABLE C-G 1 HTI-5 PROPOSED RULE PROPOSALS TO REMOVE AND REVISE ONC HEALTH IT CERTIFICATION CRITERIA THAT IMPACT THE CEHRT DEFINITION FOR THE MIPS PROMOTING INTEROPERABILITY PERFORMANCE CATEGORY

ONC Health IT Certification Criteria as Defined in the Following Sections of Title 45 CFR 170.315	Remove/Revise	Timing	Relevance to the CEHRT Definition for the MIPS Promoting Interoperability Performance Category
Patient Demographics and Observations - (a)(5)	Revise	Effective date of HTI-5 final rule.	Specified in Base EHR definition.
Implantable Device List - (a)(14)	Remove	Effective date of HTI-5 final rule.	Specified in Base EHR definition.
Decision Support Interventions - (b)(11)	Revise	Effective date of HTI-5 final rule.	Specified in Base EHR definition.
Direct Project - (h)(1)	Remove	Effective date of HTI-5 final rule.	Specified in Base EHR definition.
Direct Project, Edge Protocol, and XDR/XDM - (h)(2)	Remove	Effective date of HTI-5 final rule.	Specified in Base EHR definition.
Family Health History - (a)(12)	Remove	Effective January 1, 2027.	Specified in CEHRT definition.
Patient Health Information Capture - (e)(3)	Remove	Effective January 1, 2027.	Specified in CEHRT definition.
Automated Numerator Recording - (g)(1)	Remove	Effective January 1, 2027.	Specified in CEHRT definition.
Automated Measure Calculation – (g)(2)	Remove	Effective January 1, 2027.	Specified in CEHRT definition.

ONC Health IT Certification Criteria as Defined in the Following Sections of Title 45 CFR 170.315	Remove/Revise	Timing	Relevance to the CEHRT Definition for the MIPS Promoting Interoperability Performance Category
Clinical Quality Measures – Report – (c)(3)(i)	Revise	Effective January 1, 2027.	Specified in CEHRT definition.
Clinical Quality Measures – Report – (c)(3)(ii)	Remove	Effective January 1, 2027.	Specified in CEHRT definition.
Clinical Quality Measures – Filter – (c)(4)	Remove	Effective January 1, 2027	Specified in CEHRT definition
Transitions of Care - (b)(1)	Revise	Effective January 1, 2027.	Specified criterion for the Support Electronic Referral Loops by Sending Health Information, Support Electronic Referral Loops by Receiving and Reconciling Health Information, Health Information Exchange Bi-Directional Exchange, and Enabling Exchange Under TEFCA measures.
Clinical Information Reconciliation and Incorporation - (b)(2)	Remove	Effective January 1, 2027.	Specified criterion for the Support Electronic Referral Loops by Receiving and Reconciling Health Information measure.
View, Download, and Transmit to 3rd Party - (e)(1)	Revise	Effective date of HTI-5 final rule.	Specified criterion for the Provide Patients Electronic Access to Their Health Information measure.
Transmission to cancer registries – (f)(4)	Remove	Effective January 1, 2027	Specified criterion for the Public Health Registry Reporting measure.
Transmission to public health agencies – Electronic Case Reporting - (f)(5)	Revise	Effective date of HTI-5 final rule.	Specified criterion for the Electronic Case Reporting measure.
Transmission to public health agencies – Health Care Surveys - (f)(7)	Remove	Effective January 1, 2027.	Specified criterion for the Public Health Registry Reporting measure.
Application access — patient selection - (g)(7)	Remove	Effective January 1, 2027.	Specified criterion for the Provide Patients Electronic Access to Their Health Information and Health Information Exchange Bi-Directional Exchange measures.
Application Access – All Data Request - (g)(9)	Remove	Effective January 1, 2027.	Specified criterion for the Provide Patients Electronic Access to Their Health Information and Health Information Exchange Bi-Directional Exchange measures.

Proposed changes in the HTI-5 proposed rule would affect ONC health IT certification criteria included in the definition of CEHRT in 42 CFR 414.1305, which applies to the MIPS Promoting Interoperability performance category in several ways. First, several ONC proposals either revise or remove certain ONC Health IT Certification Program certification criteria included within the Base EHR definition at 45 CFR 170.102, which is incorporated into the definition of CEHRT at § 414.1305. Removal of these criteria from the ONC Health IT Certification Program and the Base EHR definition would therefore remove the requirement that a MIPS eligible clinician must use CEHRT that includes health IT certified to the removed criteria Specifically, ONC proposed to remove the following ONC health IT certification criteria from the Base EHR definition at:, 45 CFR 170.315(a)(14) – “implantable device list” (90 FR 60983), 45 CFR 170.315(h)(1) – “transport methods and other protocols—direct project” (90 FR

60998), and 45 CFR 170.315(h)(2) – "transport methods and other protocols—Direct Project, Edge Protocol, and XDR/XDM" (90 FR 60999). ONC also proposed to revise the following criteria referenced in the Base EHR definition: 45 CFR 170.315(b)(1) – "transitions of care" (90 FR 60984), 45 CFR 170.315(a)(5) – "patient demographics and observations" (90 FR 60981 through 60982) and 45 CFR 170.315(b)(11) – "decision support interventions" (90 FR 60986 through 60987).

Also, ONC proposed to remove the following five ONC health IT certification criteria specified in the text of the definition of CEHRT at § 414.1305. Specifically, ONC proposed to remove: 45 CFR 170.315(a)(12) – "family health history," 45 CFR 170.315(e)(3) – "patient health information capture," 45 CFR 170.315(g)(1) – "automated numerator recording," 45 CFR 170.315(g)(2) – "automated measure calculation," and 45 CFR 170.315(c)(4) – "clinical quality measures – filter" (90 FR 60982, 60991, 60994, 60995, and 60988, respectively). Also, ONC proposed to revise 45 CFR 170.315(c)(3) – "clinical quality measures – report" (90 FR 60988). Such ONC health IT certification criteria are discussed further in section IV.A.4.d.(4)(b)(ii) of this proposed rule.

In addition, ONC proposed to remove and/or revise other ONC health IT certification criteria that directly support certain MIPS Promoting Interoperability performance category measures. For example, ONC proposed to revise the "transitions of care" criterion in 45 CFR 170.315(b)(1), which supports the Support Electronic Referral Loops by Sending Health Information and Support Electronic Referral Loops by Receiving and Reconciling Health Information measures and remove the "clinical information reconciliation and incorporation" criterion in 45 CFR 170.315(b)(2), which supports the Support Electronic Referral Loops by Receiving and Reconciling Health Information measure (90 FR 60984). In addition, of the four ONC health IT certification criteria that are identified as supporting the Provide Patients Electronic Access to Their Health Information measure: 45 CFR 170.315(e)(1), 45 CFR 170.315(g)(7), 45 CFR 170.315(g)(9), and 45 CFR 170.315(g)(10), three are impacted by the

proposals in the HTI-5 proposed rule. ONC proposed to revise 45 CFR 170.315(e)(1) (90 FR 60990 through 60991) and remove 45 CFR 170.315(g)(7) and 45 CFR 170.315(g)(9) (90 FR 60998). MIPS eligible clinicians would only need to implement the remaining heath IT certification criteria identified for the Provide Patients Electronic Access to Their Health Information measure (the revised 45 CFR 170.315(e)(1) and unaltered 45 CFR 170.315(g)(10)), if ONC finalizes such proposals. Similarly, for the Support Electronic Referral Loops by Sending Health Information and Support Electronic Referral Loops by Receiving and Reconciling Health Information measures, MIPS eligible clinicians would only need to implement the remaining ONC health IT certification criteria if applicable ONC health IT certification criteria proposed for removal are finalized as proposed in the HTI-5 proposed rule. In section IV.A.4.d.(4)(g)(iv) of this proposed rule, Table C-G 8 contains a complete list of the MIPS Promoting Interoperability performance category measures, and the applicable ONC health IT certification criteria, including the impact to individual ONC health IT certification criteria if the proposals in the HTI-5 proposed rule are finalized.

Regarding the Public Health Registry Reporting measure, ONC has proposed to remove both ONC health IT certification criteria that support the measure: 45 CFR 170.315(f)(4) – "transmission to cancer registries" and 45 CFR 170.315(f)(7) – "transmission to public health agencies—health care surveys" (90 FR 60992 and 60994). If the proposed removal of the ONC health IT certification criteria is finalized as proposed in the HTI-5 proposed rule, there would be no specific ONC health IT certification criteria identified for this measure. Consistent with existing policy, a MIPS eligible clinician would still be able to use any available data exchange standard specified in 45 CFR part 170 subpart B to meet the measure. For example, the transmission could be in the form of a Consolidated Clinical Document Architecture (C-CDA) as adopted in 45 CFR 170.205(a)(4), or Quality Reporting Document Architecture (QRDA) as adopted in 45 CFR 170.205(h)(2).

Regarding the Electronic Case Reporting measure, ONC proposed to revise the following health IT criterion that supports the measure: at 45 CFR 170.315(f)(5) – "transmission to public health agencies—electronic case reporting" (90 FR 60992 through 60993). This proposal would update the ONC health IT certification criterion to focus on functional, rather than standards-based requirements. While ONC's proposal, if finalized, would revise the requirements for health IT products certified to this health IT criterion, MIPS eligible clinicians would continue to need to use health IT certified to this criterion to report the Electronic Case Reporting measure.

Also, we note that ONC proposed to remove certain ONC health IT certification criteria such as 45 CFR 170.315(g)(3) – "safety-enhanced design," 45 CFR 170.315(g)(4) – "quality management system," (90 FR 60995 through 60997), and a series of criteria related to privacy and security functionality in 45 CFR 170.315(d)(1) – (13) (90 FR 60989 and 60990), most of which are included in the Health IT Module certification requirements at 45 CFR 170.550. Such ONC health IT certification criteria represent capabilities commonly found in certified health IT products used by MIPS eligible clinicians. Furthermore, we note that the proposed removal of such health IT criteria from the ONC Health IT Certification Program would not affect a MIPS eligible clinician's obligation to ensure the privacy and safety of patient electronic health information under the Health Insurance Portability and Accountability Act of 1996 and other applicable laws. We refer readers to Table C-G 8 in section IV.A.4.d.(4)(g)(iv) of this proposed rule for a complete list of ONC health IT certification criteria that support each MIPS Promoting Interoperability performance category measure, including ONC health IT certification criteria ONC proposed to remove and/or revise. In most cases, the ONC health IT certification criteria that support measure reporting would remain part of the ONC Health IT Certification Program. For additional information regarding ONC's proposals in the HTI-5 proposed rule, we refer readers to the HTI-5 proposed rule (90 FR 60970).

(ii) Proposal to Modify the Definition of Certified Electronic Health Record Technology in the MIPS Promoting Interoperability Performance Category

Beginning with the CY 2019 performance period and subsequent performance periods, the definition of CEHRT for the MIPS Promoting Interoperability performance category in § 414.1305 requires the use of EHR technology certified under the ONC Health IT Certification Program that meets the 2015 Edition Base EHR definition or subsequent Base EHR definition (as defined at 45 CFR 170.102) and has been certified to specific ONC health IT certification criteria as adopted and updated in 45 CFR 170.315. In paragraph (2)(i) of the definition of CEHRT, the definition further specifies that EHR technology must be certified to criteria for "family health history" (45 CFR 170.315(a)(12)) and "patient health information capture" (45 CFR 170.315(e)(3)). In paragraph (2)(ii) of the definition of CEHRT, the definition specifies that EHR technology must be certified to ONC health IT certification criteria that are necessary to report on applicable objectives and measures specified for the MIPS Promoting Interoperability performance category. Paragraph (2)(ii)(A) of the definition of CEHRT includes the applicable measure calculation certification criteria at 45 CFR 170.315(g)(1) or (2) for all ONC health IT certification criteria that support an objective with a percentage-based measure. Paragraph (2)(ii)(B) includes clinical quality measure certification criteria that support the calculation and reporting of clinical quality measures at 45 CFR 170.315(c)(2) and (c)(3)(i) and (ii) and optionally (c)(4).

We are proposing to amend the definition of CEHRT (specified as "Certified electronic health record technology (CEHRT)") in § 414.1305, by modifying paragraphs (2)(i), (2)(ii)(A), and (2)(ii)(B) to align with the applicable ONC proposals to remove and revise certain ONC health IT certification criteria as proposed in the HTI-5 proposed rule. Specifically, we are proposing to remove references to the following ONC health IT certification criteria for the CY 2027 performance period/2029 MIPS payment year:

- "family health history" - 45 CFR 170.315(a)(12);
- "patient health information capture" - 45 CFR 170.315(e)(3);
- "automated numerator recording" - 45 CFR 170.315(g)(1);

- "automated measure calculation" – 45 CFR 170.315(g)(2); and
- "clinical quality measures - filter" – 45 CFR 170.315(c)(4).

If the ONC proposals to remove such ONC health IT certification criteria are finalized as proposed, the ONC health IT certification criteria at 45 CFR 170.315(a)(12), 45 CFR 170.315(e)(3), 45 CFR 170.315(g)(1), and 45 CFR 170.315(g)(2) would no longer be required and ONC health IT certification criteria at 45 CFR 170.315(c)(4) would no longer be included as an optional criterion to meet the definition of CEHRT, effective January 1, 2027. As part of this proposed modification to the definition of CEHRT, we would also specify a limited timeframe, from CY 2019 through CY 2026, for the following ONC health IT certification criteria to be included in the CEHRT definition; "family health history" (45 CFR 170.315(a)(12)), "patient health information capture" (45 CFR 170.315(e)(3)), "automated numerator recording" (45 CFR 170.315(g)(1)), "automated measure calculation" (45 CFR 170.315(g)(2), and "clinical quality measures" (45 CFR 170.315(c)(4)). Additionally, as part of the proposed modification to the definition of CEHRT, we would modify the reference to the "clinical quality measures -report" (45 CFR 170.315(c)(3)) ONC health IT certification criterion from "(c)(3)(i) and (ii)" to (c)(3), which would align with the proposed revisions in the HTI-5 proposed rule to modify (c)(3) to include the provision of (c)(3)(i), and remove subparagraphs (c)(3)(i) and (c)(3)(ii). Lastly, we are proposing to amend the definition of CEHRT in § 414.1305 by modifying paragraphs 2(i), (2)(i)(A), and (2)(i)(B).

While the proposal is consistent with the proposals in the HTI-5 proposed rule (90 FR 60970), we note that our proposal is not contingent upon the final actions that ONC will make regarding their proposals to remove and revise ONC health IT certification criteria as proposed in the HTI-5 proposed rule.

We believe that the longstanding presence of the ONC health IT certification criteria for "family health history" at 45 CFR 170.315(a)(12) and "patient health information capture" at 45 CFR 170.315(e)(3) in the ONC Health IT Certification Program (adopted in 2015 at 80 FR

62602 and 80 FR 62624 respectively) and their incorporation into the MIPS Promoting Interoperability performance category requirements means functionality reflected in such ONC health IT certification criteria is likely to be fully embedded in certified health IT and is widely available for use by MIPS eligible clinicians. Further, ONC anticipates that health IT developers will continue to retain such capabilities in their Health IT Modules despite the absence of ONC health IT certification criteria for such functionalities (90 FR 60982 and 60991). Such ONC health IT certification criteria are not identified as supporting any specific measures within the MIPS Promoting Interoperability performance category and as a result, we do not anticipate any modifications to the measure specifications due to the removal of these criteria from the definition.

If the ONC health IT certification criteria needed for measure calculation ("automated numerator recording" and "automated measure calculation" ONC health IT certification criteria in 45 CFR 170.315(g)(1) and 45 CFR 170.315(g)(2))is finalized for removal, then EHR technology used by MIPS eligible clinicians would not need to be certified to such two ONC health IT certification criteria in order to meet the requirement for MIPS eligible clinicians to use CEHRT; however, we anticipate that health IT developers seeking to support customers participating in the MIPS Promoting Interoperability performance category will continue to support the functionality of these criteria by reporting of numerators and denominators for certain MIPS Promoting Interoperability performance category measures, including the e-Prescribing measure and Provide Patients Electronic Access to Their Health Information measure. Removing the requirements for ONC health IT certification criteria at 45 CFR 170.315(g)(1) and 45 CFR 170.315(g)(2) from the definition of CEHRT in § 414.1305 would reduce administrative burden for health IT developers associated with testing and certifying to such functionality without impacting reporting requirements for the MIPS Promoting Interoperability performance category.

Additionally, for the optional ONC health IT certification criterion pertaining to "clinical quality measures - filter" in 45 CFR 170.315(c)(4), we do not believe that this criterion is a meaningful addition to the CEHRT definition for health care providers. The optional designation for this ONC health IT certification criterion has led to limited uptake while health care providers and health IT developers have indicated that this functionality is available in EHRs without relying on a regulatory requirement. Also, ONC has stated that it anticipates that health IT systems will continue to retain the clinical quality measure filtering functionality despite the absence of the ONC health IT certification criterion for such functionality (90 FR 60988).

In summary, we are proposing to amend the definition of CEHRT, specified as "Certified electronic health record technology (CEHRT)" in § 414.1305, by modifying paragraphs (2)(i), (2)(i)(A), and (2)(i)(B). Specifically--

- In paragraph (2)(i), we are proposing to remove for CY 2027 and subsequent years, the certification criteria for "family health history" (as adopted and updated at 45 CFR 170.315(a)(12)) and "patient health information capture" (as adopted and updated at 45 CFR 170.315(e)(3));
- In paragraph (2)(ii)(A), we are proposing to remove for CY 2027 and subsequent years, the ONC health IT certification criteria for "automated numerator recording" (as adopted and updated at 45 CFR 170.315(g)(1)) and "automated measure calculation" (as adopted and updated at 45 CFR 170.315(g)(2)); and
- In paragraph (2)(ii)(B), we are proposing to remove for CY 2027 and subsequent years, the ONC health IT certification criterion for "clinical quality measures - filter" (as adopted and updated at 45 CFR 170.315(c)(4)).

The revised text would read as follows:

"Certified electronic health record technology (CEHRT) […]

(2) For 2019 and subsequent years, EHR technology (which could include multiple technologies) certified under the ONC Health IT Certification Program that meets the 2015

Edition Base EHR definition, or subsequent Base EHR definition (as defined at 45 CFR 170.102) and has been certified to the ONC health IT certification criteria, as adopted and updated in 45 CFR 170.315-

(i) For CY 2019 through CY 2026, at 45 CFR 170.315(a)(12) (family health history) and 45 CFR 170.315(e)(3) (patient health information capture); and

(ii) Necessary to report on applicable objectives and measures specified for MIPS including the following:

(A) For CY 2019 through CY 2026, the applicable measure calculation certification criterion at 45 CFR 170.315(g)(1) or (2) for all certification criteria that support a meaningful use objective with a percentage-based measure.

(B) Clinical quality measure certification criteria that support the calculation and reporting of clinical quality measures at 45 CFR 170.315(c)(2) and (c)(3), and for CY 2019 through CY 2026, optionally (c)(4), and can be electronically accepted by CMS."

The proposed modifications would be effective January 1, 2027, which aligns with the effective date of ONC's proposal to remove such ONC health IT certification criteria from the Code of Federal Regulations as proposed in the HTI-5 proposed rule. If our proposed modifications are finalized, a MIPS eligible clinician's EHR technology would no longer be required to meet the ONC health IT certification criteria at 45 CFR 170.315(a)(12), (e)(3), (g)(1), or (g)(2), the ONC health IT certification criteria at 45 CFR 170.315(c)(4) would no longer be included as optional in paragraph (2)(ii)(B), and paragraph (2)(ii)(B) would reference the entirety of the certification criterion at 45 CFR 170.315(c)(3) in the definition of CEHRT at 42 CFR 414.1305. All other remaining ONC health IT certification criteria included in the definition of CEHRT would continue to be a requirement for a MIPS eligible clinician's EHR technology. We note that there is a similar proposal to remove certain ONC health IT certification criteria from the definition of CEHRT for the Medicare Promoting Interoperability Program for eligible hospitals and critical access hospitals (CAHs) in the "Medicare Program; Hospital Inpatient

Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes" (FY 2027 IPPS/LTCH PPS) proposed rule (91 FR 19620 through 19621).

We request public comment on this proposal.

(c) Proposal to Remove ONC Direct Review and ONC-Authorized Certification Bodies (ACB) Surveillance Attestations

(i) Background

In the CY 2017 Quality Payment Program final rule, we finalized policies to support MIPS eligible clinicians in ONC health IT surveillance and direct review activities through requiring two attestations, specifically, the ONC Direct Review attestation and the ONC-Authorized Certification Bodies (ACB) Surveillance attestation (81 FR 77019 through 77027). The purpose of ONC surveillance and direct review is to provide greater assurance that health IT meets certification requirements not only in a controlled testing environment, but also when used by health care providers in actual production environments (80 FR 62707). When such attestations were finalized as requirements for the MIPS Promoting Interoperability performance category (formerly the advancing care information performance category) in the CY 2017 Quality Payment Program final rule, we intended for the attestations to complement and strengthen recent updates to ONC's ability to perform surveillance and direct review activities.

Specifically, in October 2015, ONC finalized the 2015 Edition Health Information Technology (Health IT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications final rule, which added requirements for ONC–ACBs to conduct more frequent and more rigorous surveillance of certified technology and capabilities in the field (80 FR 62707). Additionally, in October 2016, ONC published the ONC Health IT Certification Program: Enhanced Oversight and Accountability final rule, which established regulatory processes to facilitate ONC's direct

review and evaluation of the performance of certified health IT in certain circumstances (81 FR 72406). In the CY 2017 Quality Payment Program final rule, we determined that surveillance and direct review activities provided greater assurance to health care providers that their certified EHR technology would perform in a manner that meets their expectations, but that such surveillance and direct review would not be effective unless health care providers cooperated with such activities, including by granting access to and assisting ONC-ACBs and ONC to observe the performance of production systems (81 FR 77020).

In § 414.1375(b)(3)(i)(A), we require an attestation that acknowledges the requirement to cooperate in good faith with ONC direct review of his or her health IT certified under the ONC Health IT Certification Program if a request to assist in ONC direct review is received. A MIPS eligible clinician must attest that he or she, if requested, cooperated in good faith with ONC direct review of his or her health IT certified under the ONC Health IT Certification Program as authorized by 45 CFR part 170, subpart E, to the extent that such technology meets (or can be used to meet) the definition of CEHRT, including by permitting timely access to such technology and demonstrating its capabilities as implemented and used by the MIPS eligible clinician in the field. Also, we specified at § 414.1375(b)(3)(i)(B) an optional attestation that acknowledges the option to cooperate in good faith with ONC-ACB surveillance of his or her health IT certified under the ONC Health IT Certification Program if a request to assist in ONC-ACB surveillance is received. A MIPS eligible clinician may attest that he or she, if requested, cooperated in good faith with ONC-ACB surveillance of his or her health IT certified under the ONC Health IT Certification Program as authorized by 45 CFR part 170, subpart E, to the extent that such technology meets (or can be used to meet) the definition of CEHRT, including by permitting timely access to such technology and demonstrating its capabilities as implemented and used by the MIPS eligible clinician in the field.

The ONC Direct Review attestation is a required element of the MIPS Promoting Interoperability performance category. Submitting a "Yes" response is the only means to fulfill

the requirement of the attestation. If a MIPS eligible clinician submits a "No" response or does not submit any attestation for the ONC Direct Review attestation, the MIPS eligible clinician will receive a score of zero for the MIPS Promoting Interoperability performance category. The ONC-ACB Surveillance attestation is optional. A MIPS eligible clinician can submit a "Yes" or "No" response or not submit any attestation for the ONC-ACB Surveillance attestation. No scenario for the ONC-ACB Surveillance attestation would impact a MIPS eligible clinician's score for the MIPS Promoting Interoperability performance category. Scoring implications for the proposal to remove the ONC Direct Review and ONC-ACB Surveillance attestations are discussed in section IV.A.4.d.(4)(g)(ii)(A) of this proposed rule.

(ii) Proposal to Remove the ONC Direct Review and ONC-ACB Surveillance Attestations Beginning with the CY 2026 Performance Period/2028 MIPS Payment Year

We are proposing to remove the required ONC Direct Review attestation and the optional ONC-ACB Surveillance attestation in § 414.1375(b)(3)(i)(A) and (B), respectively, beginning with the CY 2026 performance period/2028 MIPS payment year to reduce administrative burden. For the CY 2026 performance period, MIPS eligible clinicians would not be reporting on such attestations until the applicable submission period, which starts on January 1, 2027. Because these two attestations are reported during the applicable submission period, we have determined that it would be feasible for CMS to implement and operationalize these modifications to the MIPS Promoting Interoperability performance category requirements prior to the start of the submission period associated with the CY 2026 performance period. We continue to recognize the importance of ONC direct review and ONC-ACB surveillance activities and consider such mechanisms important for mitigating issues with health IT products that may pose serious risks to public health or safety, and we continue to collaborate with ONC to support the ONC Health IT Certification Program. As stated in the CY 2017 Quality Payment Program final rule (81 FR 77020), efforts to strengthen surveillance and direct review of certified health IT are critical to the success of HHS programs and initiatives that require the use of certified health IT to improve

health care quality and the efficient delivery of care. We do not anticipate that the commitment from ONC and the ONC-ACBs toward such goals will change.

While ONC-ACB surveillance and ONC direct review activities remain important to being a user of certified health IT, we no longer consider the administrative step of attesting to cooperating and/or participating in such activities to be necessary. Since 2016 (1 year prior to the enactment of MACRA, in which the MIPS Promoting Interoperability performance category replaced the Medicare EHR Incentive Program for eligible professionals), the ONC-ACB surveillance and ONC direct review activities and processes have become known to MIPS eligible clinicians and as a result, the value of participation has become evident without dependence on an ongoing need to conduct annual attestations. Therefore, the administrative burden associated with such attestations outweighs their value compared to when they were originally adopted.

The proposal to remove the ONC Direct Review attestation and ONC-ACB Surveillance attestation aligns with the goals of reducing administrative burden while simultaneously focusing on high-value, outcome-oriented measures. Specifically, the removal of such attestations from the MIPS Promoting Interoperability performance category requirements provides an opportunity to reduce the number of discrete manual steps and reporting fields required for successful adherence to reporting requirements without diminishing the integrity or central goals of the MIPS Promoting Interoperability performance category. Although we are proposing to remove such attestations, we strongly encourage MIPS eligible clinicians to continue participating in the surveillance and direct review processes when assistance is requested by ONC or an ONC-ACB. CMS will continue to support surveillance and direct review activities as appropriate.

We are proposing to amend § 414.1375(b)(3)(i) by modifying the requirements to include a specific allotted timeframe (CY 2017 performance period/2019 MIPS payment year through CY 2025 performance period/2027 MIPS payment year) for requiring the reporting of

attestations pertaining to the ONC Direct Review attestation and ONC-ACB Surveillance attestation. Specifically, we are proposing to amend § 414.1375(b)(3)(i) as follows: "Supporting providers with the performance of CEHRT (SPPC). To engage in activities related to supporting providers with the performance of CEHRT beginning with the 2019 MIPS payment year through the 2027 MIPS payment year, the MIPS eligible clinician—…" We are proposing to remove the required ONC Direct Review attestation and the optional ONC-ACB Surveillance attestation beginning with the CY 2026 performance period/2028 MIPS payment year to reduce burden. If the proposal to remove the ONC Direct Review attestation and ONC-ACB Surveillance attestation is finalized as proposed, for the CY 2026 performance period/2028 MIPS payment year, MIPS eligible clinicians would not, in the case of the ONC Direct Review attestation, be required to report on such attestation, and in the case of the ONC-ACB Surveillance attestation, have the option of reporting on such attestation during the applicable submission period (January 1, 2027 through March 1, 2027). The proposed removal of such attestations would not affect a MIPS eligible clinician's score for the MIPS Promoting Interoperability performance category for the CY 2026 performance period/2028 MIPS payment year, respectively. We note that the proposals to remove the ONC Direct Review attestation and optional ONC-ACB Surveillance attestation align with the same proposals for the Medicare Promoting Interoperability Program as proposed in the FY 2027 IPPS/LTCH PPS proposed rule (91 FR 19621).

We refer readers to Tables C-G 2, C-G 3, and C-G 6 in sections IV.A.4.d.(4)(g)(i) and IV.A.4.d.(4)(g)(ii)(D) of this proposed rule for information regarding the reporting requirements and scoring methodology of the MIPS Promoting Interoperability performance category for the CY 2026 performance period/2028 MIPS payment year, if the proposal to remove the ONC Direct Review attestation and ONC-ACB Surveillance attestation is finalized as proposed. We note that if the proposal is finalized as proposed, the CY 2025 performance period/2027 MIPS payment year would be the last performance period/MIPS payment year in which the ONC

Direct Review attestation and ONC-ACB Surveillance attestation would be included under the MIPS Promoting Interoperability performance category.

We request public comment on these proposals.

(d) Proposal to Remove Security Risk Analysis Measure

(i) Background

The HIPAA Security Rule [378] (45 CFR part 160 and subparts A and C of part 164) contains, among other things, the administrative safeguards that covered entities and business associates (45 CFR 164.308) must implement, such as the standard and implementation specifications for security management processes. Among such safeguards are implementation specifications that require covered entities and business associates to conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information (ePHI) held by the covered entity or business associate (45 CFR 164.308(a)(1)(ii)(A)). Safeguards also include implementing security measures sufficient to reduce risks and vulnerabilities to a reasonable and appropriate level to comply with the general requirements of the HIPAA Security Rule at 45 CFR 164.306(a).

Ensuring the privacy and security of ePHI is essential for demonstrating meaningful use of CEHRT (90 FR 49871). Since 2010, we adopted and maintained the Security Risk Analysis measure based on the HIPAA Security Rule risk analysis requirement in 45 CFR 164.308(a)(1)(ii)(A) for the Medicare EHR Incentive Program for Eligible Professionals,[379] the predecessor to the MIPS Promoting Interoperability performance category.[380] In the CY 2017 Quality Payment Program final rule (81 FR 77219 through 77220), we adopted the Protect

---

[378] On January 6, 2025, the U.S. Department of Health and Human Services published the HIPAA Security Rule to Strengthen the Cybersecurity of Electronic Protected Health Information proposed rule (90 FR 898). The proposed rule has not been finalized as of the publication of this proposed rule.

[379] Medicare and Medicaid Programs: Electronic Health Record Incentive Program final rule (75 FR 44368 and 44369); established at 42 CFR 495.6(d)(15)(ii).

[380] Section 101(b) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) sunset the Medicare EHR Incentive Program for Eligible Professionals, set forth at section 1848(o) of the Act. As discussed previously, section 1848(o)(2) of the Act has been incorporated into the MIPS Promoting Interoperability performance category's requirements via section 1848(q)(2)(B)(iv) of the Act. *See* CY 2017 Quality Payment Program final rule (81 FR 77018 and 77019) for more information regarding the sunsetting of the Medicare EHR Incentive Program for Eligible Professionals.

Patient Health Information objective for the MIPS Promoting Interoperability performance category and included the Security Risk Analysis measure within this objective. We subsequently modified this measure in the CY 2019 PFS final rule (83 FR 59790) and the CY 2026 PFS final rule (90 FR 49871 through 49874).

As described in the CY 2026 PFS final rule, the MIPS Promoting Interoperability Security Risk Analysis measure requires MIPS eligible clinicians to attest "Yes" to having conducted security risk management and attest "Yes" to having conducted or reviewed a security risk analysis as required by the HIPAA Security Rule (90 FR 49870 through 49874). The scoring implications associated with the proposal to remove the Security Risk Analysis measure are discussed in section IV.A.4.d.(4)(g)(ii)(B) of this proposed rule.

(ii) Proposal to Remove the Security Risk Analysis Measure Beginning with the CY 2027 Performance Period/2029 MIPS Payment Year

We are proposing to remove the Security Risk Analysis measure beginning with the CY 2027 performance period/2029 MIPS payment year to reduce reporting burden. The HIPAA Security Rule (45 CFR part 160 and subparts A and C of part 164) contains, among other requirements, the administrative safeguards that covered entities and business associates (45 CFR 164.308) must implement, such as the standard and implementation specifications for security risk analysis and risk management processes. The administrative safeguards also require implementation of security measures sufficient to reduce risks and vulnerabilities to a reasonable and appropriate level to comply with the general requirements of the HIPAA Security Rule at 45 CFR 164.306.

Given that MIPS eligible clinicians are covered entities under the HIPAA Security Rule and the requirements of the Security Risk Analysis measure derive from the HIPAA Security Rule requirements, removal of the Security Risk Analysis measure will not weaken any cybersecurity requirements for MIPS eligible clinicians. When the Security Risk Analysis measure was adopted in the CY 2017 Quality Payment Program final rule, we determined that

requiring an attestation regarding HIPAA Security Rule requirements promoted awareness of these requirements among MIPS eligible clinicians (81 FR 77219 through 77220).

However, we have considered the ongoing applicability of the measure given its longstanding presence in the MIPS Promoting Interoperability performance category and the established awareness of HIPAA Security Rule requirements among MIPS eligible clinicians. In assessing whether it remains appropriate to maintain the Security Risk Analysis measure from the MIPS Promoting Interoperability performance category, we considered the extent to which the measure continues to advance its goals relative to the costs associated with its continued use. We believe these costs include not only the burden associated with reporting the requisite attestations, but also the costs associated with administering and maintaining the measure within the program. These costs may include but are not limited to the following: clinician burden associated with information collection and submission; clinician burden associated with complying with overlapping programmatic and regulatory requirements, including the HIPAA Security Rule; and CMS resources associated with oversight, maintenance, education, and operational support for the measure. In the case of the Security Risk Analysis measure, because the underlying security risk analysis and risk management activities are already required under the HIPAA Security Rule, we believe it may be unnecessarily costly and of limited incremental benefit to retain this measure where its continued inclusion no longer meaningfully advances the objectives of the MIPS Promoting Interoperability performance category beyond the separate regulatory requirements that already apply. For these reasons, we believe removal of the Security Risk Analysis measure at this time would balance the goals of reducing unnecessary administrative burden, maintaining a parsimonious and meaningful measure set, and preserving the focus of the MIPS Promoting Interoperability performance category on high-value measures that more directly support program objectives.

This proposal aligns with our goals of reducing administrative burden while simultaneously focusing on high-value, outcome-oriented measures. Specifically, the removal of

the Security Risk Analysis measure from the MIPS Promoting Interoperability performance category provides an opportunity to reduce the number of discrete manual steps and reporting fields required for successful adherence to reporting requirements without diminishing the integrity or central goals of the MIPS Promoting Interoperability performance category. Although we are proposing to remove the Security Risk Analysis measure, we remind MIPS eligible clinicians to continue to conduct security risk analysis and security risk management to safeguard ePHI as required under the HIPAA Security Rule. We anticipate that MIPS eligible clinicians will continue to conduct security risk analysis and security risk management activities to comply with the requirements pertaining to the security of data created and maintained by CEHRT in accordance with the HIPAA Security Rule.

Retirement of the Security Risk Analysis measure from the MIPS Promoting Interoperability performance category beginning with the CY 2027 performance period/2029 MIPS payment year would reduce burden by removing the attestation requirement and supporting a more parsimonious and outcomes-oriented measure set. Specifically, we propose in § 414.1375(b)(2)(ii)(A) to specify a limited timeframe, through the 2028 MIPS payment year for which a MIPS eligible clinician would be required to report that they completed the actions included in the Security Risk Analysis measure during the year in which the performance period occurs.

We refer readers to Tables C-G 2, C-G 4, C-G 6 and C-G 8 in sections IV.A.4.d.(4)(g)(i), IV.A.4.d.(4)(g)(ii)(D), and IV.A.4.d.(4)(g)(iv) of this proposed rule for more information regarding the reporting requirements and scoring methodology of the MIPS Promoting Interoperability performance category starting with the CY 2027 performance period/2029 MIPS payment year, which is contingent upon the finalization of the proposal to remove the Security Risk Analysis measure.

We request public comment on this proposal.

(e) Proposal to Adopt a New Electronic Prior Authorization for Prescription Drugs Measure Beginning with the CY 2028 Performance Period/2030 MIPS Payment Year

(i) Background

Under section 1848(o)(2)(A) of the Act, the MIPS Promoting Interoperability performance category assesses whether MIPS eligible clinicians use CEHRT in a meaningful manner. By statute, such demonstration includes the use of electronic prescribing as determined to be appropriate by the Secretary. The MIPS Promoting Interoperability performance category has therefore included measures related to electronic prescribing since its inception (75 FR 44337; and 81 FR 77229 through 77237). Separately from the MIPS Promoting Interoperability performance category, we have also advanced the adoption of electronic prescribing through authority under section 1860D-4(e) of the Act, which requires that prescriptions for covered Medicare Part D drugs transmitted electronically comply with a uniform transaction standard specified by CMS. Under the same authority under section 1860D-4(e) of the Act, we also generally require that Schedule II, III, IV, and V controlled substances under Medicare Part D and Medicare Advantage prescription drug plans be prescribed electronically in accordance with an electronic prescription drug program. That required standard includes transactions for the electronic prior authorization of Part D-covered drugs prescribed to Part D-eligible individuals (85 FR 86827 through 86832 and 89 FR 51242 through 51247).

Historically, the ONC Health IT Certification Program and the Part D Program have maintained complementary policies of aligning ONC health IT certification criteria and associated standards related to electronic prescribing, medication history, and electronic prior authorization for prescriptions (89 FR 51257). In successive rules supporting the ONC Health IT Certification Program, ONC has adopted the National Council for Prescription Drugs Program (NCPDP) SCRIPT standard as the required exchange standard for the electronic prescribing certification criterion at 45 CFR 170.315(b)(3). In the “Medicare Program; Medicare Prescription Drug Benefit Program; Health Information Technology Standards and Implementation Specifications”

final rule (89 FR 51242 through 51247), the Part D Program finalized at § 423.160(b)(1) the requirement that Part D sponsors, prescribers and dispensers, when electronically transmitting prescriptions and prescription-related information for covered Part D drugs for Part D eligible individuals, must comply with the standard in 45 CFR 170.205(b). Taken in conjunction with the standards and expiration date adopted by ONC in the same rule (89 FR 51258 through 51259), § 423.160(b)(1) will require Part D sponsors, prescribers and dispensers to use NCPDP SCRIPT standard version 2023011, which ONC adopted at 45 CFR 170.205(b)(2), beginning January 1, 2028, and expire NCPDP SCRIPT standard version 2017071, which ONC previously adopted at 45 CFR 170.205(b)(1) as of January 1, 2028. The NCPDP SCRIPT standard version 2023011 includes enhancements to support electronic prescribing and transmission of prescription-related and electronic prior authorization information.

On April 14, 2026, the "Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability Standards and Prior Authorization for Drugs for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, and Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges" (2026 CMS Interoperability Standards and Prior Authorization for Drugs) proposed rule was published and introduced proposals that require Medicare Advantage organizations, state Medicaid and CHIP FFS programs, Medicaid managed care plans, CHIP managed care entities, and Qualified Health Plans offered on the Federally-facilitated Exchanges (collectively "impacted payers") to support certain exchange standards for the electronic prior authorization of prescription drugs (91 FR 19890). We proposed that, beginning on October 1, 2027, impacted payers be required to support electronic prior authorization for all drugs that require prior authorization. Two separate sets of standards were proposed for payers to facilitate electronic prior authorization for drugs: three NCPDP standards (NCPDP SCRIPT Standard©, NCPDP Formulary and Benefit (F&B) Standard©, and NCPDP Real-Time Prescription Benefit (RTPB) Standard©) for prescription

drugs covered under a pharmacy benefit; and six Fast Healthcare Interoperability Resources® (FHIR®) standards including the HL7 FHIR Da Vinci—Coverage Requirements Discovery (CRD) Implementation Guide (IG), the HL7 FHIR Da Vinci—Documentation Templates and Rules (DTR) IG, the HL7 FHIR Da Vinci—Prior Authorization Support (PAS) IG) for prescription drugs covered under a medical benefit.

Concurrent with other CMS efforts to promote standards adoption in electronic prior authorization, the MIPS Promoting Interoperability performance category has placed increasing emphasis on prior authorization through its adoption of the Electronic Prior Authorization measure (89 FR 8909) as established in the "Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program" (2024 CMS Interoperability and Prior Authorization) final rule. The Electronic Prior Authorization measure assesses MIPS eligible clinicians on the use of a Prior Authorization application programming interface (API) to request prior authorization for medical items and services. However, the measure does not assess the use of electronic prior authorization for prescription drugs, in part because the Prior Authorization API requirements finalized in the 2024 CMS Interoperability and Prior Authorization final rule excluded prescription drugs (89 FR 8918).

(ii) Proposal to Adopt Electronic Prior Authorization for Prescription Drugs Measure

Across the healthcare industry, a majority of prior authorizations for prescription drugs covered under a pharmacy benefit remain a separate manual process outside of the EHR workflow, not connected to e-prescribing, and could cause major points of friction and delay in

the prescribing and prior authorization workflow. In 2023, approximately 38 percent of prescription drug prior authorizations were fully electronic and 15 percent were fully manual, indicating continuing capacity for improvement in the domain.[381] This current level of adoption of electronic prior authorization for prescription drugs contributes to a reliance on payer portals and manual processes, including processes based on phone, or fax, which are entirely outside the EHR and that may delay patients' access to needed medications, increase administrative complexity for clinicians and staff, and undermine the efficiency and clinical value of electronic prescribing. As more payers support standardized electronic prior authorization, we have determined that measuring the use of prior authorization for prescription drugs would be a valuable addition to our assessment of meaningful use of CEHRT under the MIPS Promoting Interoperability performance category. Standards-based electronic prior authorization should improve timeliness and transparency of medication access by facilitating document-gathering and tracking of prior authorization status within clinician EHR workflows to support care coordination and help close the prescriber-to-dispenser loop. Thus, we believe that incorporating electronic prior authorization for prescription drugs is an appropriate aspect of demonstrating meaningful use of CEHRT by MIPS eligible clinicians.

Action in this area is further supported by longstanding efforts to promote standards adoption for prescription-related transactions under the Part D Program and the ONC Health IT Certification Program. As previously noted, CMS and ONC have maintained complementary policies aligning electronic prescribing and prescription-related standards at 42 CFR 423.160(b)(1) for Part D transactions and 45 CFR 170.315(b)(3) for the ONC Health IT Certification Program. Health IT developers also have experience with the underlying transaction standards because of their use in Part D transactions. Therefore, we believe that MIPS eligible clinicians and their health IT vendors have a foundation to implement the functionality for a new

[381] For more information, see: https://www.caqh.org/hubfs/Issue%20Briefs/CAQH_Insights_NCPDP_SCRIPT_Issue_Brief.pdf.

measure we are proposing in this proposed rule, the Electronic Prior Authorization for Prescription Drugs measure.

We are proposing to adopt a new measure, Electronic Prior Authorization for Prescription Drugs, for the MIPS Promoting Interoperability performance category beginning with the CY 2028 performance period/2030 MIPS payment year. We intend for the new Electronic Prior Authorization for Prescription Drugs measure to be included in the Health Information Exchange objective for the MIPS Promoting Interoperability performance category to emphasize the role of prior authorization in promoting care coordination and collocate the new measure in the same objective as the previously adopted Electronic Prior Authorization measure. The new Electronic Prior Authorization for Prescription Drugs measure aims to assess a MIPS eligible clinician's utilization of standards-based electronic prior authorization. We are proposing the specifications of the Electronic Prior Authorization for Prescription Drugs measure to be as follows:

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

- *Reporting Requirements:* "Yes"/"No" response.

- *Exclusion:* Any MIPS eligible clinician who—

++ Does not prescribe drugs that require prior authorization during the applicable performance period;

++ Only prescribes drugs requiring prior authorization where the payer does not support the specified electronic prior authorization standard during the applicable performance period; or

++ Prescribes fewer than 100 permissible prescription drugs during the performance period.

We note that the last exclusion matches an exclusion in the Electronic Prescribing measure. For this exclusion, "permissible prescriptions" means all drugs that meet the current definition of a prescription as ordered by a MIPS eligible clinician to dispense a drug that would

not be dispensed without such order. "Permissible prescriptions" may include electronic prescriptions of controlled substances where creation of an electronic prescription for the medication is feasible using CEHRT and where allowable by state and local law. Additionally, for purposes of this exclusion, permissible prescriptions include any prescription, not only those requiring prior authorization. To successfully report this measure, MIPS eligible clinicians must submit a "Yes" response, in which they are affirmatively attesting to having requested prior authorization electronically using CEHRT for at least one prescription drug ordered by the MIPS eligible clinician during the performance period or (if applicable) claim an exclusion. We expect that once a MIPS eligible clinician has the capability of requesting prior authorization electronically, that MIPS eligible clinician would do so more frequently, though we are not proposing to measure frequency of use at this time with this initial version of the measure. The new measure would apply to prescription drugs covered under a pharmacy benefit, as functionally defined by whether prior authorization can be requested for the drug can be authorized using the NCPDP SCRIPT standard.

The proposal to use CEHRT for this measure would require use of health IT certified to the ONC health IT certification criteria at 45 CFR 170.315(b)(3) – "Electronic prescribing" and at 45 CFR 170.315(b)(4) – "Real-time prescription benefit" to support any electronic prior authorization requests used to satisfy this measure. Use of both "electronic prescribing" and "real-time prescription benefit" certification criteria ensures that MIPS eligible clinicians use standards-based capabilities within their health IT systems to successfully complete the measure. Beginning January 1, 2028, the specified standards within the certification criteria in 45 CFR 170.315(b)(3) and 45 CFR 170.315(b)(4) would be the same versions of the NCPDP SCRIPT Standard and NCPDP RTPB Standard, respectively, required for Medicare Part D sponsors and proposed to be required for other impacted payers in the 2026 CMS Interoperability Standards and Prior Authorization for Drugs proposed rule (91 FR 19925 through 19927). For purposes of the proposed new Electronic Prior Authorization for Prescription Drugs measure, "requested

electronically" means initiating and submitting an electronic prior authorization request from within CEHRT using health IT certified under 45 CFR 170.315(b)(3) and 45 CFR 170.315(b)(4). Using health IT certified to the "real-time prescription benefit" criterion in 45 CFR 170.315(b)(4) allows a MIPS eligible clinician to ascertain the patient-specific out-of-pocket cost of a prescription drug, the cost of suitable alternatives, compare prescription costs at different pharmacies, and learn whether prior authorization for a specific prescription drug is required.

The 2026 CMS Interoperability Standards and Prior Authorization for Drugs proposed rule also proposed that impacted payers support the NCPDP F&B standard (91 FR 19926). We are not including this standard as part of required CEHRT for this measure at this juncture. However, we believe that the NCPDP F&B standard complements the NCPDP SCRIPT and RTPB standards certification criteria for Health IT Modules in 45 CFR 170.315(b)(3) and 45 CFR 170.315(b)(4), respectively, and we encourage MIPS eligible clinicians to use the F&B standard functions within their EHRs as part of an electronic prior authorization workflow as well.

We note that adoption of the new Electronic Prior Authorization for Prescription Drugs measure is not contingent upon the finalization of the proposals in the 2026 CMS Interoperability Standards and Prior Authorization for Drugs proposed rule. We note the proposed new Electronic Prior Authorization for Prescription Drugs measure includes an exclusion for cases in which no applicable payer supports the specified electronic prior authorization standard.

Electronic prior authorization requests for prescription drugs covered under a pharmacy benefit, which would leverage the NCPDP SCRIPT Standard and NCPDP RTPB Standard, are often for those prescription drugs dispensed at a retail pharmacy. We recognize that other prescription drugs may be covered under a medical benefit and are usually administered or dispensed by a medical provider in a health care setting. Those drugs covered under a medical benefit generally use FHIR-based electronic prior authorization processes, such as those supported by the Da Vinci CRD, DTR, and PAS implementation guides finalized under ONC

health IT certification criteria, and therefore are not in scope for the proposed new Electronic Prior Authorization for Prescription Drugs measure. A MIPS eligible clinician that only needs prior authorization for prescription drugs covered under a medical benefit and not a pharmacy benefit would be eligible to claim an exclusion for not ordering an applicable prescription drug during the performance period.

For purposes of the new Electronic Prior Authorization for Prescription Drugs measure, "one prescription drug ordered by the MIPS eligible clinician" includes a new prescription and, where applicable, a prescription renewal or refill request that generates a prior authorization requirement at the time of prescribing. A prescription drug "for which prior authorization is required" is one for which the applicable payer rules indicate a prior authorization requirement at the point of prescribing for the patient and plan. We believe the NCPDP F&B Standard would help inform MIPS eligible clinicians when a prior authorization is required or not, even if not a mandate of the Electronic Prior Authorization for Prescription Drugs measure. We recognize that coverage for certain prescription drugs may fall under either the pharmacy or medical benefit and we will continue to consider future policies to reduce workflow fragmentation across prior authorization approaches. In section IV.A.4.d.(4)(f)(vii) of this proposed rule, we request public comment on the potential to expand the scope of the Electronic Prior Authorization to include prescription drugs covered under a medical benefit.

We are proposing that the Electronic Prior Authorization for Prescription Drugs measure would require an attestation of "Yes" or "No" response from a MIPS eligible clinician. Starting with the CY 2028 performance period/2030 MIPS payment year and subsequent years for MIPS eligible clinicians, a MIPS eligible clinician would be required to submit a "Yes" response for the measure or claim an applicable exclusion in order to earn a score for the MIPS Promoting Interoperability performance category. If a MIPS eligible clinician submits a "No" response, fails to submit any attestation, or does not claim an applicable exclusion for the Electronic Prior Authorization for Prescription Drugs measure, the MIPS eligible clinician would receive a score

of zero for the MIPS Promoting Interoperability performance category (weighted at 25 percent of the MIPS final score), and would not be considered a meaningful EHR user for purposes of the MIPS Promoting Interoperability performance category for an applicable performance period. We refer readers to Tables C-G 2, C-G 5, C-G 6, and C-G 8 in sections IV.A.4.d.(4)(g)(i), IV.A.4.d.(4)(g)(ii)(D), and IV.A.4.d.(4)(g)(iv) of this proposed rule for information regarding the reporting requirements and scoring methodology of the MIPS Promoting Interoperability performance category, which is contingent upon the finalization of the proposal to adopt the new Electronic Prior Authorization for Prescription Drugs measure.

We propose that this measure would initially require an attestation of a "Yes" or "No" response to allow MIPS eligible clinicians to gain familiarity with electronic prior authorization for prescription drugs and measure reporting. We anticipate a future conversion of the Electronic Prior Authorization for Prescription Drugs measure to numerator/denominator reporting once standardized data capture and reporting have further progressed. We would monitor the measure's feasibility and consider updates, including volume-based thresholds or rate-based scoring, to ensure the measure reflects meaningful use at scale.

We request public comment on these proposals.

(f) Proposal to Modify the Electronic Prior Authorization Measure

(i) Background

In the 2024 CMS Interoperability and Prior Authorization final rule (89 FR 8909 through 8927), we adopted the Electronic Prior Authorization measure under the Health Information Exchange objective in the MIPS Promoting Interoperability performance category. We finalized that MIPS eligible clinicians would be required to attest to the Electronic Prior Authorization measure beginning with the CY 2027 performance period/2029 MIPS payment year (89 FR 8910); and subsequently, once the measure would become effective as a required measure in the MIPS Promoting Interoperability performance category, MIPS eligible clinicians would be required to satisfactorily report on the measure (and meet the other reporting requirements) in

order to earn a score for the MIPS Promoting Interoperability performance category. For purposes of the Electronic Prior Authorization measure, a prior authorization request would need to be made using a Prior Authorization API using data from CEHRT to submit a "Yes" response for the measure, unless a MIPS eligible clinician claims an applicable exclusion. We finalized the following measure description for the Electronic Prior Authorization measure (89 FR 8916):

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

Exclusions: Any MIPS eligible clinician who:

(1) Does not order any medical items or services (excluding drugs) requiring prior authorization during the applicable performance period; or

(2) Only orders medical items or services (excluding drugs) requiring prior authorization from a payer that does not offer an API that meets CMS's Prior Authorization API requirements during the applicable performance period.

In addition to becoming a required measure beginning with the CY 2027 performance period/2029 MIPS payment year, we finalized that the Electronic Prior Authorization measure would not be scored (that is, not assigned points for successful completion) for the CY 2027 performance period/2029 MIPS payment year. For the MIPS Promoting Interoperability performance category, satisfactory performance on the Electronic Prior Authorization measure can be demonstrated only by submitting a "Yes" response to affirmatively attest to the measure or by claiming an applicable exclusion. MIPS eligible clinicians who submit a "No" response, fail to submit any attestation response, or do not claim an applicable exclusion for the Electronic Prior Authorization measure will receive a score of zero for the MIPS Promoting Interoperability performance category (weighted at 25 percent of the MIPS final score), and will not be considered a meaningful EHR user for purposes of the MIPS Promoting Interoperability performance category for the applicable performance period (89 FR 8911).

The 2024 CMS Interoperability and Prior Authorization final rule also finalized that Medicare Advantage plans, state Medicaid Fee-for-service (FFS) programs, state Children's Health Insurance Program (CHIP) FFS programs, Medicaid managed care plans, CHIP managed care entities, and Qualified Health Plans (QHP) issuers on the Federally-Facilitated Exchange (collectively referred to as "impacted payers") must implement and maintain a Prior Authorization API beginning in CY 2027. The compliance date is January 1, 2027, for MA organizations and state Medicaid and CHIP FFS programs; by the first rating period beginning on or after January 1, 2027 for Medicaid managed care plans and CHIP managed care entities; and for plan years beginning on or after January 1, 2027, for individual market QHP issuers on the FFEs (89 FR 8759 through 8760). In that rule, we recommended, rather than required, specific FHIR Implementation Guides (IGs) to support the APIs (89 FR 8937).

In the Health Data, Technology, and Interoperability: Electronic Prescribing, Real-Time Prescription Benefit and Electronic Prior Authorization final rule (HTI-4 final rule), which was published as part of the FY 2026 IPPS/LTCH PPS final rule (90 FR 37164 through 37182), ONC finalized three ONC health IT certification criteria for electronic prior authorization:

- "Provider prior authorization API—coverage requirements discovery" in 45 CFR 170.315(g)(31);
- "Provider prior authorization API—documentation templates and rules" in 45 CFR 170.315(g)(32); and
- "Provider prior authorization API—prior authorization support" in 45 CFR 170.315(g)(33).

These certification criteria are based on three IGs developed by the HL7 Da Vinci project which ONC adopted in the HTI-4 final rule[382] at 45 CFR 170.215(j)(1), (2), and (3)--

- HL7® FHIR® Da Vinci—Coverage Requirements Discovery (CRD) IG;

[382] In the 2026 CMS Interoperability Standards and Prior Authorization for Drugs proposed rule, ONC has proposed updated versions of such Implementation Guides (91 FR 19910 and 19911).

- HL7 FHIR Da Vinci—Documentation Templates and Rules (DTR) IG; and
- HL7 FHIR Da Vinci—Prior Authorization Support (PAS) IG.

Together, these ONC health IT certification criteria can enable electronic prior authorization for healthcare providers. We refer readers to the HTI-4 final rule (90 FR 37162 through 37175) for more information regarding ONC's finalized certification criteria at 45 CFR 170.315(g)(31) through (33) and section XI.B.4.b. of the HTI-4 final rule (90 FR 36541 through 36542) for a summary of all ONC finalized policies.

In the 2026 CMS Interoperability Standards and Prior Authorization for Drugs proposed rule, we proposed to require impacted payers to implement and maintain Prior Authorization APIs that conform to the CRD, DTR, and PAS IGs adopted by ONC on behalf of the Secretary at 45 CFR 170.215(j)(1), (2), and (3). We proposed compliance dates for impacted payers to conform to the proposed standards and IGs beginning October 1, 2027 (however, impacted payers must still implement Prior Authorization APIs beginning in CY 2027). Finally, in section II.J.6 of the 2026 CMS Interoperability Standards and Prior Authorization for Drugs proposed rule (91 FR 20002), ONC proposed to adopt updated versions of the CRD, DTR, and PAS IGs. If finalized, these proposed updated versions will enable payers and health IT developers to implement Prior Authorization APIs and Health IT Modules conforming to the finalized ONC health IT certification criteria at 45 CFR 170.315(g)(31), (32), and (33) to utilize the latest versions of these specifications.

The 2026 CMS Interoperability Standards and Prior Authorization for Drugs proposed rule includes proposals for impacted payers to implement and maintain Prior Authorization APIs using the CRD, DTR, and PAS IGs. Those proposals, along with the provisions ONC finalized in the HTI-4 final rule to adopt the CRD, DTR, and PAS IGs and establish electronic prior authorization certification criteria for health IT developers, collectively support the Electronic Prior Authorization measure for MIPS eligible clinicians and advance interoperability by applying consistent standards across HHS programs. We refer readers to the 2026 CMS

Interoperability Standards and Prior Authorization for Drugs proposed rule and the HTI-4 final rule (90 FR 37169) for more information regarding the three ONC health IT certification criteria to support electronic prior authorization at 45 CFR 170.315(g)(31), (32), and (33).

(ii) Proposal to Modify the Electronic Prior Authorization Measure for the CY 2027 Performance Period/2029 MIPS Payment Year

We are proposing to amend the Electronic Prior Authorization measure for the CY 2027 performance period/2029 MIPS payment year by modifying the measure description.

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

For the proposed modification to the measure description, we are amending the phrase from "using data from CEHRT" to "using CEHRT" to clarify that MIPS eligible clinicians must use certified Health IT modules where necessary to support the electronic prior authorization processes specified in this measure. When we adopted the Electronic Prior Authorization measure, we did not identify specific ONC health IT certification criteria required to complete the actions specified in the measure (89 FR 8910 through 8915). We stated that gathering structured data from CEHRT would be achievable without additional certification criteria (89 FR 8925) that had not been proposed or finalized at the time of the 2024 CMS Interoperability and Prior Authorization final rule. The proposed update to the measure description to require that a prior authorization be requested electronically "using CEHRT" is consistent with the availability of certified Health IT Modules that must be used to complete the action specified in the Electronic Prior Authorization measure. At this juncture, we are not proposing to modify the exclusion criteria that were finalized when we adopted the Electronic Prior Authorization measure (89 FR 8916). The proposal to amend the Electronic Prior Authorization measure by modifying the measure description for the CY 2027 performance period/2029 MIPS payment

year aligns with the same proposal for the Medicare Promoting Interoperability Program as proposed in the FY 2027 IPPS/LTCH PPS proposed rule (91 FR 19621).

We request public comment on this proposal.

(iii) Proposal to Modify the Electronic Prior Authorization Measure Beginning with the CY 2028 Performance Period/2030 MIPS Payment Year

We are proposing to amend the Electronic Prior Authorization measure description beginning with the CY 2028 performance period/2030 MIPS payment year to include a complete set of actions necessary to support robust prior authorization and require use of Health IT modules certified to the ONC health IT certification criteria at 45 CFR 170.315(g)(31),[383] (32),[384] and (33)[385] as part of the measure requirements. We are proposing to update the measure in order to take a step-wise approach to the certified health IT capabilities necessary to complete the measure and ensure that MIPS eligible clinicians continue to progress towards adoption of capabilities necessary to fully support electronic prior authorization.

Specifically, we are proposing to modify the measure description as follows beginning with the CY 2028 performance period/2030 MIPS payment year: For at least one medical item or service (excluding drugs) ordered by the MIPS eligible clinician during the performance period, the MIPS eligible clinician uses CEHRT to electronically request and receive coverage requirements, request and populate prior authorization documentation using templates and rules, submit the prior authorization request, and receive the payer response through a provider Prior Authorization API.

We are proposing to modify the measure description to explicitly delineate the requirement to use ONC health IT certification criteria for the Electronic Prior Authorization measure beginning with the CY 2028 performance period/2030 MIPS payment year. We propose

---

[383] https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-D/part-170/subpart-C/section-170.315#p-170.315(g)(31).

[384] https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-D/part-170/subpart-C/section-170.315#p-170.315(g)(32).

[385] https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-D/part-170/subpart-C/section-170.315#p-170.315(g)(33).

to modify the measure description to specify the following actions required for meeting the requirement of the measure: "electronically request and receive coverage requirements," "request and populate prior authorization documentation using templates and rules," "submit the prior authorization request," and "receive the payer response" (does not require the approval of the prior authorization request by the payer, but does require that the MIPS eligible clinician receive a prior authorization decision or determination response from the payer) to reflect the specific capabilities supported by Health IT Modules certified to the ONC health IT certification criteria at 45 CFR 170.315(g)(31), (32), and (33). We note that we would interpret this requirement to mean that each of these specific actions should occur within the same prior authorization request.

We request public comment on this proposal.

(iv) ONC Health IT Certification Criteria to Support the Electronic Prior Authorization Measure

If the proposal to require that an electronic prior authorization must be requested using CEHRT to satisfy the Electronic Prior Authorization measure is finalized, we would require MIPS eligible clinicians to use Health IT Modules certified to the ONC health IT certification criteria in 45 CFR 170.315(g)(31), (32), and/or (33) as finalized in the HTI-4 final rule. Specifically, for the CY 2027 performance period/2029 MIPS payment year, MIPS eligible clinicians would be required to use CEHRT for electronic prior authorization requests that includes the utilization of one, or more than one, Health IT Modules certified to the ONC health IT certification criteria in 45 CFR 170.315(g)(31), (32), or (33) to meet the requirements of the Electronic Prior Authorization measure. Beginning with the CY 2028 performance period/2030 MIPS payment year, MIPS eligible clinicians would be required to use CEHRT for electronic prior authorization requests that includes the utilization of all three Health IT Modules certified to the ONC health IT certification criteria in 45 CFR 170.315(g)(31), (32), and (33)to meet the requirements of the Electronic Prior Authorization measure. Using certified health IT to support these electronic prior authorization transactions ensures that MIPS eligible clinicians have

standards-based capabilities within their health IT systems to interact with Prior Authorization APIs impacted payers are required to implement and maintain.

Specifically, the three criteria at 45 CFR 170.315(g)(31), (32), and (33) are based on the HL7 Da Vinci CRD, DTR, and PAS IGs, and address different parts of the electronic prior authorization workflow. The "provider prior authorization API – coverage requirements discovery" in 45 CFR 170.315(g)(31) enables a healthcare provider to request information from payers about coverage requirements. Where further information is needed to support a prior authorization request, the "provider prior authorization API – documentation templates and rules" criterion in 45 CFR 170.315(g)(32) provides a mechanism for providers to assemble the documentation needed to support a prior authorization request according to a payer's requirements. Finally, the "provider prior authorization API – prior authorization support" in 45 CFR 170.315(g)(33) enables submission of prior authorization requests from health IT systems as well as to check the status of a previously submitted request. By finalizing each component of the workflow as a separate ONC health IT certification criterion, ONC sought to support a more dynamic health IT marketplace in which a health IT developer could develop Health IT Modules demonstrating conformance to all three IGs or focus on a specific element or elements (90 FR 37169).

For the CY 2027 performance period/2029 MIPS payment year, we are proposing modifications to the Electronic Prior Authorization measure in section IV.A.4.d.(4)(f)(ii) of this proposed rule such that a MIPS eligible clinician could submit a "Yes" response, in which they are affirmatively attesting to the measure, if a "prior authorization is requested electronically through a Prior Authorization API using CEHRT." Different prior authorization scenarios that allow a MIPS eligible clinician to successfully attest to the measure, as proposed for CY 2027 performance period/2029 MIPS payment year, may require the functionality of one, or more than one, Health IT Modules certified to the criteria in 45 CFR 170.315(g)(31), (32), and (33). For instance, a MIPS eligible clinician could successfully report on the measure for the CY 2027

performance period/2029 MIPS payment year using CEHRT that includes a Health IT Module that is only certified to the "provider prior authorization API—coverage requirements discovery" criterion in 45 CFR 170.315(g)(31), but not to the ONC health IT certification criteria at 45 CFR 170.315(g)(32) or (33).

Consider an example in which a patient is a Medicare Advantage (MA) enrollee who has stable coronary artery disease and new exertional dyspnea (feeling shortness of breath during physical exertion). The patient's cardiologist wants to order an outpatient transthoracic echocardiogram (TTE) to assess left ventricular function and valvular disease. When the cardiologist places an order for a TTE in the EHR, a Health IT Module certified to the "provider prior authorization API—coverage requirements discovery" criterion (45 CFR 170.315(g)(31)) automatically sends a real-time query to the patient's MA plan endpoint to determine whether prior authorization is required for the requested service (the TTE) and, if so, what documentation is needed. The MA plan returns a CRD response (via CDS Hooks "card") indicating that prior authorization is necessary and has been approved under the beneficiary's plan benefits and network status, including information such as the prior authorization number and assumed billing codes.

In this first example, the prior authorization request is satisfied using only the capabilities represented with the "provider prior authorization API—coverage requirements discovery" (45 CFR 170.315(g)(31)). The MIPS eligible clinician submitted a query for prior authorization, the payer responded that prior authorization was required, the prior authorization was approved, and the MIPS eligible clinician received a response indicating this approval from the payer through the payer's Prior Authorization API. In this case, the receipt of an approval indicates that the MIPS eligible clinician effectively submitted a request for prior authorization, consistent with the requirements of the Electronic Prior Authorization measure. Conversely, if the MIPS eligible clinician receives a response that no prior authorization is required, that query would not fulfill the requirements of the measure. Also, we considered whether the allowance of using CEHRT to

conduct a check to determine if an item or service requires prior authorization should be able to satisfy the measure when the MIPS eligible clinician successfully submits a prior authorization coverage requirements determination query, regardless of whether the payer's response indicates that prior authorization is required. We request comment on whether such additional flexibility would benefit MIPS eligible clinicians.

Based on feedback we have received from implementers about their likely approach to phasing in electronic prior authorization capabilities, we expect that the use of health IT certified to the "provider prior authorization API—coverage requirements discovery" (45 CFR 170.315(g)(31)), as described in the example above, may be a common approach for the CY 2027 performance period/2029 MIPS payment year. However, we note that under the approach to use certified Health IT Modules for the Electronic Prior Authorization measure for the CY 2027 performance period/2029 MIPS payment year as described in this proposed rule, there could be additional scenarios that would qualify for the measure in which a MIPS eligible clinician uses only the certified Health IT Module in 45 CFR 170.315(g)(32) or (g)(33) as part of the workflow for submitting a prior authorization request.

For the following second example, the case illustrates a prior authorization workflow that would meet the requirements of the Electronic Prior Authorization measure as proposed for the CY 2027 performance period/2029 MIPS payment year and also meet the more stringent requirements for the measure proposed beginning with the CY 2028 performance period/2030 MIPS payment year, as described in section IV.A.4.d.(4)(f)(iii) of this proposed rule, when all three certified Health IT Modules in 45 CFR 170.315(g)(31), (32) and (33) would be required. The initial prior authorization query from a MIPS eligible clinician to a payer could result in a response indicating the need for additional information before a determination as to whether prior authorization is approved or denied can be provided, based on the coverage requirements identified. Additional certified Health IT Modules supporting additional elements of the

electronic prior authorization workflow would then need to be used to submit the prior authorization request after collecting the necessary documentation.

Consider an example in which the patient is an MA enrollee who has been diagnosed with metastatic colorectal cancer. The patient's oncologist has ordered a PET-CT scan and immunotherapy infusion. The oncologist places the order for a PET-CT scan and immunotherapy infusion in the EHR, which is certified to the "provider prior authorization API—coverage requirements discovery" criterion (45 CFR 170.315(g)(31)) and automatically queries the patient's MA plan's FHIR API. The EHR receives a response via CDS Hooks card indicating that prior authorization is required for both services and describes coverage criteria and documentation needs. Because the EHR is also certified to 45 CFR 170.315(g)(32), the certified health IT enables the oncologist to complete prior authorization following the DTR IG. An embedded Substitutable Medical Applications and Reusable Technologies (SMART) on FHIR app fetches the payer's specific documentation template and rules for oncology prior authorizations. For the PET-CT, the payer's documentation rules ask for the cancer staging information and previous imaging results; the immunotherapy, the payer's documentation rules require the patient's biomarker (for example, PD-L1 expression) status, prior treatment history, and recent lab results. Much of this information can be auto-populated because the embedded DTR app uses Clinical Quality Language (CQL) logic and FHIR queries to pull the patient's latest CT scan report and lab results from her medical record, and it confirms her cancer diagnosis and stage from the problem list. The oncologist answers a few additional questions (such as confirming the patient has no contraindications and that a required biomarker test was positive). By the end of this step, the EHR has compiled all necessary supporting documentation for the prior authorization, ensuring the request will be complete.

Next, the oncologist's office submits the prior authorization request electronically using the capabilities under the "provider prior authorization API-prior authorization support" criterion (45 CFR 170.315(g)(33)) to bundle the request and documentation and send it to the MA plan's

prior authorization endpoint. This bundle is transmitted via a FHIR RESTful interaction to the payer, as defined by the PAS IG. The EHR's certified Health IT Module ensures the request conforms to the required FHIR structure and sends it securely. Because all required information was provided up front and matched the plan's coverage criteria, the MA plan's system could potentially automatically adjudicate and approve the requests in near real-time. If that happened, the oncologist could now schedule the patient's therapy without delay, confident that the services are covered.

Both examples result in a prior authorization request that would meet the proposed modification to Electronic Prior Authorization measure for the CY 2027 performance period/2029 MIPS payment year because in each case, the MIPS eligible clinician requests prior authorization electronically using CEHRT. However, each example utilized different combinations of Health IT Modules certified to electronic prior authorization certification criteria in 45 CFR 170.315(g)(31), (32), and (33). In the first example, the MIPS eligible clinician used a single Health IT Module certified to the "provider prior authorization API—coverage requirements discovery" criterion (45 CFR 170.315(g)(31)) to complete actions necessary to successfully attest "Yes" to the Electronic Prior Authorization measure. In the second example, the MIPS eligible clinician used Health IT Modules certified to all three of the electronic prior authorization certification criteria to complete all actions for the MIPS eligible clinician to successfully attest "Yes" to the Electronic Prior Authorization measure as proposed for CY 2027 performance period/2029 MIPS payment year.

Consistent with the hypothetical examples, we note that a MIPS eligible clinician would be able to successfully attest "Yes" to the Electronic Prior Authorization measure for the CY 2027 performance period/2029 MIPS payment year using only those certified Health IT Modules necessary to meet the requirements of the measure. MIPS eligible clinicians would not be required to adopt additional electronic prior authorization certified Health IT Modules if they are not needed for the purposes of successfully reporting the Electronic Prior Authorization measure.

We expect that the ability to utilize different combinations of certified Health IT Modules to meet the measure for the CY 2027 performance period/2029 MIPS payment year would afford MIPS eligible clinicians and health IT developers flexibility in how they deploy, adopt, and use different aspects of certified health IT functionality for electronic prior authorization.

Beginning with the CY 2028 performance period/2030 MIPS payment year, we are proposing to modify the measure language to state that a MIPS eligible clinician must use CEHRT to "electronically request and receive coverage requirements, request and populate prior authorization documentation using templates and rules, submit the prior authorization request, and receive the payer response through a provider prior authorization API." In order for a MIPS eligible clinician to attest "Yes" to the Electronic Prior Authorization measure, all three certified health IT modules at 45 CFR 170.315(g)(31), (32), and (33) would be required, consistent with the actions associated with the proposed modifications to the measure, which require capabilities corresponding to each of the certified Health IT Modules. Only the second example described above, in which a prior authorization request is submitted after obtaining additional documentation necessary for the request and utilizing health IT certified to the complete set of ONC health IT certification criteria for electronic prior authorization, would be relevant if the proposal for the CY 2028 performance period/2030 MIPS payment year is finalized.

We request public comment on the proposal to use certified health IT to support the Electronic Prior Authorization measure.

(v) Proposal to Modify the Electronic Prior Authorization Measure to an Optional Measure for the CY 2027 Performance Period/2029 MIPS Payment Year

We are proposing to amend our previously finalized requirement that MIPS eligible clinicians must report the Electronic Prior Authorization measure to be considered a meaningful EHR user for the CY 2027 performance period/2029 MIPS payment year (89 FR 8919). Subsequent to the Electronic Prior Authorization measure being established, we proposed in the 2026 CMS Interoperability Standards and Prior Authorization for Drugs proposed rule to require

that impacted payers implement and maintain Prior Authorization APIs that use HL7 FHIR and conform to the HL7 FHIR Da Vinci CRD, DTR, and PAS implementation guides, as adopted by ONC, with compliance generally beginning October 1, 2027 (91 FR 19910 through 19911). We expect additional implementation complexity for MIPS eligible clinicians, who are downstream from impacted payers and health IT developers who will be required to implement these API standards version requirements in CY 2027 if the CMS Interoperability Standards and Prior Authorization for Drugs proposed rule is finalized as proposed (91 FR 19910 through 19911). As a result, we believe that MIPS eligible clinicians may need additional time and flexibility before requiring the Electronic Prior Authorization measure to account for these changes to the underlying transaction standards occurring in CY 2027. First, we recognize that MIPS eligible clinicians and health IT developers will need additional time for procurement, integration, and testing to operationalize standards-based electronic prior authorization capabilities that support the Electronic Prior Authorization measure. Second, interested parties have indicated that achieving widespread implementation and routine use of these capabilities in CY 2027 may be challenging, particularly for small, rural, and otherwise under-resourced MIPS eligible clinicians. Third, there may be additional implementation complexity for MIPS eligible clinicians because the CMS Interoperability Standards and Prior Authorization for Drugs proposed rule includes proposals to update the versions of underlying transaction standards within the relevant ONC health IT certification criteria. For these reasons, we propose that a year of optional reporting will both incentivize adoption of Health IT Modules certified to ONC criteria for electronic prior authorization through bonus points and offer flexibility to those MIPS eligible clinicians that could benefit from additional time to test, implement, and deploy the CEHRT functionality that is required to support the Electronic Prior Authorization measure. We note that we do not believe that finalization of this proposal is contingent on finalization of proposals in the CMS Interoperability Standards and Prior Authorization for Drugs proposed rule because health care providers, payers, and health IT developers have already begun to adopt and test standards-based

electronic prior authorization capabilities, and we expect standards adoption, conformance testing, and validation for the relevant Health IT Modules to continue.[386]

Therefore, in section IV.A.4.d.(4)(f)(v) of this proposed rule, we are proposing to modify the Electronic Prior Authorization measure, with the proposed measure updates, to be an optional measure. The measure would be eligible for 10 bonus points for MIPS eligible clinicians who submit a "Yes" response for the measure indicating that they have requested a prior authorization electronically using CEHRT from a payer's Prior Authorization API for at least one medical item or service (excluding drugs) ordered within the CY 2027 performance period. To account for the Electronic Prior Authorization measure being an optional measure for the CY 2027 performance period/2029 MIPS payment year with an allocation of 10 bonus points, we are proposing to modify the scoring methodology for optional measures under the MIPS Promoting Interoperability performance category as described in section IV.B.1.d. of this proposed rule. If the proposal to modify the Electronic Prior Authorization measure from a required measure to an optional measure is finalized as proposed, a MIPS eligible clinician who submits a "No" response would not have an affected score for the MIPS Promoting Interoperability performance category, and their response would not impact the MIPS eligible clinician being considered a meaningful EHR user for the CY 2027 performance period/2029 MIPS payment year.

Such proposed modification would change the policy adopted for the Electronic Prior Authorization measure as finalized in the 2024 CMS Interoperability and Prior Authorization final rule (89 FR 8911). The optional reporting of the Electronic Prior Authorization measure for the CY 2027 performance period/2029 MIPS payment year may be particularly beneficial for MIPS eligible clinicians in small, rural, or otherwise under-resourced clinical practice settings navigating new measure requirements while minimizing and balancing operational and reporting burden and demand. If the proposal to amend the Electronic Prior Authorization measure by

[386] For example, CMS has announced early adopters advancing electronic prior authorization solutions; see https://www.cms.gov/newsroom/press-releases/cms-announces-early-adopters-advance-solutions-electronic-prior-authorization-accelerating-momentum.

modifying the measure from a required measure to an optional measure is finalized as proposed, exclusions would not be available for the Electronic Prior Authorization measure for the CY 2027 performance period/2029 MIPS payment year because there will be no negative consequences for MIPS eligible clinicians who do not report on the optional measure. Given the allocated timeframe for MIPS eligible clinicians to become familiar with the Electronic Prior Authorization measure since the CY 2024 performance period as provided in the 2024 CMS Interoperability and Prior Authorization final rule, we believe that proposing to amend the Electronic Prior Authorization measure by modifying it from being a required measure to being as an optional bonus measure solely for the CY 2027 performance period/2029 MIPS payment year would provide MIPS eligible clinicians sufficient time to adopt and begin utilizing the certified health IT necessary to successfully report the Electronic Prior Authorization measure.

We refer readers to Tables C-G 2, C-G 4, C-G 6, and C-G 8 in sections IV.A.4.d.(4)(g)(i), IV.A.4.d.(4)(g)(ii)(D), and IV.A.4.d.(4)(g)(iv) of this proposed rule for information regarding the reporting requirements and scoring methodology of the MIPS Promoting Interoperability performance category for the CY 2027 performance period/2029 MIPS payment year, which is contingent upon the finalization of the proposal to amend the Electronic Prior Authorization by modifying the measure from being a required measure to being an optional measure. We note that the proposal to amend the Electronic Prior Authorization by modifying the measure from being a required measure to an optional measure for the CY 2027 performance period/2029 MIPS payment year aligns with the same proposal for the Medicare Promoting Interoperability Program as proposed in the FY 2027 IPPS/LTCH PPS proposed rule (91 FR 19625).

We request public comment on this proposal.

(vi) Proposal to Require the Electronic Prior Authorization Measure Beginning with the CY 2028 Performance Period/2030 MIPS Payment Year

When the Electronic Prior Authorization measure was adopted in the 2024 CMS Interoperability and Prior Authorization final rule (89 FR 8909 through 8927), we finalized that

for a MIPS eligible clinician to satisfactorily meet the requirements of the measure, they would be required to affirmatively attest or claim an applicable exclusion for the Electronic Prior Authorization measure beginning with the CY 2027 performance period/2029 MIPS payment year (89 FR 8910). If a MIPS eligible clinician submits a "No" response, fails to submit any attestation, or does not claim an applicable exclusion for the Electronic Prior Authorization measure, the MIPS eligible clinician would receive a score of zero for the MIPS Promoting Interoperability performance category (weighted at 25 percent of the MIPS final score) and would not be considered a meaningful EHR user for purposes of the MIPS Promoting Interoperability performance category for the applicable performance period (89 FR 8911).

We are proposing to amend the Electronic Prior Authorization measure by modifying the measure to require MIPS eligible clinicians to report the Electronic Prior Authorization measure beginning with the CY 2028 performance period/2030 MIPS payment year. Specifically, beginning with the CY 2028 performance period/2030 MIPS payment year, we are proposing that a MIPS eligible clinician must use CEHRT to electronically request and receive coverage requirements, request and populate prior authorization documentation using templates and rules, submit the prior authorization request, and receive the payer response through a Prior Authorization API for at least one medical item or service (excluding drugs) ordered within the applicable performance period. A MIPS eligible clinician would submit a "Yes" response, or alternatively claim an applicable exclusion, to satisfy the requirements of the Electronic Prior Authorization measure. In each case, the Electronic Prior Authorization measure would not affect the total score for the MIPS Promoting Interoperability performance category. If a MIPS eligible clinician submits a "No" response, fails to submit any attestation, or does not claim an applicable exclusion for the Electronic Prior Authorization measure, the MIPS eligible clinician would receive a score of zero for the MIPS Promoting Interoperability performance category (weighted at 25 percent of the MIPS final score) and would not be considered a meaningful EHR user for purposes of the MIPS Promoting Interoperability performance category for the

applicable performance period (89 FR 8911). This proposal reflects the measure reporting requirements that were first adopted for the Electronic Prior Authorization measure as described in the 2024 CMS Interoperability and Prior Authorization final rule (89 FR 8911), but it would modify the measure to being a required measure for the MIPS Promoting Interoperability performance category beginning with the CY 2028 performance period/2030 MIPS payment year instead of beginning with the CY 2027 performance period/2029 MIPS payment year as originally finalized.

The measure exclusions originally adopted in the 2024 CMS Interoperability and Prior Authorization final rule (89 FR 8916 through 8923) would be available to MIPS eligible clinicians for the CY 2028 performance period/2030 MIPS payment year and subsequent years. The available exclusions would be for any MIPS eligible clinician who: (1) Does not order any medical items or services (excluding drugs) requiring prior authorization during the applicable performance period; or (2) Only orders medical items or services (excluding drugs) requiring prior authorization from a payer that does not offer an API that meets CMS's Prior Authorization API requirements during the applicable performance period. A MIPS eligible clinician would also be able to claim the first exclusion if none of its prior authorization requests required the functionality described in the certification criteria at 45 CFR 170.315(g)(31), (32) and (33) for electronic prior authorization. For instance, if no prior authorization request submitted by a MIPS eligible clinician during the performance period required gathering and submitting additional documentation to support the request, which is supported by health IT certified to the criteria in 45 CFR 170.315(g)(32) and 45 CFR 170.315(g)(33), then no prior authorization request that MIPS eligible clinician performed would fulfill the measure and the MIPS eligible clinician would be able to claim an exclusion. More broadly, if the MIPS eligible clinician is unable to use CEHRT to effectively exchange information and submit a prior authorization request with any payer from which they are seeking an authorization, we believe that would be

sufficient for a MIPS eligible clinician to claim that the payer does not have a functioning Prior Authorization API for the purpose of the reporting and exclusion eligibility.

We note that CMS's specified payer Prior Authorization API requirements are proposed to include conformance to the three IGs underlying the ONC health IT certification criteria at 45 CFR 170.315(g)(31), (32), and (33). Therefore, if those Prior Authorization API requirements are finalized as proposed, a MIPS eligible clinician could claim the second exclusion if all their requests are with payers that do not support all three FHIR IGs. If we do not finalize the Prior Authorization API requirements for payers as proposed in the 2026 CMS Interoperability Standards and Prior Authorization for Drugs proposed rule, we would still intend for this exclusion under the Electronic Prior Authorization measure to apply to Prior Authorization APIs that do not use all three IGs underlying the ONC health IT certification criteria at 45 CFR 170.315(g)(31), (32), and (33).

We refer readers to Tables C-G 2, C-G 5, C-G 6 and C-G 8 in sections IV.A.4.d.(4)(g)(i), IV.A.4.d.(4)(g)(ii)(D), and IV.A.4.d.(4)(g)(iv) of this proposed rule for information regarding the reporting requirements and scoring methodology of the MIPS Promoting Interoperability performance category beginning with the CY 2028 performance period/2030 MIPS payment year, which is contingent upon the finalization of the proposal to amend the Electronic Prior Authorization by modifying the measure to be a required measure.

We request public comment on this proposal.

(vii) Request for Information on Future Potential Performance-Based Measures of Electronic Prior Authorization

While the current measure requirement of achieving "at least one" electronic prior authorization is appropriate for the initial inclusion of the Electronic Prior Authorization measures for both medical items and services and for prescription drugs in the MIPS Promoting Interoperability performance category, we do not expect this minimal requirement to effectively increase electronic prior authorization usage over time. Therefore, we are seeking comments on

potential future updates we could make to this measure to incentivize MIPS eligible clinicians to use CEHRT for electronic prior authorization for a more substantial set of the electronic prior authorization requests that they submit over the course of a performance period and corresponding MIPS payment year. Consistent with statutory requirements in section 1886(n)(3)(A)(ii) of the Act, we envision that expanding the scope of the measures in future rulemaking would lead to increased interoperable exchange of data that would not only decrease administrative burden, but could improve the quality of health by reducing the time needed for a patient to get access to necessary medical services and items as well as prescription drugs covered under the medical benefit. Reducing delays in the exchange of data and as a result providing patients care more efficiently, drives better care coordination which is a key objective of meaningful use. Additionally, because electronic prior authorization requires data sharing, this advances interoperability, which is a primary focus of meaningful use. We also intend to drive adoption of health IT capabilities supporting the complete electronic prior authorization workflow over time, by requiring MIPS eligible clinicians to address a wider array of prior authorization requests that require more complex interactions with payers. The public input we receive will contribute to future considerations for potentially updating the Electronic Prior Authorization measures in a manner that helps achieve HHS's goals of promoting meaningful use of certified EHR technology, electronic exchange of health information, and submission of clinical quality measures.

We seek public comment on potential future updates to this measure. We seek public comment on barriers and challenges that MIPS eligible clinicians in small, rural, or otherwise under-resourced practice settings might face when reporting performance-based electronic prior authorization measures. Also, we request comment on what alternative approaches should be considered to support use of electronic prior authorization. We seek public comment on how we can further strengthen the Electronic Prior Authorization measures in a manner that incentivizes

progress while avoiding undue administrative complexity and implementation challenges for MIPS eligible clinicians.

(g) Proposal to Modify Requirements and Scoring Policies for the MIPS Promoting Interoperability Performance Category

(i) Proposal to Modify Objectives and Measures

In this proposed rule, we are proposing updates that would occur in different performance periods. For reference, Table C-G 2 sets forth the objectives and measures for the Promoting Interoperability performance category that would be required for the CY 2027 performance period/2029 MIPS payment year, the CY 2028 performance period/2030 MIPS payment year, and subsequent years if our proposals are finalized as proposed. Table C-G 2 reflects proposed modifications to previously established objectives and measures, including the proposals:

- For the CY 2026 performance period/2028 MIPS payment year: Remove the ONC Direct Review and ONC-ACB Surveillance attestations.
- For the CY 2027 performance period/2029 MIPS payment year: Remove the Security Risk Analysis measure and make the existing Electronic Prior Authorization measure an optional measure.
- For the CY 2028 performance period/2030 MIPS payment year: Make the existing Electronic Prior Authorization measure required and unscored and create a new Electronic Prior Authorization for Prescription Drugs measure.

TABLE C-G 2: PROPOSED OBJECTIVES AND MEASURES FOR THE MIPS PROMOTING INTEROPERABILITY PERFORMANCE CATEGORY FOR THE CY 2026 PERFORMANCE PERIOD/2028 MIPS PAYMENT YEAR, CY 2027 PERFORMANCE PERIOD/2029 MIPS PAYMENT YEAR, THE CY 2028 PERFORMANCE PERIOD/2030 MIPS PAYMENT YEAR, AND SUBSEQUENT YEARS

Objective	Measure	Numerator	Denominator	Exclusion
Electronic Prescribing: Generate and transmit permissible prescriptions electronically	e-Prescribing – At least one permissible prescription written by the MIPS eligible clinician is transmitted electronically using CEHRT.	Number of prescriptions in the denominator generated and transmitted electronically using CEHRT.	Number of prescriptions written for drugs requiring a prescription to be dispensed other than controlled substances during the performance period; or number of prescriptions written for drugs requiring a prescription to be dispensed during the performance period.	Any MIPS eligible clinician who writes fewer than 100 permissible prescriptions during the performance period.
Electronic Prescribing	Query of PDMP – For at least one Schedule II opioid or Schedule III or IV drug electronically prescribed using CEHRT during the performance period, the MIPS eligible clinician uses data from CEHRT to conduct a query of a PDMP for prescription drug history.	N/A (measure is Yes/No and requires an affirmative attestation to meet requirement)	N/A (measure is Yes/No and requires an affirmative attestation to meet requirement)	Any MIPS eligible clinician who: 1. Is unable to electronically prescribe Schedule II opioids and Schedule III and IV drugs in accordance with applicable law during the performance period; OR 2. Does not electronically prescribe any Schedule II opioids or Schedule III or IV drugs during the performance period.
Health Information Exchange: The MIPS eligible clinician provides a summary of care record when transitioning care or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition of care or referral or upon the first patient encounter with a new patient, and reconciles summary of care information from other healthcare providers into their EHR using the functions of CEHRT	Support Electronic Referral Loops by Sending Health Information – For at least one transition of care or referral, the MIPS eligible clinician that transitions care of a patient or refers their patient to another setting of care or healthcare provider: 1. Creates a summary of care using CEHRT; AND 2. Electronically exchanges the summary of care record.	Number of transitions of care and referrals in the denominator where the summary of care record was created using CEHRT and exchanged electronically.	Number of transitions of care and referrals during the performance period for which the MIPS eligible clinician was the transferring or referring clinician.	Any MIPS eligible clinician who transfers a patient to another setting or refers a patient fewer than 100 times during the performance period.
Health Information Exchange (HIE)	Support Electronic Referral Loops by Receiving and Reconciling Health	Number of electronic summary of care records in the denominator for	Number of electronic summary of care records received using CEHRT for	Any MIPS eligible clinician who receives transitions of care or referrals or has patient encounters in which

Objective	Measure	Numerator	Denominator	Exclusion
	Information – For at least one electronic summary of care record received for patient encounters during the performance period for which a MIPS eligible clinician was the receiving party of a transition of care or referral, or for patient encounters during the performance period in which the MIPS eligible clinician has never before encountered the patient, the MIPS eligible clinician conducts clinical information reconciliation for medication, mediation allergy, and current problem list.	which clinical information reconciliation is completed using CEHRT for the following three clinical information sets: 1. Medication – Review of the patient's medication, including the name, dosage, frequency, and route of each medication; 2. Medication allergy – Review of the patient's known medication allergies; and 3. Current Problem List – Review of the patient's current and active diagnoses.	patient encounters during the performance period for which a MIPS eligible clinician was the receiving party of a transition of care or referral, and for patient encounters during the performance period in which the MIPS eligible clinician has never before encountered the patient.	the MIPS eligible clinician has never before encountered the patient fewer than 100 times during the performance period.
Health Information Exchange (HIE)	Health Information Exchange Bi-Directional Exchange – Statement 1: I participate in an HIE to enable secure, bi-directional exchange to occur for every patient encounter, transition of care or referral and record stored or maintained in the EHR during the performance period in accordance with applicable law and policy. Statement 2: The HIE that I participate in is capable of exchanging information across a broad network of unaffiliated exchange partners including those using disparate EHRs and not engaging in exclusionary behavior when determining exchange partners. Statement 3: I use the functions of CEHRT to support bi-	N/A (measure is Yes/No and requires an affirmative attestation to meet requirement)	N/A (measure is Yes/No and requires an affirmative attestation to meet requirement)	N/A

Objective	Measure	Numerator	Denominator	Exclusion
	directional exchange with an HIE.			
Health Information Exchange	Enabling Exchange Under TEFCA – MIPS eligible clinicians attest to the following. Statement 1: I participate as a signatory to a Framework Agreement (as that term is defined by the Common Agreement for Nationwide Health Information Interoperability as published in the **Federal Register** and on ONC website) in good standing (that is, not suspended) and enabling secure, bi-directional exchange of information to occur, in production, for every patient encounter, transition of care or referral, and record stored or maintained in the EHR during the performance period, in accordance with applicable law and policy. Statement 2: I use the functions of CEHRT to support bi-directional exchange of patient information, in production, under this Framework Agreement.	N/A (measure is Yes/No and requires an affirmative attestation to meet requirement)	N/A (measure is Yes/No and requires an affirmative attestation to meet requirement)	N/A
Health Information Exchange	Electronic Prior Authorization for Prescription Drugs (CY 2028 and subsequent performance periods) – For at least one prescription written by the MIPS eligible clinician during the performance period for which prior authorization is required, the prior authorization is requested electronically using CEHRT.*	N/A (measure is Yes/No and requires an affirmative attestation to meet requirement)	N/A (measure is Yes/No and requires an affirmative attestation to meet requirement)	Any MIPS eligible clinician who: 1. Does not write a prescription that requires prior authorization during the applicable performance period; or 2. only writes prescriptions requiring prior authorization where the payer does not support the specified electronic prior authorization standard during the applicable performance period; or 3 writes fewer than 100 permissible prescriptions during the performance period.*

Objective	Measure	Numerator	Denominator	Exclusion
Health Information Exchange	Electronic Prior Authorization (CY 2027 performance period *only*) – For at least one medical item or service (excluding drugs) ordered by the MIPS eligible clinician during the performance period, the prior authorization is requested electronically through a Prior Authorization API using CEHRT.**	N/A (measure is Yes/No and requires an affirmative attestation to meet requirement)	N/A (measure is Yes/No and requires an affirmative attestation to meet requirement)	None**
Health Information Exchange	Electronic Prior Authorization (CY 2028 and subsequent performance periods) – For at least one medical item or service (excluding drugs) ordered by the MIPS eligible clinician during the performance period, the MIPS eligible clinician uses CEHRT to electronically discover applicable coverage requirements, complete required documentation, submit the prior authorization request, and receive the payer response through a Prior Authorization API.*	N/A (measure is Yes/No and requires an affirmative attestation to meet requirement)	N/A (measure is Yes/No and requires an affirmative attestation to meet requirement)	Any MIPS eligible clinician who: 1. Does not order any medical items or services (excluding drugs) requiring prior authorization during the applicable performance period; OR 2. Only orders medical items or services (excluding drugs) requiring prior authorization from a payer that does not offer an API that meets CMS's specified Prior Authorization API requirements.*
Provider to Patient Exchange: The MIPS eligible clinician provides patients (or patient-authorized representative) with timely electronic access to their health information.	Provide Patients Electronic Access to Their Health Information – For at least one unique patient seen by the MIPS eligible clinician: 1. The patient (or the patient-authorized representative) is provided timely access to view online, download, and transmit his or her health information; AND 2. The MIPS eligible clinician ensures the patient's health information is available for the	Number of patients (or patient authorized representatives) in the denominator who are provided timely access to health information to view online, download, and transmit to a third party and to access using an application of their choice that is configured to meet the technical specifications of the API in the MIPS eligible clinician's CEHRT.	Number of unique patients seen by the MIPS eligible clinician during the performance period.	N/A

Objective	Measure	Numerator	Denominator	Exclusion
	patient (or patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the Application Programming Interface (API) in the MIPS eligible clinician's CEHRT.			
Public Health and Clinical Data Exchange: The MIPS eligible clinician is in active engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using CEHRT, except where prohibited, and in accordance with applicable law and practice.	Immunization Registry Reporting – The MIPS eligible clinician is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).	N/A (measure is Yes/No and requires an affirmative attestation to meet requirement)	N/A (measure is Yes/No and requires an affirmative attestation to meet requirement)	The MIPS eligible clinician: 1. Does not administer any immunizations to any of the populations for which data is collected by its jurisdiction's immunization registry or immunization information system during the performance period; OR 2. Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the performance period; OR 3. Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data as of 6 months prior to the start of the performance period.
Public Health and Clinical Data Exchange	Electronic Case Reporting – The MIPS eligible clinician is in active engagement with a PHA to electronically submit case reporting of reportable conditions.	N/A (measure is Yes/No and requires an affirmative attestation to meet requirement)	N/A (measure is Yes/No and requires an affirmative attestation to meet requirement)	The MIPS eligible clinician: 1. Does not treat or diagnose any reportable diseases for which data is collected by their jurisdiction's reportable disease system during the performance period; OR 2. Operates in a jurisdiction for which no PHA is capable of receiving electronic case reporting data in the specific standards required to meet the CEHRT definition at the start of the performance period; OR 3. Operates in a jurisdiction where no PHA has declared readiness to receive electronic case reporting data as of 6

Objective	Measure	Numerator	Denominator	Exclusion
				months prior to the start of the performance period.
Public Health and Clinical Data Exchange	Public Health Registry Reporting (Optional) – The MIPS eligible clinician is in active engagement with a PHA to submit data to public health registries.	N/A (measure is Yes/No and requires an affirmative attestation to meet requirement)	N/A (measure is Yes/No and requires an affirmative attestation to meet requirement)	None
Public Health and Clinical Data Exchange	Clinical Data Registry Reporting (Optional) – The MIPS eligible clinician is in active engagement to submit data to a clinical data registry.	N/A (measure is Yes/No and requires an affirmative attestation to meet requirement)	N/A (measure is Yes/No and requires an affirmative attestation to meet requirement)	None
Public Health and Clinical Data Exchange	Syndromic Surveillance Reporting (Optional) – The MIPS eligible clinician is in active engagement with a PHA to submit syndromic surveillance data from an urgent care setting.	N/A (measure is Yes/No and requires an affirmative attestation to meet requirement)	N/A (measure is Yes/No and requires an affirmative attestation to meet requirement)	None
Public Health and Clinical Data Exchange	Public Health Reporting Using TEFCA (Optional)* – The MIPS eligible clinician: 1. Is participating as a signatory to a Framework Agreement (as that term is defined by the Common Agreement for Nationwide Health Information Interoperability as published in the **Federal Register** and on ONC's website); 2. Is not suspended from participating in TEFCA exchange; 3. Submits health information using TEFCA to a PHA consistent with one or more of the measures under the Public Health and Clinical Data Exchange objective; 4. Is in active engagement Option 2 (validated data production) with a PHA to transfer health information for	N/A (measure is Yes/No and requires an affirmative attestation to meet requirement)	N/A (measure is Yes/No and requires an affirmative attestation to meet requirement)	None

Objective	Measure	Numerator	Denominator	Exclusion
	one or more of the measures under the Public Health and Clinical Data Exchange objective; AND 5. Uses the functions of CEHRT to exchange with the PHA.			
Protect Patient Health Information: Protect electronic protected health information (ePHI) created or maintained by CEHRT through the implementation of appropriate technical, administrative, and physical safeguards. Protect Patient Health Information	High Priority Practices SAFER Guide – Beginning with the CY 2024 performance period/2026 MIPS payment year, submit an affirmative attestation regarding the MIPS eligible clinician's completion of the annual self-assessment under the High Priority Practices SAFER Guide measure using the 2025 High Priority Practices SAFER Guide during the year in which the performance period occurs.	N/A (measure is Yes/No and requires an affirmative attestation to meet requirement)	N/A (measure is Yes/No and requires an affirmative attestation to meet requirement)	None

* Signifies a proposal in this proposed rule that would apply to the CY 2028 performance period and subsequent years.
** Signifies a proposal in this proposed rule that would apply to the CY 2027 performance period.

(ii) Proposal to Modify Scoring Methodology

For reference, Tables C-G 3, C-G 4 and C-G 5 set forth the scoring methodology for the MIPS Promoting Interoperability performance category for CY 2026 performance period/2028 MIPS payment year, the CY 2027 performance period/2029 MIPS payment year, and the CY 2028 performance period/2030 MIPS payment year and subsequent years. In sections IV.A.4.d.(4)(c)(ii), IV.A.4.d.(4)(d)(ii), IV.A.4.d.(4)(e)(ii), IV.A.4.d.(4)(f)(ii), IV.A.4.d.(4)(f)(iii), IV.A.4.d.(4)(f)(iv), IV.A.4.d.(4)(f)(v), and IV.A.4.d.(4)(f)(vi) of this proposed rule, we discuss the proposed removal of certain measures, addition of certain measures, and modifications/updates to certain measures for the MIPS Promoting Interoperability performance category. We refer readers to section IV.B.1.d. of this proposed rule for the discussion regarding the proposal that modifies the scoring methodology to account for the Electronic Prior

Authorization measure being changed to an optional measure with an allocation of 10 bonus points for the CY 2027 performance period/2029 MIPS payment year. There are no implications to the scoring methodology for the proposal to update the definition of CEHRT in section IV.A.4.d.(4)(b)(ii) of this proposed rule. This section includes a discussion of scoring implications for the proposed changes in this proposed rule for the MIPS Promoting Interoperability performance category--

- Removal of the ONC Direct Review and ONC-ACB Surveillance attestations;
- Removal of the Security Risk Analysis measure;
- Addition of an Electronic Prior Authorization for Prescription Drugs measure; and
- Updates to the Electronic Prior Authorization measure.

(A) Proposal to Modify Scoring for the ONC Direct Review and ONC-ACB Surveillance Attestations

The proposal to remove the ONC Direct Review and ONC-ACB Surveillance attestations beginning with the CY 2026 performance period/2028 MIPS payment year as discussed in section IV.A.4.d.(4)(c)(ii) of this proposed rule will be reflected in the scoring of the MIPS Promoting Interoperability performance category in the following manner. Currently, to earn a score for the MIPS Promoting Interoperability performance category for inclusion in the MIPS final score, a MIPS eligible clinician must be a meaningful EHR user for MIPS and submit a "Yes" response attesting to engaging in activities supporting providers with performance of CEHRT, including acknowledging the requirement to cooperate in good faith with ONC Direct Review. The ONC-ACB Surveillance attestation is optional, and MIPS eligible clinicians can attest "Yes", "No" or not submit an attestation (81 FR 77019 to 77028).

Starting in the CY 2026 performance period/2028 MIPS payment year, we are proposing to remove scoring policies related to the ONC Direct Review attestation and the optional ONC-ACB Surveillance attestation since we are proposing in section IV.A.4.d.(4)(c)(ii) of this proposed rule to remove the attestations. The ONC Direct Review attestation will no longer be

required to earn a score for the MIPS Promoting Interoperability performance category for inclusion in the final score. Since we did not provide measure points for either the attestation of ONC Direct Review and ONC-ACB Surveillance, removal of the attestation requirements and scoring policies starting with the CY 2026 performance period/2028 MIPS payment year will not result in a need to redistribute measure points in the MIPS Promoting Interoperability performance category.

We refer readers to Table C-G 3 in section IV.A.4.d.(4)(g)(ii)(D) of this proposed rule for more information on the scoring methodology for the MIPS Promoting Interoperability performance category for the CY 2026 performance period/2028 MIPS payment year.

We request public comment on this proposal.

(B) Proposal to Modify Scoring for the Security Risk Analysis Measure

We are proposing to remove the Security Risk Analysis measure beginning with the CY 2027 performance period/2029 MIPS payment year as discussed in section IV.A.4.d.(4)(d)(ii) of this proposed rule. Thus, we are proposing to remove the scoring policies corresponding to the Security Risk Analysis measure. The measure is not scored individually and the attestation of a "Yes" response does not contribute to the MIPS eligible clinician's MIPS Promoting Interoperability performance category score for the Protect Patient Health Information objective and measures. An attestation of a "No" demonstrates that the MIPS eligible clinician did not complete the actions included in the measure as required by § 414.1375(b)(2)(ii)(A) and did not satisfy the definition of a meaningful EHR user at § 414.1305. Therefore, if the MIPS eligible clinician submits a "No" response for this measure, they would not earn a score for the MIPS Promoting Interoperability performance category, resulting in a score of zero, in accordance with § 414.1375(b)(2) (90 FR 49870 and 49871). The proposed removal of the Security Risk Analysis measure, which does not contribute to the MIPS eligible clinician's MIPS Promoting Interoperability performance category score, will not result in the need to redistribute measure points in the MIPS Promoting Interoperability performance category. We refer readers to Table

C-G 4 in section IV.A.4.d.(4)(g)(ii)(D) of this proposed rule for more information on the scoring methodology for the MIPS Promoting Interoperability performance category for the CY 2027 performance period/2029 MIPS payment year, which would no longer include the Security Risk Analysis measure, which is proposed for removal.

We request public comment on this proposal.

(C) Proposal to Modify Scoring for the New Electronic Prior Authorization for Prescription Drugs Measure

We are proposing to adopt a new attestation-based Electronic Prior Authorization for Prescription Drugs measure beginning with the CY 2028 performance period/2030 MIPS payment year as discussed in section IV.A.4.d.(4)(e)(ii) of this proposed rule. We are proposing that the Electronic Prior Authorization for Prescription Drugs measure would not be scored for the CY 2028 performance period/2030 MIPS payment year and subsequent years for MIPS eligible clinicians. A MIPS eligible clinician would be required to attest "Yes" to the measure or claim an exclusion, but the measure would not affect the total score for the MIPS Promoting Interoperability performance category. MIPS eligible clinicians that report a "No" attestation, fail to submit the measure, or fail to claim an applicable exclusion would receive a score of zero for the MIPS Promoting Interoperability performance category (currently weighted at 25 percent of the MIPS final score), and would not be considered a meaningful EHR user for MIPS for that performance year.

We request public comment on this proposal.

(D) Proposal to Modify Scoring for the Electronic Prior Authorization Measure

When we adopted the Electronic Prior Authorization measure in the 2024 CMS Interoperability and Prior Authorization final rule (89 FR 8909 through 8927), we finalized that MIPS eligible clinicians would report the measure as an unscored attestation for the CY 2027 performance period specifically (89 FR 8910), but we did not specify its scoring methodology

for subsequent years because we determined that it would be more appropriate to determine the measure's scoring structure closer in time to its effective date.

In sections IV.A.4.d.(4)(f)(v) and IV.B.1.d. of this proposed rule, we are proposing to modify the Electronic Prior Authorization measure by making the measure optional and eligible for 10 bonus points for MIPS eligible clinicians who submit a "Yes" response attesting to meeting the requirements of the measure for the CY 2027 performance period/2029 MIPS payment year. We are proposing to make the measure eligible for 10 bonus points for MIPS eligible clinicians that submit a "Yes" response attesting to meeting the requirements of measure. Allocating 10 bonus points is an appropriate and effective incentive to promote the adoption and use of certified technology for requesting electronic prior authorizations among MIPS eligible clinicians. To account for the allocation of bonus points specific to the Electronic Prior Authorization measure for the CY 2027 performance period/2029 MIPS payment year, we are proposing to amend § 414.1380(b)(4)(ii)(C) by adding a new provision at § 414.1380(b)(4)(ii)(C)(4). We refer readers to section IV.B.1. of this proposed rule for the proposal to establish the allocation of 10 bonus points in § 414.1380(b)(4)(ii)(C)(4), respectively, for MIPS eligible clinicians who affirmatively attested to meeting the requirements of the Electronic Prior Authorization measure for the CY 2027 performance period/2029 MIPS payment year.

Also, as described in section IV.A.4.d.(4)(f)(v) of this proposed rule, we are proposing to require the measure for the CY 2028 performance period/2030 MIPS payment year and subsequent years. Similar to its original scoring methodology as adopted in the 2024 CMS Interoperability and Prior Authorization final rule (89 FR 8909 through 8927), we are proposing that the Electronic Prior Authorization measure would remain unscored for the CY 2028 performance period and subsequent years. This scoring methodology would allow time for MIPS eligible clinicians to adjust to the new electronic prior authorization workflow using Prior Authorization APIs without undue focus on scoring implications in the MIPS Promoting

Interoperability performance category. We anticipate the Electronic Prior Authorization measure will retain its importance as an aspect of health information exchange.

We request public comment on these proposals.

TABLE C-G 3: PROPOSED SCORING METHODOLOGY FOR THE CY 2026 PERFORMANCE PERIOD/2028 MIPS PAYMENT YEAR

Objective	Measure	Maximum Points	Required/Optional
Electronic Prescribing	e-Prescribing	10 points	Required
	Query of PDMP	10 points	Required
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	15 points	Required (MIPS eligible clinician's choice of one of the three reporting options)
	Support Electronic Referral Loops by Receiving and Reconciling Health Information	15 points	
	-OR-		
	Health Information Exchange Bi-Directional Exchange	30 points	
	-OR-		
	Enabling Exchange Under TEFCA	30 points	
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	25 points	Required
Public Health and Clinical Data Exchange	Report the following two measures: • Immunization Registry Reporting • Electronic Case Reporting	25 points	Required
	Report one of the following measures: • Public Health Registry Reporting • Clinical Data Registry Reporting • Syndromic Surveillance Reporting • Public Health Reporting Using TEFCA	5 points (*bonus*)	Optional
Protect Patient Health Information	Security Risk Analysis	Not scored*	Required
	High Priority Practices SAFER Guide	Not scored*	Required
No Associated Objective: Attestation Requirements**	Actions to Limit or Restrict the Compatibility of CEHRT	Not scored*	Required

* Measures and attestations that are required but not scored do not have associated points, but failure to fulfill such requirements will result in a zero score for the MIPS Promoting Interoperability performance category.
**Attestation Requirements: The proposed removal of the ONC-Direct Review attestation and the ONC-ACB Surveillance attestation is applicable starting with the CY 2026 performance period/2028 MIPS payment year as discussed in section IV.A.4.d.(4)(c)(ii) of this proposed rule.

TABLE C-G 4: PROPOSED SCORING METHODOLOGY FOR THE CY 2027 PERFORMANCE PERIOD/2029 MIPS PAYMENT YEAR

Objective	Measure	Maximum Points	Required/Optional
Electronic Prescribing	e-Prescribing	10 points	Required
	Query of PDMP	10 points	Required
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	15 points	Required (MIPS eligible clinician's choice of one of the three reporting options)
	Support Electronic Referral Loops by Receiving and Reconciling Health Information	15 points	
	-OR-		
	Health Information Exchange Bi-Directional Exchange	30 points	
	-OR-		
	Enabling Exchange Under TEFCA	30 points	
	Electronic Prior Authorization*	10 points (*bonus*)	Optional
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	25 points	Required
Public Health and Clinical Data Exchange	Report the following two measures: • Immunization Registry Reporting • Electronic Case Reporting	25 points	Required
	Report one of the following measures: • Public Health Registry Reporting • Clinical Data Registry Reporting • Syndromic Surveillance Reporting • Public Health Reporting Using TEFCA	5 points (*bonus*)	Optional
Protect Patient Health Information**	High Priority Practices SAFER Guide	Not scored***	Required
No Associated Objective: Attestation Requirements****	Actions to Limit or Restrict the Compatibility of CEHRT	Not scored***	Required

* In sections IV.A.4.d.(4)(f)(v) and IV.A.4.d(4)(f)(vi) of this proposed rule, we are proposing to make the Electronic Prior Authorization measure an optional measure for the CY 2027 performance period and required, but unscored, starting with the CY 2028 performance period.

** The proposed removal of the Security Risk Analysis measure is applicable starting with the CY 2027 performance period/2029 MIPS payment year as described in section IV.A.4.d.(4)(d)(ii) of this proposed rule.

*** Measures and attestations that are required, but not scored do not have associated points, but failure to fulfill such requirements will result in a zero score for the MIPS Promoting Interoperability performance category.

**** Attestation Requirements: The proposed removal of the ONC-Direct Review attestation and the ONC-ACB Surveillance attestation is applicable starting with the CY 2026 performance period/2028 MIPS payment year as discussed in section IV.A.4.d.(4)(c)(ii) of this proposed rule.

TABLE C-G 5: PROPOSED SCORING METHODOLOGY FOR THE CY 2028 PERFORMANCE PERIOD/2030 MIPS PAYMENT YEAR AND SUBSEQUENT YEARS

Objective	Measure	Maximum Points	Required/Optional
Electronic Prescribing	e-Prescribing	10 points	Required
	Query of PDMP	10 points	Required
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	15 points	Required (MIPS eligible clinician's choice of one of the three reporting options)
	Support Electronic Referral Loops by Receiving and Reconciling Health Information	15 points	
	-OR-		
	Health Information Exchange Bi-Directional Exchange	30 points	
	-OR-		
	Enabling Exchange Under TEFCA	30 points	
	Electronic Prior Authorization*	Not scored**	Required
	Electronic Prior Authorization for Prescription Drugs***	Not scored**	Required
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	25 points	Required
Public Health and Clinical Data Exchange	Report the following two measures: • Immunization Registry Reporting • Electronic Case Reporting	25 points	Required
	Report one of the following measures: • Public Health Registry Reporting • Clinical Data Registry Reporting • Syndromic Surveillance Reporting • Public Health Reporting Using TEFCA	5 points (*bonus*)	Optional
Protect Patient Health Information****	High Priority Practices SAFER Guide	Not scored**	Required
No Associated Objective: Attestation Requirements*****	Actions to Limit or Restrict the Compatibility of CEHRT	Not scored***	Required

* In section IV.A.4.d.(4)(f)(vi) of this proposed rule, we are proposing to make the Electronic Prior Authorization measure a required and unscored measure for the CY 2028 performance period. We note we are also proposing in section IV.A.4.d.(4)(f)(v) of this proposed rule to make the measure optional for the CY 2027 performance period.
** Measures and attestations that are required but not scored do not have associated points, but failure to fulfill such requirements will result in a zero score for the MIPS Promoting Interoperability performance category.
*** In section IV.A.4.d.(4)(e)(ii) of this proposed rule, we are proposing to adopt a new Electronic Prior Authorization for Prescription Drugs measure for the CY 2028 performance period, which is required and not scored.
**** The proposed removal of the Security Risk Analysis measure is applicable starting with the CY 2027 performance period/2029 MIPS payment year as discussed in section IV.A.4.d.(4)(d)(ii) of this proposed rule.
*****Attestation Requirements: The proposed removal of the ONC-Direct Review attestation and the ONC-ACB Surveillance attestation is applicable starting with the CY 2026 performance period/2028 MIPS payment year as discussed in section IV.A.4.d.(4)(c)(ii) of this proposed rule.

The proposals in this proposed rule include changes that would occur in the CY 2026 performance period/2028 MIPS payment year, CY 2027 performance period/2029 MIPS payment year, and CY 2028 performance period/2030 MIPs payment year. Table C-G 6 summarizes the required measures and attestations for each of these three performance periods.

TABLE C-G 6: SUMMARY OF PROPOSED REQUIREMENTS FOR THE PROMOTING INTEROPERABILITY PERFORMANCE CATEGORY FOR THE CY 2026 PERFORMANCE PERIOD/2028 MIPS PAYMENT YEAR, CY 2027 PERFORMANCE PERIOD/2029 MIPS PAYMENT YEAR, CY 2028 PERFORMANCE PERIOD/2030 MIPS PAYMENT YEAR, AND SUBSEQUENT YEARS

Objective	Measure	2026 Performance Period	2027 Performance Period	2028 Performance Period and Subsequent Years
Electronic Prescribing	e-Prescribing	Required (10 points)	Required (10 points)	Required (10 points)
	Query of PDMP	Required (10 points)	Required (10 points)	Required (10 points)
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	Required (30 points for selected option)	Required (30 points for selected option)	Required (30 points for selected option)
	Support Electronic Referral Loops by Receiving and Reconciling Health Information			
	-OR-			
	Health Information Exchange Bi-Directional Exchange			
	-OR-			
	Enabling Exchange Under TEFCA			
	Electronic Prior Authorization	---	Optional (10 bonus points)	Required (not scored)*
	Electronic Prior Authorization for Prescription Drugs	---	---	Required (not scored)*
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	Required (25 points)	Required (25 points)	Required (25 points)
Public Health and Clinical Data Exchange	Report the following two measures: • Immunization Registry Reporting • Electronic Case Reporting	Required (25 points)	Required (25 points)	Required (25 points)
	Report one of the following measures: • Public Health Registry Reporting • Clinical Data Registry Reporting • Syndromic Surveillance Reporting • Public Health Reporting Using TEFCA	Optional (5 bonus points)	Optional (5 bonus points)	Optional (5 bonus points)
Protect Patient Health Information	Security Risk Analysis	Required (not scored)*	---	---
	High Priority Practices SAFER Guide	Required (not scored)*	Required (not scored)*	Required (not scored)*
No Associated Objective: Attestation Requirements	Actions to Limit or Restrict the Compatibility of CEHRT	Required (not scored)*	Required (not scored)*	Required (not scored)*

* Measures and attestations that are required but not scored do not have associated points, but failure to fulfill such requirements will result in a zero score for the MIPS Promoting Interoperability performance category.

(iii) Exclusion Redistribution

Many required measures would have exclusions associated with them as set forth in Table C-G 7. If a MIPS eligible clinician determines an exclusion for a particular measure applies to them, they may claim it when they submit their data. The maximum available points, as shown in Table C-G 7, do not include the points that would be redistributed if a MIPS eligible clinician claims an exclusion for a specific measure. Table C-G 7 sets forth how points would be redistributed among the objectives and measures specified for the MIPS Promoting Interoperability performance category for the CY 2027 performance period/2029 MIPS payment year in the event a MIPS eligible clinician claims an exclusion for a given measure.

TABLE C-G 7: PROPOSED EXCLUSION REDISTRIBUTION FOR CY 2027 PERFORMANCE PERIOD/2029 MIPS PAYMENT YEAR

Objective	Measure	Redistribution if exclusion is claimed
Electronic Prescribing	e-Prescribing	10 points to HIE objective
	Query of PDMP	10 points to e-Prescribing measure
Health Information Exchange (HIE)	Support Electronic Referral Loops by Sending Health Information	15 points to Provide Patients Electronic Access to Their Health Information measure
	Support Electronic Referral Loops by Receiving and Reconciling Health Information	15 points to the Support Electronic Referral Loops by Sending Health Information measure
	-OR-	
	Health Information Exchange Bi-Directional Exchange	No exclusion
	-OR-	
	Enabling Exchange Under TEFCA	No exclusion
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	No exclusion
Public Health and Clinical Data Exchange	Report the following two measures: • Electronic Case Reporting • Immunization Registry Reporting	If an exclusion is claimed for both measures, 25 points are redistributed to the Provide Patients Electronic Access to Their Health Information measure

(iv) ONC Health IT Certification Criteria

Table C-G 8 sets forth the objectives and measures for the MIPS Promoting Interoperability performance category for the CY 2027 performance period/2029 MIPS payment year and the associated ONC health IT certification criteria set forth at 45 CFR 170.315, as is currently applicable. Table C-G 8 also summarizes any changes to the relevant ONC Health IT

certification criteria if the HTI-5 proposals are finalized as proposed. We refer readers to section IV.A.4.d.(4)(b)(ii) of this proposed rule for discussion of and amendments to the definition of CEHRT at § 414.1305.

TABLE C-G 8: MIPS PROMOTING INTEROPERABILITY PERFORMANCE CATEGORY OBJECTIVES AND MEASURES AND ONC HEALTH IT CERTIFICATION CRITERIA

Objective	Measure	Certification Criteria (CY 2027 Performance Period/2029 MIPS Payment Year) in Title 45 of the CFR	ONC Health IT Certification Criteria Changes if HTI-5 Proposals are Finalized as Proposed
Electronic Prescribing	e-Prescribing	§ 170.315(b)(3) Electronic prescribing	No change
	Query of PDMP	§ 170.315(b)(3) Electronic prescribing	No change
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	§ 170.315(b)(1) Transitions of care	Revised
	Support Electronic Referral Loops by Receiving and Reconciling Health Information	§ 170.315(b)(1) Transitions of care	Revised
		§ 170.315(b)(2) Clinical information reconciliation and incorporation	Removed
Health Information Exchange (alternative)	Health Information Exchange Bi-Directional Exchange	Examples of certified health IT capabilities to support the actions of this measure may include but are not limited to technology certified to the following criteria:	
		§ 170.315(b)(1) Transitions of care	Revised
		§ 170.315(b)(2) Clinical information reconciliation and incorporation	Removed
		§ 170.315(g)(7) Application access — patient selection	Removed
		§ 170.315(g)(9) Application access — all data request	Removed
		§ 170.315(g)(10) Standardized API for patient and population services	No change
Health Information Exchange (alternative)	Enabling Exchange Under TEFCA	Examples of certified health IT capabilities to support the actions of this measure may include but are not limited to technology certified to the following criteria:	
		§ 170.315(b)(1) Transitions of care	Revised
		§ 170.315(b)(2) Clinical information reconciliation and incorporation	Removed
		§ 170.315(g)(7) Application access — patient selection	Removed
		§ 170.315(g)(9) Application access — all data request	Removed
		§ 170.315(g)(10) Standardized API for patient and population services	No change
Health Information Exchange	Electronic Prior Authorization*	Certified health IT capabilities that may support the actions of this measure	
		170.315(g)(31) Provider prior authorization API — coverage requirements discovery*	No change

Objective	Measure	Certification Criteria (CY 2027 Performance Period/2029 MIPS Payment Year) in Title 45 of the CFR	ONC Health IT Certification Criteria Changes if HTI-5 Proposals are Finalized as Proposed
		170.315(g)(32) Provider prior authorization API — documentation templates and rules*	No change
		170.315(g)(33) Provider prior authorization API — prior authorization support*	No change
Health Information Exchange	Electronic Prior Authorization for Prescription Drugs**	170.315(b)(3) Electronic prescribing**	No change
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	§ 170.315(e)(1) View, download, and transmit to 3rd party	Revised
		§ 170.315(g)(7) Application access — patient selection	Removed
		§ 170.315(g)(9) Application access — all data request	Removed
		§ 170.315(g)(10) Standardized API for patient and population services	No change
Public Health and Clinical Data Exchange	Immunization Registry Reporting	§ 170.315(f)(1) Transmission to immunization registries	No change
	Syndromic Surveillance Reporting (Optional)	§ 170.315(f)(2) Transmission to public health agencies — syndromic surveillance	No change
	Electronic Case Reporting	§ 170.315(f)(5) Transmission to public health agencies — electronic case reporting	Revised
	Public Health Registry Reporting (Optional)	§ 170.315(f)(4) Transmission to cancer registries	Removed
		§ 170.315(f)(7) Transmission to public health agencies — health care surveys	Removed
	Clinical Data Registry Reporting (Optional)	No ONC health IT certification criteria at this time.	No change
	Public Health Reporting Using TEFCA (Optional)	Examples of certified health IT capabilities to support the actions of this measure may include but are not limited to technology certified to the following criteria:	
		§ 170.315(f)(5) Transmission to public health agencies — electronic case reporting	Revised
Protect Patient Health Information	Security Risk Analysis	The requirements are a part of CEHRT specific to each certification criterion.	
	High Priority Practices SAFER Guide	No ONC health IT certification criteria at this time.	No change

* In sections IV.A.4.d.(4)(f)(v) and IV.A.4.d.(4)(f)(vi) of this proposed rule, we are proposing to make the Electronic Prior Authorization measure an optional bonus measure for the CY 2027 performance period and required, but unscored, starting with the CY 2028 performance period. ** In section IV.A.4.d.(4)(e)(ii) of this proposed rule, we are proposing to adopt a new Electronic Prior Authorization for Prescription Drugs measure for the CY 2028 performance period, which is unscored.

B. MIPS Final Score Methodology

1. Performance Category Scores

a. Background

Sections 1848(q)(1)(A)(i) and (ii) and (5)(A) of the Act provide, in relevant part, that the Secretary shall develop a methodology for assessing the total performance of each MIPS eligible clinician according to certain specified performance standards and, using such methodology, provide for a final score for each MIPS eligible clinician. Section 1848(q)(2)(A)(i) of the Act requires us to use the quality performance category in determining each MIPS eligible clinician's final score, and section 1848(q)(2)(B)(i) of the Act describes the measures and activities that must be specified under the quality performance category. The statute does not specify the number of quality measures on which a MIPS eligible clinician must report, nor does it specify the amount or type of information that a MIPS eligible clinician must report on each quality measure.

In this section, we propose scoring policies that are consistent with the proposed MIPS core measure reporting requirement in section IV.A.4.d.(1)(c)(iii) of this proposed rule. Additionally, we propose policies building on the current scoring policies for topped out quality measures. Moreover, we propose policies to modify the benchmarks for Medicare CQMs and apply flat benchmarks to Medicare eCQMs that are consistent with the proposed Medicare eCQM collection type in section III.G.3.d.(3) of this proposed rule. In this section, we also propose policy to update scoring for the Electronic Prior Authorization measure in the Promoting Interoperability performance category. Lastly, we also include a request for information (RFI) on the future direction of MVP scoring policies. Specifically, we propose to:

- Establish a policy for scoring MIPS core measures;
- Apply the defined topped out benchmark for certain topped out measures for clinicians impacted by limited measure choice;
- Apply the defined topped out benchmark for topped out MIPS core measures;

● Modify the publishing location of topped out measures impacted by limited measure choice and scored according to the defined topped out benchmark;

● Modify the flat benchmarking methodology for the Medicare CQMs collection type;

● Establish a flat benchmarking methodology for the Medicare eCQMs collection type; and

● Modify the Electronic Prior Authorization measure from a required measure to an optional measure under the Promoting Interoperability performance category for the CY 2027 performance period/2029 MIPS payment year.

Additionally, we discuss the impact of the proposed MIPS core measure scoring for small practices and explain that we would apply the historical benchmark if a measure is no longer topped out. We note that the proposed policies for scoring the quality performance category would apply to both traditional MIPS and MVP scoring.

b. Scoring the Quality Performance Category for the Following Collection Types: Medicare Part B Claims Measures, eCQMs, MIPS CQMs, QCDR Measures, the CAHPS for MIPS Survey Measures and Administrative Claims Measures

We refer readers to the CY 2017, CY 2018, and CY 2019 Quality Payment Program final rules, the CY 2020, CY 2021, CY 2022, CY 2023, CY 2024, CY 2025, and CY 2026 PFS final rules (81 FR 77276 through 77308, 82 FR 53716 through 53748, 83 FR 59841 through 59855, 84 FR 63011 through 63018, 85 FR 84898 through 84913, 86 FR 65490 through 65509, 87 FR 70088 through 70091, 88 FR 79368 and 79369, 89 FR 98427 through 98439, and 90 FR 49903 through 49914), and § 414.1380(b)(1) for our current policies regarding, among other things, quality measure benchmarks, calculating total measure achievement points, calculating the quality performance category score, including achievement and improvement points, the small practice bonus, and scoring flexibilities. In the CY 2026 PFS final rule (90 FR 49903 through 49914), we finalized policies for scoring topped out measures impacted by limited measure

choice and the scoring methodology for administrative claims-based quality measures at § 414.1380(b)(1)(i) and (b)(1)(ii)(D).

(1) Proposal for Scoring of MIPS Core Measures

Section 1848(q)(5)(B)(i) of the Act requires the Secretary to treat any MIPS eligible clinician who fails to report on a required measure or activity as achieving the lowest potential score applicable to the measure or activity. In the CY 2017 Quality Payment Program final rule (81 FR 77291), we finalized at § 414.1380(b)(1) that MIPS eligible clinicians receive zero measure achievement points for each measure required under § 414.1335, on which no data is submitted in accordance with § 414.1325. In the CY 2022 PFS final rule (86 FR 65421), we finalized that scoring the required quality measures in an MVP is consistent with traditional MIPS scoring policies described under § 414.1380(b)(1).

In section IV.A.4.d.(1)(c)(iii)(B) of this proposed rule, we propose that MIPS eligible clinicians would need to report a MIPS core measure, as one of their six required quality measures in traditional MIPS or one of their four required quality measures in MVP reporting. The proposed MIPS core measure requirement would replace the existing outcome or high priority measure requirement for clinicians participating in traditional MIPS and MVP reporting. In the same section, we propose an attestation requirement, during data submission, for clinicians who do not have an available and applicable MIPS core measure. Additionally, we propose in that section that the MIPS core measure reporting requirement would not apply to clinicians in small practices. We refer readers to section IV.A.4.d.(1)(c)(iii) of this proposed rule for details on the proposed MIPS core measure reporting requirement, the attestation process, and exemption of small practices from the MIPS core measure reporting requirement. We refer readers to Appendix 1: MIPS Quality Measures of this proposed rule for details on the MIPS core measures inventory for the CY 2027 performance period/2029 MIPS payment year.

Beginning in the CY 2027 performance period/2029 MIPS payment year, for scoring the quality performance category for clinicians that are not part of small practices, we would include

the proposed MIPS core measure as one of the six required quality measures for clinicians participating in traditional MIPS or one of the four required quality measures for clinicians participating in MVP reporting. As discussed in section IV.A.4.d.(1)(c)(iii)(B) of this proposed rule, clinicians who attest to not having an applicable and available MIPS core measure would still need to report enough measures to meet the required number of six quality measures in traditional MIPS or four quality measures in MVP reporting. We would use the highest scoring six or four quality measures, respectively, to determine the quality performance category score. As discussed in section IV.A.4.d.(1)(c)(iii)(B), there may be instances in which a clinician attested to not having an applicable and available MIPS core measure, but new information or changing circumstances later made it so that the clinician does have an applicable and available MIPS core measure to report. To account for these cases, if an attestation is submitted during data submission and a MIPS core measure is also reported, we would score the MIPS core measure as one of the six required quality measures in traditional MIPS reporting or one of the four required quality measures in MVP reporting. If a MIPS eligible clinician submits data for more than one MIPS core measure, we would use the highest scoring MIPS core measure as one of the six or four quality measures, and the remaining scored measures will consist of either the five highest scoring quality measures or the three highest scoring measures, as applicable, in traditional MIPS and MVP reporting.

As discussed in section IV.A.4.d.(1)(c)(iii)(B) of this proposed rule, we propose to remove the current quality measure data submission requirement of one outcome measure (or, if an outcome measure is not available, one high priority measure) for traditional MIPS and MVP reporting and replace the requirement with a MIPS core measure data submission requirement. As discussed in section IV.A.4.d.(1)(c)(i) of this proposed rule, one of the factors considered for the proposed MIPS core measure selection includes an emphasis on whether the measure is an outcome-based measure. We refer readers to section IV.A.4.d.(1)(c)(i) of this proposed rule for additional details on the proposal to designate MIPS core measures. Therefore, we propose to

assign zero measure achievement points for one quality measure if clinicians reporting traditional MIPS or MVP do not submit a MIPS core measure and do not attest during data submission that they do not have an available and applicable MIPS core measure. This proposal is consistent with the existing rule under § 414.1380(b)(1)(i). Under the existing policy under § 414.1380(b)(1)(i), MIPS eligible clinicians who submit data in accordance with § 414.1325 on a greater number of measures than required under § 414.1335 are scored only on the measures with the greatest number of measure achievement points. Therefore, we are not proposing any changes to the regulatory text for this proposal.

We request public comment on this proposal.

(2) Small Practice Scoring Exemption Clarification for MIPS Core Measures

Historically, we have heard from clinicians in small practices that they face unique challenges to successfully participate in MIPS. To further support clinicians in small practices, who often have limited resources to successfully participate in MIPS, we implemented policies to provide them with more flexibilities. For example, as described under § 414.1380(b)(1)(v)(C), beginning with the CY 2019 performance period/2021 MIPS payment year, MIPS eligible clinicians in small practices receive 6 measure bonus points if they submit data to MIPS on at least 1 quality measure. To continue the existing flexibilities and further support clinicians in small practices, we propose in section IV.A.4.d.(1)(c)(iii)(C) of this proposed rule that small practice clinicians participating in both traditional MIPS and MVP reporting would be exempt from the MIPS core measure reporting requirement. Under this proposal, clinicians in small practices are not required to submit MIPS core measures and would not need to attest during data submission if they do not have an available and applicable MIPS core measure. The existing regulation text under § 414.1380(b)(1)(i) states that MIPS eligible clinicians receive zero measure achievement points for each measure required under § 414.1335 for which no data is submitted in accordance with § 414.1325. Consistent with the existing regulation at § 414.1380(b)(1)(i) and given the proposal to exempt small practices from the MIPS core measure

requirement in section IV.A.4.d.(1)(c)(iii)(C) of this proposed rule, we would not assign zero measure achievement points for one MIPS core measure if clinicians in small practices do not submit data for such measure in traditional MIPS and MVP reporting. If a small practice chooses to submit data on a MIPS core measure, we would include the core measure in the quality performance category score only if the MIPS core measure is one of the six highest scoring measures in traditional MIPS or one of the four highest scoring measures in MVP reporting, in accordance with the existing regulation under §414.1380(b)(1)(i). We refer readers to Appendix 1: MIPS Quality Measures of this proposed rule for details on the proposed MIPS core measures inventory for the CY 2027 performance period/2029 MIPS payment year.

(3) Scoring Topped Out Measures

(a) Background on Scoring Topped Out Measures

We refer readers to the CY 2017, CY 2018, and CY 2019 Quality Payment Program final rules (81 FR 77282 through 77287, 82 FR 53721 through 53727), the CY 2023, CY 2025, and CY 2026 PFS final rules (83 FR 59761 through 59765, 88 FR 70090 and 70091, 89 FR 98428 through 98435, and 90 FR 49902 through 49908), and § 414.1380(b)(1)(iv) for established topped out measure scoring policies.

Topped out measures are measures for which measure performance is considered so high and unvarying that meaningful distinctions and improvements in performance can no longer be made (81 FR 77136). Section 1848(q)(3)(B) of the Act requires that in establishing performance standards with respect to measures and activities, we consider, among other things, the opportunity for continued improvement. Topped out measures do not provide an opportunity for continued improvement, nor do payment adjustments based on topped out measures incentivize clinicians to improve their care. As a result, we finalized policies in the CY 2018 Quality Payment Program final rule (82 FR 53723 through 53727) to identify and cap the scoring potential of topped out measures. Additionally, we established policies for the removal of topped out measures, such as establishing the topped out measure lifecycle, to continue to drive quality

improvement in areas where such improvement is possible and necessary. The topped out measure lifecycle is described in the CY 2018 Quality Payment Program final rule (82 FR 53721 through 53727). We established at § 414.1380(b)(1)(iv)(B) that we will cap scoring for topped out measures at seven measure achievement points in the second consecutive year that the measure benchmark is identified as topped out. If a measure has been identified as topped out for three consecutive years after being originally identified through the benchmarks, such measure may then be proposed for removal through notice-and-comment rulemaking (83 FR 59761). This timeline, however, is not fixed. We noted our concern that removal of topped out measures may leave clinicians with fewer than six applicable measures to report and that such removal in those instances will impact some specialties more than others (82 FR 53721). We stated that consideration for ensuring available applicable measures would be made when considering measure removals (83 FR 59763).

In the CY 2018 Quality Payment Program final rule (82 FR 53727), we established the topped out scoring cap to encourage MIPS eligible clinicians to submit measures that are not topped out. However, we created an exemption to this policy in the CY 2025 PFS final rule (89 FR 98428 through 98435) for certain topped out measures that are frequently used by certain specialties impacted by limited measure choice (89 FR 98428 through 98435). To address scoring scenarios in which limited measure choice compels clinicians to report topped out measures with scoring caps, we finalized in the CY 2025 PFS final rule (89 FR 98428 through 98435) at § 414.1380(b)(1)(iv)(C) that beginning with the CY 2025 performance period/2027 MIPS payment year, topped out measures frequently used by certain specialties reporting specialty measure sets that are impacted by limited measure choice, as specified in accordance with § 414.1380(b)(1)(ii)(E), are not subject to the 7-point scoring cap. In the CY 2025 PFS final rule, we finalized at § 414.1380(b)(1)(ii)(E) that beginning with the CY 2025 performance period/2027 MIPS payment year, we will annually publish a list in the **Federal Register** of topped out measures determined to be impacted by limited measure choice. Measures included in

the list are scored from 1 to 10 measure achievement points according to defined topped out measure benchmarks calculated from performance data in the baseline period, in which a performance rate of 97 percent corresponds to 10 percent of the performance threshold for the corresponding performance year.

In the CY 2026 PFS final rule (90 FR 49904 through 49908), we modified our approach for identifying the list of measures impacted by limited measure choice and subject to defined topped out measure benchmarks. We finalized that each specialty measure set and MVP is reviewed by collection type to identify if the prevalence of topped out measures within such a set of measures hinders a clinician's ability to successfully participate in the MIPS quality performance category. To make such a determination, we finalized a policy stating that we will analyze the ability of clinicians reporting the specialty measure sets and MVPs to reasonably achieve 75 percent of available quality achievement points based upon the measures available to them and program requirements. Specifically, at the collection type level, each measure is assigned points based upon the current benchmarking data: new measures receive 7 or 5 points based on year in the program, measures with benchmarks are given points based upon the highest decile achievable with a less than perfect score (less than 100 percent or greater than 0 percent for inverse measures), and measures with no available historic benchmark are given 0 points. All measure set points are added together to get an output of scoring potential; the Medicare Part B claims collection type measure sets have an additional 6 points added to the output to account for the small practice bonus. The sum of quality achievement points for each specialty measure set and MVP are then compared to the analysis threshold of 75 percent of available quality achievement points, based on the number of available measures. Any specialty measure sets or MVPs that are unable to meet or exceed the analysis threshold are flagged as “at-risk.” Additional factors that we take into consideration include whether the topped out measure is considered a cross-cutting measure or is a broadly applicable measure, which we consider to be a measure included in three or more specialty sets or MVPs. We also consider whether the

specialty measure set or MVP contains more than ten measures, by collection type (90 FR 49904 through 49908).

(b) Proposal of Measures Impacted by Limited Measure Choice to be Subject to Defined Topped Out Benchmark for the CY 2027 Performance Period/2029 MIPS Payment Year

Table C-H1 of this proposed rule contains the list of measures that meet the criteria for topped out measures impacted by limited measure choice in specialty measure sets and MVPs as finalized in the CY 2026 PFS final rule (90 FR 49904 through 49908), and for which we are proposing to apply the defined topped out measure benchmark for the CY 2027 performance period/2029 MIPS payment year.

TABLE C-H1: PROPOSED TOPPED OUT MEASURES IMPACTED BY LIMITED MEASURE CHOICE AND SUBJECT TO DEFINED TOPPED OUT MEASURE BENCHMARKS FOR THE CY 2027 PERFORMANCE PERIOD/2029 MIPS PAYMENT YEAR

Measure ID	Collection Type	Measure Title
127	MIPS CQM	Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention - Evaluation of Footwear
144	MIPS CQM	Oncology: Medical and Radiation - Plan of Care for Pain
145	Medicare Part B Claims, MIPS CQM	Radiology: Exposure Dose Indices Reported for Procedures Using Fluoroscopy
249	Medicare Part B Claims, MIPS CQM	Barrett's Esophagus
250	Medicare Part B Claims, MIPS CQM	Radical Prostatectomy Pathology Reporting
351	MIPS CQM	Total Knee or Hip Replacement: Venous Thromboembolic and Cardiovascular Risk Evaluation
360	MIPS CQM	Optimizing Patient Exposure to Ionizing Radiation: Count of Potential High Dose Radiation Imaging Studies: Computed Tomography (CT) and Cardiac Nuclear Medicine Studies
364	MIPS CQM	Optimizing Patient Exposure to Ionizing Radiation: Appropriateness: Follow-up CT Imaging for Incidentally Detected Pulmonary Nodules According to Recommended Guidelines
395	Medicare Part B Claims, MIPS CQM	Lung Cancer Reporting (Biopsy/Cytology Specimens)
396	MIPS CQM	Lung Cancer Reporting (Resection Specimens)
397	Medicare Part B Claims, MIPS CQM	Melanoma Reporting
405	MIPS CQM	Appropriate Follow-up Imaging for Incidental Abdominal Lesions
406	Medicare Part B Claims, MIPS CQM	Appropriate Follow-up Imaging for Incidental Thyroid Nodules in Patients
430	MIPS CQM	Prevention of Post-Operative Nausea and Vomiting (PONV) - Combination Therapy
440	MIPS CQM	Skin Cancer: Biopsy Reporting Time - Pathologist to Clinician
463	MIPS CQM	Prevention of Post-Operative Vomiting (POV) - Combination Therapy (Pediatrics)
477	MIPS CQM	Multimodal Pain Management

We had considered proposing measures 143: Oncology: Medical and Radiation - Pain Intensity Quantified (eCQM and MIPS CQM), 320: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patient (Medicare Part B Claims and MIPS CQM), and 350: Total Knee or Hip Replacement: Shared Decision-Making: Trial of Conservative (Non-surgical)

Therapy (MIPS CQM) to be subject to the defined topped out measure benchmark for the CY 2027 performance period/2029 MIPS payment year since the measures meet the criteria for topped out measures in specialty measure sets or MVPs impacted by limited measure choice according to the methodology finalized in the CY 2026 PFS final rule (90 FR 49904 through 49908). However, we are not proposing these measures for the defined topped out measure benchmark for the CY 2027 performance period/2029 MIPS payment year because we are proposing to remove these measures from the quality performance category measure inventory for the CY 2027 performance period/2029 MIPS payment year in section IV.A.4.d.(1)(e)(ii) of this proposed rule. We propose that if we do not finalize the removal of these measures from the MIPS quality performance category inventory for the CY 2027 performance period/2029 MIPS payment year, we would score these measures with the defined topped out measure benchmark for the CY 2027 performance period/2029 MIPS payment year.

We request public comment on this proposal.

(c) Proposal to Score Topped Out MIPS Core Measures According to Defined Topped Out Benchmark

In section IV.A.4.d.(1)(c)(iii)(B) of this proposed rule, we are proposing that MIPS eligible clinicians would need to report a MIPS core measure as one of their six required quality measures in traditional MIPS or one of their four required quality measures in MVP reporting, beginning in the CY 2027 performance period/2029 MIPS payment year. We refer readers to Appendix 1: MIPS Quality Measures of this proposed rule for the proposed MIPS core measure inventory. There are 19 proposed MIPS core measures that are topped out and subject to the 7-point topped out measure scoring cap for the CY 2026 performance period/2028 MIPS payment year. As described in section IV.B.1.b.(3)(a) of this proposed rule, to address scoring scenarios in which limited measure choice compels clinicians to report topped out measures with scoring caps, we finalized the defined topped out benchmark in the CY 2025 PFS final rule (89 FR 98428 through 98435). The defined topped out benchmark removes the 7-point scoring cap for

topped out measures and scores them from 1 to 10 measure achievement points according to a benchmark calculated from performance data in the baseline period in which a performance rate of 97 percent corresponds to 10 percent of the performance threshold for the corresponding performance year.

The prevalence of topped out MIPS core measures, combined with the limited measure choice associated with MIPS core measures, could result in a clinician being compelled to report a topped out MIPS core measure as one of their six required quality measures in traditional MIPS or one of their four required quality measures in MVP reporting. Given the combination of limited measure choice and the 7-point scoring cap for topped out measures, we are concerned that the application of the 7-point scoring cap to topped out MIPS core measures would penalize clinicians for complying with the proposed reporting requirement. Therefore, we are proposing that MIPS core measures in their second or more consecutive year of being topped out would not be subject to the 7-point topped out measure scoring cap, and instead the measures would be scored from 1 to 10 measure achievement points according to the defined topped out benchmark.

Subsequently, we are proposing to create the scoring methodology for MIPS core measures that are topped out. Thus, we are proposing to amend and codify at § 414.1380(b)(1)(ii) by establishing a new provision at § 414.1380(b)(1)(ii)(H), which would establish the scoring (1 to 10 measure achievement points) for MIPS core measures that have benchmarks identified as topped out for 2 or more consecutive years. Specifically, we are proposing to establish and codify at § 414.1380(b)(1)(ii)(H), which would determine the following: Beginning in the CY 2027 performance period/2029 MIPS payment year, MIPS core measures, which are required under § 414.1335(a)(1)(i) and (ii), for which the benchmark for the applicable collection type is identified as topped out for 2 or more consecutive years, are scored from 1 to 10 measure achievement points according to defined topped out measure benchmarks calculated from performance data in the baseline period in which a performance rate of 97 percent corresponds to 10 percent of the performance threshold for the corresponding

performance year. Also, we are proposing for MIPS core measures not to be subject to the 7-point topped out measure scoring cap. Specifically, we are proposing to amend and codify at § 414.1380(b)(1)(iv) by establishing a new provision at § 414.1380(b)(1)(iv)(D), which would determine the following: Beginning with the CY 2027 performance period/2029 MIPS payment year, MIPS core measures, which are required under § 414.1335(a)(1)(i) and (ii), are not subject to the 7 measure achievement point cap specified at § 414.1380(b)(1)(iv)(B).

We request public comment on this proposal.

(d) Clarification Regarding Scoring Non-Topped Out Measures According to Historical Benchmark

In the CY 2025 PFS final rule (89 FR 98428 through 98435), we finalized at § 414.1380(b)(1)(ii)(E) that beginning with the CY 2025 performance period/2027 MIPS payment year, CMS will publish a list in the **Federal Register** of topped out measures determined to be impacted by limited measure choice on an annual basis. Measures included in the list will be scored from 1 to 10 measure achievement points according to defined topped out measure benchmarks calculated from performance data in the baseline period in which a performance rate of 97 percent corresponds to 10 percent of the performance threshold for the corresponding performance year. The measures are identified using a methodology finalized in the CY 2026 PFS final rule (90 FR 49904 through 49908), which analyzes whether the prevalence of topped out measures within a specialty measure set or an MVP hinders a clinician's ability to successfully participate in the MIPS quality performance category. Using current benchmarking data, the analysis evaluates the ability of clinicians to reasonably achieve 75 percent of available quality achievement points given the measures available to them and program requirements.

At the time of the internal analysis to inform the list of measures impacted by limited measure choice, the most current benchmarking data is for the performance period prior to that which the defined topped out measure benchmark would be applied. For example, we analyzed

CY 2026 benchmarks to inform the list of measures impacted by limited measure choice for the CY 2027 performance period/2029 MIPS payment year. Therefore, there are instances in which a measure is finalized to be scored according to the defined topped out benchmark for a given performance period, but it is later determined that the historic baseline period benchmark for that measure is not topped out for that performance period. This was the case for Medicare Part B Claims Measure 141: Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 20% OR Documentation of a Plan of Care for the CY 2026 performance period/2028 MIPS payment year. In the CY 2026 PFS final rule (90 FR 49906 through 49908), we finalized Medicare Part B Claims Measure 141 to be scored according to the defined topped out measure benchmark for the CY 2026 performance period/2028 MIPS payment year based on an analysis of the CY 2025 performance period/2027 MIPS payment year benchmarks, the most recently available benchmarks at the time of the analysis. However, the subsequently released benchmarks for the CY 2026 performance period/2028 MIPS payment year indicated that the baseline period benchmark for Medicare Part B Claims Measure 141 was not topped out. Given the topped out measure lifecycle, as finalized in the CY 2018 Quality Payment Program final rule (82 FR 53721 through 53727), Medicare Part B Claims Measure 141 would not be capped at 7 measure achievement points for the CY 2026 performance period/2028 MIPS payment year since it was not topped out.

If a measure is not topped out, it no longer meets the criteria for the removal of the 7 measure achievement point cap. We clarify that if a measure previously finalized for removing the 7-point cap is no longer topped out, it would be scored using its historical benchmark instead of the topped-out measure benchmark.

(e) Proposal to Modify Location for Publishing List of Measures Subject to Defined Topped Out Benchmark

In the CY 2025 PFS final rule (89 FR 98428 through 98435), we finalized at § 414.1380(b)(1)(ii)(E) to state that beginning with the CY 2025 performance period/2027 MIPS

payment year, CMS will publish a list in the **Federal Register** of topped out measures determined to be impacted by limited measure choice on a yearly basis. Measures included in the list are scored from 1 to 10 measure achievement points according to defined topped out measure benchmarks calculated from performance data in the baseline period in which a performance rate of 97 percent corresponds to 10 percent of the performance threshold for the corresponding performance year. In the CY 2026 PFS final rule (90 FR 49904 through 49908), we finalized the methodology to identify topped out measures impacted by limited measure choice. We analyze whether the prevalence of topped out measures with a 7-point cap within a specialty measure set or an MVP hinders a clinician's ability to successfully participate in the MIPS quality performance category. This analysis is based on the most current benchmarking data available at that time. We finalized in the CY 2018 Quality Payment Program final rule that MIPS eligible clinicians will know the quality performance category measure benchmarks in advance of the performance period, when possible (81 FR 77271 and 77272), and that the benchmarks will be posted on the Quality Payment Program website (81 FR 77139).

Given the benchmark availability timeline, the list of topped out measures scored from 1 to 10 measure achievement points according to the defined topped out measure benchmark published in the **Federal Register** for a performance period may not accurately indicate whether a measure is topped out for that performance period. For example, as discussed in section IV.B.1.b.(3)(d) of this proposed rule, a measure previously determined to be topped out and scored from 1 to 10 points for the CY 2026 performance period/2028 MIPS payment year based on data using the CY 2025 performance period benchmarks was later found not to be topped out based on the updated CY 2026 benchmarks.. This occurs because, during the time of the analysis to identify measures impacted by limited measure choice, only the most recent benchmarks s from the prior performance period are available. For example, we analyzed CY 2026 performance period benchmarks to inform topped out measures impacted by limited measure choice for the CY 2027 performance period/2029 MIPS payment year.

We are concerned that publishing the list of topped out measures impacted by limited measure choice and scored from 1 to 10 measure achievement points according to the defined topped out measure benchmark in the **Federal Register**, prior to the benchmark information for that performance period being available, can lead to confusion. To avoid confusion for clinicians, we are proposing that, beginning in the CY 2027 performance period/2029 MIPS payment year, we would publish the list of topped out measures impacted by limited measure choice and scored from 1 to 10 measure achievement points according to the defined topped out measure benchmark annually on the Quality Payment Program website at https://qpp.cms.gov. Specifically, we are proposing to remove the phrase "in the Federal Register" under § 414.1380(b)(1)(ii)(E).

Further, we note that the measures included in this list would still be identified using the previously finalized methodology for determining topped out measures impacted by limited measure choice in specialty measure sets and MVPs, as finalized in the CY 2026 PFS final rule (90 FR 49904 through 49908). By publishing the list of topped out measures impacted by limited measure choice on the Quality Payment Program website, we would be able to update the list, once the benchmark information for that performance period becomes available, to remove measures that are not topped out for that performance period, consistent with the topped out measure lifecycle, finalized in the CY 2018 Quality Payment Program final rule (82 FR 53721 through 53727). We refer readers to section IV.B.1.b.(3)(d) of this proposed rule for our discussion that measures previously finalized to be scored using the defined topped out benchmark would instead be scored using the baseline period benchmark if updated benchmark data show the measure is not topped out for that performance period.

We would publish the list of topped out measures impacted by limited measure choice and scored from 1 to 10 measure achievement points according to the defined topped out measure benchmark on the Quality Payment Program website no later than the publication of the proposed rule for that CY performance period/MIPS payment year. This timeline would provide

interested parties with sufficient opportunity to review and provide comments on the list of measures during the public comment period for that proposed rule. Once the list of topped out measures impacted by limited measure choice and scored from 1 to 10 measure achievement points according to the defined topped out measure benchmark is finalized during rulemaking, the only changes to the list would be the removal of a measure because it is no longer topped out based on most current benchmarks published in the performance period.

Thus, we are proposing to amend § 414.1380(b)(1)(ii)(E) by removing the phrase "in the **Federal Register**". Also, we are proposing a technical amendment in § 414.1380(b)(1)(ii)(E) for grammar purposes, which would modify the beginning of the second sentence in § 414.1380(b)(1)(ii)(E) from "...measure included in the list…" to "measure included on the list…". The revised § 414.1380(b)(1)(ii)(E) would state: Beginning with the CY 2025 performance period/2027 MIPS payment year, CMS will publish a list of topped out measures determined to be impacted by limited measure choice on a yearly basis. Measures included on the list are scored from 1 to 10 measure achievement points according to defined topped out measure benchmarks calculated from performance data in the baseline period in which a performance rate of 97 percent corresponds to 10 percent of the performance threshold for the corresponding performance year.

We request public comment on these proposals.

c. Scoring the Quality Performance Category for Medicare Shared Savings Program ACOs

(1) Proposal to Use Flat Benchmarks to Score Medicare Shared Savings Program ACOs Reporting Medicare CQMs

In the CY 2025 PFS final rule (89 FR 98117), we finalized our proposal to establish new benchmarks for scoring Medicare Shared Savings Program ACOs on the Medicare CQMs under MIPS in alignment with MIPS benchmarking policies. As historical Medicare CQM data would not be available, we finalized that for performance years 2024 and 2025, we will score Medicare CQMs using performance period benchmarks. We also finalized that, for performance year 2026

and subsequent performance years, when baseline period data are available to establish historical benchmarks in a manner that is consistent with the MIPS benchmarking policies at § 414.1380(b)(1)(ii), we would score Medicare CQMs using historical benchmarks. In the CY 2025 PFS final rule, we also finalized our proposal to add § 414.1380(b)(1)(ii)(F) to state that beginning in the CY 2025 performance period/2027 MIPS payment year, measures of the Medicare CQM collection type would be scored using flat benchmarks for their first two performance periods in MIPS (89 FR 98120).

As described in section III.G.3.c. of this proposed rule, we are proposing to modify § 414.1380(b)(1)(ii)(F) by removing the applicability of the first two performance periods to the use of flat benchmarks and extending the use of flat benchmarks to score all Medicare CQMs for performance year 2025 and subsequent performance years. Also, we are proposing to retroactively apply flat benchmarks to Quality IDs 001 (Diabetes: Glycemic Status Assessment Greater Than 9%), 134 (Preventive Care and Screening: Screening for Depression and Follow-up Plan), and 236 (Controlling High Blood Pressure), if reported via the Medicare CQMs collection type for performance year 2026.

Specifically, we are proposing to amend and codify at § 414.1380(b)(1)(ii)(F), by converting such section to a title section entitled "Medicare CQMs collection type benchmarks" and establishing § 414.1380(b)(1)(ii)(F)(*1*) and (*2*). In § 414.1380(b)(1)(ii)(F)(*1*), we are proposing that for the CY 2025 performance period/2027 MIPS payment year, measures of the Medicare CQMs collection type would utilize flat benchmarks for their first two performance periods in MIPS. In § 414.1380(b)(1)(ii)(F)(*2*), we are proposing to retroactively apply the utilization of flat benchmarks for the Medicare CQMs collection type beginning with the CY 2026 performance period/2028 MIPS payment year. Specifically, we are proposing that beginning with the CY 2026 performance period/2028 MIPS payment year, measures of the Medicare CQMs collection type would utilize flat benchmarks. We refer readers to section III.G.3.c. of this proposed rule for further discussion regarding the extension of applying the

utilization of flat benchmarks for the Medicare CQMs collection type, including discussion about the retroactive use of flat benchmarks for the Medicare CQMs collection type in the CY 2026 performance period/2028 MIPS payment year.

We request public comment on these proposals.

(2) Proposal to Use Flat Benchmarks to Score Medicare Shared Savings Program ACOs Reporting Medicare eCQMs

As described in section III.G.3.d.(3) of this proposed rule, we are proposing to develop a policy that establishes the utilization of flat benchmarks for measures of the newly proposed Medicare eCQMs collection type reported by Medicare Shared Savings Program ACOs. As a result, Medicare eCQMs would be scored using flat benchmarks beginning with the 2027 performance period. To effectuate such proposal under MIPS for purposes of assessing and scoring performance for the quality performance category, we are proposing to add § 414.1380(b)(1)(ii)(G) to establish a new provision specific to benchmarks for measures of the Medicare eCQMs collection type, entitled "Medicare eCQMs collection type benchmarks." Subsequently, we are proposing to add § 414.1380(b)(1)(ii)(G)(1), which establishes the utilization of flat benchmarks under the Medicare eCQMs collection benchmarks provision established at § 414.1380(b)(1)(ii)(G). Specifically, we are proposing in § 414.1380(b)(1)(ii)(G)(1) to establish that beginning with the CY 2027 performance period/2029 MIPS payment year, measures of the Medicare eCQMs collection type would utilize flat benchmarks.

We request public comment on this proposal.

d. Scoring the Promoting Interoperability Performance Category

Proposal to Modify the Scoring of the Electronic Prior Authorization Measure for CY 2027 Performance Period/2029 MIPS Payment Year

In section IV.A.4.d.(4)(f)(ii) of this proposed rule, we are proposing to modify the Electronic Prior Authorization measure by changing the measure from a required measure to an

optional measure and eligible for 10 bonus points when MIPS eligible clinicians affirmatively attest ("Yes" response) to meeting the requirements of the measure for the CY 2027 performance period/2029 MIPS payment year. We believe that the allocation of 10 bonus points is an appropriate and effective incentive to promote the adoption and use of certified technology for requesting electronic prior authorizations among MIPS eligible clinicians. To account for the allocation of bonus points specific to the Electronic Prior Authorization measure for the CY 2027 performance period/2029 MIPS payment year, the scoring methodology for optional measures available for bonus points needs to be amended.

In § 414.1380(b)(4)(ii)(C)(3), the optional measures available for reporting are not identified or categorized by objective; however, the applicable optional measures available in the MIPS Promoting Interoperability performance category as of the CY 2026 performance period (Syndromic Surveillance Reporting, Public Health Registry Reporting, Clinical Data Registry Reporting, and Public Health Reporting Using TEFCA) are all under the Public Health and Clinical Data Exchange objective. When reporting one, more than one, or all such optional measures, the total number of bonus points that could be earned is five bonus points. To distinguish between such optional measures that are available under the Public Health and Clinical Data Exchange objective and the Electronic Prior Authorization measure as an optional measure for the CY 2027 performance period/2029 MIPS payment year that is under the Health Information Exchange objective and has an allocation of 10 bonus points, we are proposing to modify the scoring methodology to account for the optional measures available under each applicable objective within the MIPS Promoting Interoperability performance category.

We are proposing to modify the scoring methodology for optional measures to reflect an allocation of a total of five bonus points when reporting one, more than one, or all optional measures (Syndromic Surveillance Reporting, Public Health Registry Reporting, Clinical Data Registry Reporting, and Public Health Reporting Using TEFCA) available under the Public Health and Clinical Data Exchange objective bonus and an allocation of a total of 10 bonus

points when reporting the optional Electronic Prior Authorization measure for the CY 2027 performance period/2029 MIPS payment year available under the Health Information Exchange objective.

Thus, we are proposing to amend § 414.1380(b)(4)(ii)(C)(*3*) by modifying the provision to identify the MIPS Promoting Interoperability performance category objective, specifically the Public Health and Clinical Data Exchange objective, in which the applicable optional measures are available to earn a total of five bonus points when reporting one, more than one, or all optional measures. Specifically, we are proposing to amend § 414.1380(b)(4)(ii)(C)(*3*) by modifying the provision to indicate that the total number of bonus points available to be earned when reporting one optional measure, more than one optional measure, or all optional measures under the Public Health and Clinical Data Exchange objective is a total of five bonus points beginning with the CY 2026 performance period/2028 MIPS payment year. Additionally, we are proposing to establish a new provision at § 414.1380(b)(4)(ii)(C)(*4*) to account for the Electronic Prior Authorization measure being an optional measure under the Health Information Exchange objective and having an allocation of a total of 10 bonus points for the CY 2027 performance period/2029 MIPS payment year. Specifically, we are proposing to establish § 414.1380(b)(4)(ii)(C)(*4*), which would determine that the total number of bonus points available to be earned when reporting the Electronic Prior Authorization optional measure is a total of 10 bonus points for the CY 2027 performance period/2029 MIPS payment year. The establishment of such provision (only applicable to the CY 2027 performance period/2029 MIPS payment year) would enable a MIPS eligible clinician to earn 10 bonus points for affirmatively attesting that they requested a prior authorization electronically using CEHRT to send a request through a payer's Prior Authorization API for at least one medical item or service (excluding drugs) ordered within the CY 2027 performance period/2029 MIPS payment year.

We request public comment on this proposal.

e. MVP Scoring Request for Information

As discussed in section IV.A.3.c. of this proposed rule, we are proposing to move to full implementation of MVP reporting beginning in the CY 2029 performance year/2031 MIPS payment year. As a part of the transition to full MVP implementation, we intend to examine current MVP scoring policies to align with full MVP reporting. For example, we could consider scoring approaches that allow us to more fairly compare performance of clinicians within the same MVP. MVPs focus on measures that are relevant to a given specialty and offer clinicians with meaningful groupings of measures and activities that relate to a specialty or medical condition. Reporting from these smaller, more aligned sets of quality and cost measures, improvement activities, and foundational layer of Promoting Interoperability measures and population health measures allows for performance measurement that more closely compares clinicians within the same specialty and provides connected assessment of quality of care.

In the CY 2022 PFS final rule (86 FR 65419 through 65427), we finalized policies for MVP scoring at § 414.1365(d). We noted that unless there was a compelling reason to adopt a different scoring policy to further the goals of the MVP framework, we generally applied the traditional MIPS scoring policies to MVPs to reduce complexity as clinicians transition to reporting MVPs.

In the CY 2025 PFS proposed rule, we issued an RFI on how we can achieve full MVP implementation as we move toward the sunsetting of traditional MIPS (89 FR 62011 through 62016). In response to that RFI, we received feedback from interested parties regarding the scoring of MVPs. Commenters discussed scoring fairness within MVP reporting and across MVPs. Specifically, commenters shared concerns about the availability of measures in an MVP, having topped out measures with a 7-point cap, and reporting Class 2 measures that cannot be scored based on performance due to the lack of a benchmark or failure to meet the case minimum.

We recognize that MVP performance data is currently limited as we have data from only the CY 2023 through 2025 performance periods/2025 through 2027 MIPS payment years and

MVP participation remains nascent in the early years. Hence, a small number of MIPS eligible clinicians voluntarily reported MVPs during those three performance periods. While additional data will be needed to confirm any findings, we are assessing whether an MVP score normalization is needed within an MVP to ensure scoring fairness across MVPs. We are also considering the timing for implementing a new MVP scoring methodology: beginning with the CY 2029 performance period/2031 MIPS payment year, consistent with the proposed timeline for full MVP implementation described in section IV.A.3.c. of this proposed rule, or whether an earlier pilot rollout would be appropriate to give clinicians experience with the new scoring approach while traditional MIPS reporting is available. We request feedback on when a potential change to MVP scoring should be implemented.

As we move toward the full implementation of MVPs in the CY 2029 performance period/2031 MIPS payment year, we are exploring scoring policies that consider commenter feedback and align with the intended goals of MVPs. Specifically, we are exploring an MVP scoring methodology and policies to fairly evaluate and reward MVP participants for delivering high-quality and low-cost care by comparing clinician performance to others reporting the same MVP. As we consider policy options for MVP scoring, we are seeking comments on the following questions to further discussion and considerations for the future of MVP scoring.

- We are seeking feedback on a scoring methodology that would help us ensure appropriate comparisons between clinicians participating in different MVPs, with each MVP focusing on measures and activities that are relevant to a given specialty or medical condition.

++ Prior to MIPS payment adjustment determination, should we consider normalizing scores, such that MIPS eligible clinicians reporting a given MVP would have their scores compared to other MIPS eligible clinicians reporting the same MVP? If so, should normalization occur at the final score level or at a performance category level? If at a performance category level, which performance category(ies) should be normalized?

++ For example, should we consider normalizing performance category or final scores using a methodology similar to the current standard-deviation based benchmark methodology used to score cost and administrative claims-based quality measures. Current cost and administrative claims-based quality measures use performance period standard deviation, median, and an anchored point value that is derived from the performance threshold.

++ How would a new scoring approach of normalizing final scores influence provider behaviors?

++ How would a new scoring approach of normalizing performance category scores influence provider behaviors?

++ Should we normalize scores within each MVP to result in similar distributions of scores across MVPs? We anticipate doing so would change scores based on a clinician's relative performance within their MVP. Would this approach justify the interest of scoring fairness across MVPs while impacting final scores and payment adjustments?

- We are also soliciting feedback on any additional scoring methodologies or approaches we should consider to ensure fairness within and across MVPs.

- While we are considering scoring fairness within and across specialty-based MVPs as a primary goal for the future of MVP scoring, we are also interested in other goals to consider.

++ For example, should we consider whether MVP scoring policies provide more meaningful rewards for the high performing clinicians via larger positive payment adjustments?

++ Given that MIPS is a budget-neutral program, would an increase in rewards for high performers warrant the trade-off of having more clinicians receiving negative payment adjustments?

++ Some scoring approaches may increase scoring fairness within and across MVPs while it may also reduce a clinician's ability to predict their performance category or final score. However, clinicians and practices still have access to the benchmarks used for normalization in

the prior year. How could we better support scoring transparency and predictability as a key consideration for the future of MVP scoring?

- If we move forward with proposing a scoring normalization for MVPs in future rulemaking, what resource materials would be most helpful to understand and navigate new MVP scoring policies?

Please note, this is an RFI only. In accordance with the implementing regulations of the Paperwork Reduction Act of 1995 (PRA), specifically 5 CFR 1320.3(h)(4), this general solicitation is exempt from the PRA. Facts or opinions submitted in response to general solicitations of comments from the public, published in the **Federal Register** or other publications, regardless of the form or format thereof, provided that no person is required to supply specific information pertaining to the commenter, other than that necessary for self-identification, as a condition of the agency's full consideration, are not generally considered information collections and therefore not subject to the PRA.

f. Proposed Improvement Activities scoring for APMs

In the CY 2017 Quality Payment Program final rule (81 FR 77008 through 77012), we established policies for scoring the improvement activities performance category, including criteria for weighting and attestation. In that same rule, we also established special scoring provisions for MIPS eligible clinicians participating in Alternative Payment Models (APMs), recognizing that such clinicians are often already engaged in activities aligned with MIPS improvement activities through their APM participation. Specifically, we finalized a policy under § 414.1380(b)(3)(i) to assign a minimum score for the improvement activities performance category for MIPS eligible clinicians participating in APMs (81 FR 77096). We explained that this approach was intended to reduce reporting burden while acknowledging that APM participants are typically undertaking practice improvement efforts consistent with the goals of the improvement activities performance category.

We have maintained this policy in subsequent rulemaking, specifically the CY 2021 PFS

final rule (85 FR 84472), we attempted to ensure that scoring this category did not inadvertently harm participants. However, in doing so we introduced scenarios where IA scores for some APM participants would not be awarded credit as established in section 1848(q) of the Act.

We are proposing to revise § 414.1380(b)(3)(i) to clarify and maintain that, for MIPS eligible clinicians participating in APMs, the improvement activities performance category score is at least 50 percent. This revision is consistent with the policy we established in the CY 2017 Quality Payment Program.

We request public comment on this proposal.

H. Third Party Intermediaries General Requirements

1. Background

We refer readers to 42 CFR 414.1305,414.1400, the CY 2017 Quality Payment Program final rule (81 FR 77362 through 77390), the CY 2018 Quality Payment Program final rule (82 FR 53806 through 53819), the CY 2019 PFS final rule (83 FR 59894 through 59910), the CY 2020 PFS final rule (84 FR 63049 through 63080), the May 8th COVID–19 IFC (85 FR 27594 and 27595), the CY 2021 PFS final rule (85 FR 84926 through 84947), the CY 2022 PFS final rule (86 FR 65538 through 65550), CY 2023 PFS final rule (87 70102 FR through 70109), the CY 2024 PFS final rule (88 FR 79381 through 79394), the CY 2025 PFS final rule (89 FR 98459), and the CY 2026 PFS final rule (90 FR 49920) for our previously established policies regarding third party intermediaries.

In this section of the proposed rule, we propose to update our requirements for third party intermediaries related to conditions for approval for Qualified Clinical Data Registries (QCDRs) and qualified registries, remove the additional requirements for health IT vendors, and update our remedial action/termination policies. Specifically, we propose the following:

- Additional Requirements for Health IT Vendors:

++ Clarifying that additional requirements for health IT vendors do not apply beginning with the CY 2025 performance period/2027 MIPS payment year, because beginning in the CY 2025 performance period/2027 MIPS payment year health IT vendors are no longer allowed to submit MIPS data as a third-party intermediary,

- Conditions for Approval:

++ Clarifying that performance feedback reports would be provided based on participation level (for example, individual, group, subgroup, virtual group, or APM entity).

++ Updating the existing two policies in which (1) a third party intermediary with fewer than 10 Quality Payment Program participants submitting MIPS data must audit all Quality

Payment Program participants and (2) a third party intermediary submitting data for Quality Payment Program participants with fewer than 5 patient records must audit all patient records.

++ Updating the policy in which third party intermediaries that do not submit data for one year are required to submit a self-nomination participation plan.

++ Modifying the qualified postings' policy in which changes to the information submitted should not be done after the qualified posting is publicly posted on the Quality Payment Program's Resource Library page.

++ Revising existing policies to specify a QCDR or a qualified registry must be able to submit to CMS data for at least six quality measures including at least one MIPS core measure to align with the proposed removal of high priority designation from MIPS quality measures and the MIPS core measure reporting requirements in section IV.A.4.d.(1)(c) of this proposed rule.

- Remedial Action and Termination of Third Party Intermediaries:

++ Clarifying that if a third party intermediary does not submit data for one year, they would be required to provide documentation and would be terminated if documentation cannot be provided and/or the documentation shows that they would not be submitting data for the given MIPS performance period.

2. Proposal to Further Clarify in Regulation Text that Health IT Vendors Can Not Submit Data Beginning with the CY 2025 Performance Period/ 2027 MIPS Payment Year and that Preexisting Requirements for Health IT Vendors No Longer Apply

In the CY 2017 Quality Payment Program final rule (81 FR 77377 through 77382), we established the category of health IT vendors as a type of third party intermediary in the Quality Payment Program. In the CY 2019 PFS final rule, we codified the definition of a health IT vendor as an entity that supports the health IT requirements on behalf of a MIPS eligible clinician (including obtaining data from a MIPS eligible clinician's Certified Electronic Health Record Technology (CEHRT) (83 FR 59907). In the CY 2022 PFS final rule (86 FR 65541), we finalized a reorganization of the regulatory text governing third party intermediaries to improve

clarity and readability. In that revised text, we established general requirements at § 414.1400(a), additional requirements for QCDRs and qualified registries at § 414.1400(b), and additional requirements for health IT vendors at § 414.1400(c).

The CY 2024 PFS final rule eliminated health IT vendors from the category of third party intermediaries in the Quality Payment Program beginning in the CY 2025 performance period/2027 MIPS payment year at § 414.1400(a)(1)(iii) (88 FR 79390 and 79391). We noted that the removal of health IT vendors from the definition of third party intermediary would not preclude the vendors from assisting MIPS eligible clinicians with reporting under the program by providing their technology for clinicians to directly report under MIPS. We also noted that eliminating the category of health IT vendor as a distinct type of third party intermediary created a clearer distinction between (1) vendors that are submitting data to CMS for the purposes of MIPS and must meet the requirements of a qualified registry or QCDR, and (2) vendors that work with clinicians through the sale and support of health IT permitting the clinician or group to submit the data.

We recognize that § 414.1400(c)(1) outlines additional requirements for health IT vendors submitting data for the MIPS performance category beginning with the CY 2021 performance period/2023 MIPS payment year even though we removed the category of health IT vendors for the Quality Payment Program beginning in the CY 2025 performance period/2027 MIPS payment year at § 414.1400(a)(1)(iii). These requirements being left in the regulation text caused confusion for some organizations interested in serving as third party intermediaries because it was not clear that these additional requirements for health IT vendors were no longer in place. If an organization that was previously under the health IT vendor category as a third party intermediary would like to continue serving as a third party intermediary for the Quality Payment Program, they must meet the requirements to become a qualified registry or QCDR. Therefore, to reduce confusion and further clarify our existing policies, we propose to add at § 414.1400(c)(2) that beginning with the CY 2025 performance period/CY 2027 MIPS payment

year, health IT vendors cannot submit MIPS data unless they meet the requirements for a qualified registry or QCDR. We also propose to modify § 414.1400(c)(1) to clarify that the additional requirements for health IT vendors only apply for the CY 2021 performance period/CY 2023 MIPS payment year through the CY 2024 performance period/2026 MIPS payment year, when health IT vendors were still a separate type of third party intermediaries.

We request public comment on these proposals.

3. Conditions for Approval

a. Proposal to Provide Performance Feedback Reports at the Level of Data Submitted

In the CY 2017 Quality Payment Program final rule, we established requirements for performance feedback for QCDRs (81 FR 77367 through 77374) and qualified registries (81 FR 77383 through 77387) to provide timely feedback, at least four times a year, on all MIPS performance categories that the QCDR or qualified registry would report. We also finalized that the feedback should be given to the individual MIPS eligible clinician or group (if participating as a group) at the individual participant level or group level, as applicable, for which the QCDR or qualified registry reports. In the CY 2020 PFS final rule, we codified the requirement for QCDRs (84 FR 63057 and 63058) and qualified registries (84 FR 63076 and 63077) to provide timely feedback at least four times per year along with a new requirement to provide specific feedback to their clinicians and groups on how they compare to other clinicians who have submitted data on a given measure. In the CY 2022 PFS final rule (86 FR 65538 through 65550), we reorganized and consolidated the regulatory text governing third party intermediaries for clarity and simplicity and specifically to consolidate regulations that applied identically to both QCDRs and qualified registries. In that reorganization, the previously established policy for QCDRs and qualified registries to provide feedback which had been established at § 414.1400(b)(1) and (c)(1) was consolidated and redesignated at § 414.1400(b)(3)(iii) without a change in requirements. In the initial codification of the requirements for performance feedback in the CY 2020 PFS final rule for QCDRs (84 FR 63057 and 63058) and qualified registries (84

FR 63076 and 63077), we did not codify but also did not propose to remove the requirements previously established in the CY 2017 Quality Payment Program final rule for QCDRs (81 FR 77367 through 77374) and qualified registries (81 FR 77383 through 77387) that the feedback should be given to the individual MIPS eligible clinician or group (if participating as a group) at the individual participant level or group level, as applicable, for which the QCDR or qualified registry reports. We also did not refer to this requirement in the CY 2022 PFS final rule reorganization and redesignation of the regulatory text.

We have identified situations in which QCDRs or qualified registries provide the required performance feedback, but the feedback may reflect the performance of the individual when the clinician is reporting within a group. Alternatively, the feedback report reflects the performance of a group, but it was the individual that is reporting. We believe that this undermines the improvement opportunity that is inherent in these feedback reports and the value of these QCDRs and qualified registries. For this reason, we propose to add at § 414.1400(b)(3)(iii) that QCDRs and qualified registries must provide the performance feedback at the level at which the data was or will be submitted (for example, individual, group, virtual group, subgroup, APM entity). This proposal would codify the requirements that were previously established but not codified in the CY 2017 Quality Payment Program final rule for QCDRs (81 FR 77367 through 77374) and qualified registries (81 FR 77383 through 77387) to provide feedback at the level at which data is submitted. We also propose to remove the term "clinicians and groups" in both places in this portion of the regulation. We believe that this requirement aligns with the requirement originally established in the CY 2017 Quality Payment Program Rule (81 FR 77363) but reflects the increased types of reporting entities available to MIPS eligible clinicians to include individuals, groups, virtual groups, subgroups, and APM entities.

We request public comment on these proposals.

b. Data Validation Requirements

(1) Background

Section 414.1400(b)(3)(v) outlines the requirements for a third party intermediary's annual data validation audit. As finalized in the CY 2024 PFS final rule (88 FR 79388), specified at § 414.1400(b)(3)(v)(E), the QCDR or qualified registry must conduct each data validation audit using a sampling methodology that meets the following requirements: (1) Uses a sample size of at least 3 percent of a combination of individual clinicians, groups, virtual groups, subgroups and APM entities for which the QCDR or qualified registry will submit data to CMS, except that the sample size may be no fewer than a combination of 10 individual clinicians, groups, virtual groups, subgroups and APM entities, and no more than a combination of 50 individual clinicians, groups, virtual groups, subgroups and APM entities; and (2) Uses a sample that includes at least 25 percent of the patients of each individual clinician, group, virtual group, subgroup or APM entity in the sample, except that the sample for each individual clinician, group, virtual group, subgroup or APM entity must include a minimum of 5 patients and need not include more than 50 patients.

(2) Proposal to Update Sampling Methodology for Data Validation Purposes

We noticed that recently certain third party intermediaries are using less than the minimum sample size as required by § 414.1400(b)(3)(v)(E) , which raises concern as to whether the data sample that is being submitted is adequate. Hence, to ensure that our data remains true, accurate, and complete, we propose the following updates:

- If the third party intermediary submits MIPS data to CMS for fewer than 10 Quality Payment Program participants, the data validation audit sample must include all Quality Payment Program participants. Hence, we propose to modify the existing requirements at § 414.1400(b)(2)(v)(E)(1) and (2) that govern a QCDR or qualified registry's data validation audit sampling methodology. Specifically, we propose at §414.1400(b)(2)(v)(E)(1) that if the intermediary submits MIPS data to CMS for fewer than 10 Quality Payment Program participants, the data validation audit sample must include all Quality Payment Program participants. If the intermediary submits data for 10 or more Quality Payment Program

participants, it must use a sample size of at least 3 percent of a combination of the individual MIPS eligible clinicians, groups, virtual groups, subgroups and APM entities for which the QCDR or qualified registry will submit data to CMS, except that the sample size may be no fewer than a combination of 10 individual clinicians, groups, virtual groups, subgroups, or APM entities, and no more than a combination of 50 individual clinicians, groups, virtual groups, subgroups and APM entities.

- If there are fewer than 5 patient records from a Quality Payment Program participant, the patient record audit sample must include all patient records. Hence, we propose at §414.1400(b)(2)(v)(E)(2) that if there are fewer than 5 patient records, the patient record audit sample must include all patient records. If there are 5 or more patient records, the intermediary must use a sample that includes at least 25 percent of the patient records of the individual clinician, group, virtual group, subgroup, or APM entity in the sample, except that the sample for each individual clinician, group, virtual group, subgroup or APM entity must include a minimum of 5 patients and need not include more than 50 patients.

These updates would help third party intermediaries submit data that is true, accurate, and complete while meeting their submission requirements for data validation purposes.

We request public comment on these proposals.

c. Proposal to Require a Submission of a Self-Nomination Plan for Third Party Intermediaries that Do Not Submit Data for One Year

In the CY 2022 PFS final rule, we noted that we had identified several QCDRs and qualified registries that continued to self-nominate to become a third party intermediary for the MIPS program but had not submitted clinician, group, or virtual group data to CMS (86 FR 65545). We further noted as the MIPS program continues to mature, we wished to reduce the number of third party intermediaries that self-nominate to become a CMS-approved third party intermediary but do not actively participate in the MIPS program. Maintaining these vendors who do not actively participate does not provide a benefit to the MIPS program, rather it creates

interested parties confusion by including these vendors in our qualified postings. We also noted that our goal was to decrease the operational burden on CMS and those third party intermediaries that do not submit MIPS data to CMS (86 FR 65546).

Accordingly, we finalized requirements for approved QCDRs and qualified registries that have not submitted performance data to submit a participation plan as part of their self-nomination process. We finalized an incremental approach to addressing this issue. First, at § 414.1400(b)(3)(vii), we finalized a participation plan requirement, which requires a QCDR or qualified registry that was approved but did not submit data for any of the CY 2017 through 2020 performance periods/2019 through 2022 MIPS payment years to submit a participation plan in order to be approved for the CY 2023 performance period/2025 MIPS payment year (86 FR 65545 and 65546). Second, at § 414.1400(b)(3)(viii), we finalized that a QCDR or qualified registry that was approved but did not submit any MIPS data for either of the 2 years preceding the applicable self-nomination period must submit a participation plan in order for it to be approved for the CY 2024 performance period/2026 MIPS payment year or a future performance period/payment year (86 FR 65546).

While this policy has reduced the number of QCDRs and Qualified Registries that do not submit data, some QCDRs and Qualified Registries are still being listed on the qualified posting for as long as three years without submitting data. Maintaining these third party intermediaries that do not actively participate does not provide a benefit to the MIPS program, rather it creates confusion for interested parties by including these third party intermediaries in our qualified postings. We continue to emphasize that our goal is to continue decreasing the operational burden on CMS and interested parties. CMS would decrease its operational burden by eliminating the need to screen these third party intermediaries.

In an effort to avoid further confusion, reduce administrative burden for both CMS and interested parties, and ensure compliance, we propose to reduce the timeframe available for a QCDR or qualified registry that was approved but did not submit any MIPS data to submit a

participation plan. Currently, a QCDR or qualified registry must submit a participation plan if they do not submit data for either of the 2 years preceding the applicable self-nomination period. We propose to require a QCDR or qualified registry to submit a participation plan if they do not submit data for the year preceding the applicable self-nomination period. We propose to redesignate and amend § 414.1400(b)(3)(viii) and add § 414.1400(b)(3)(viii)(A) and (B). Additionally, we also note that we encourage QCDRs and qualified registries to implement the participation plan at the beginning of the calendar year instead of waiting until the self-nomination period, which generally opens on July 1 and closes on September 1 of the year prior to the applicable MIPS performance period.

In summary, we specifically propose to redesignate the existing text at § 414.1400(b)(3)(viii) to § 414.1400(b)(3)(vii)(B) and amend the text to reflect that this requirement applies from the CY 2024 performance period/2026 MIPS payment year through the CY 2026 performance period/2028 MIPS payment year. Additionally, we also propose to add at § 414.1400(b)(3)(vii)(C) that beginning with the CY 2027 performance period/2029 MIPS payment year, a QCDR or qualified registry that was approved but did not submit any MIPS data for the year preceding the applicable self-nomination period must submit a participation plan for CMS' approval. This participation plan must include the QCDR's and/or qualified registry's detailed plans about how the QCDR or qualified registry intends to encourage clinicians to submit MIPS data to CMS through the QCDR or qualified registry. We also propose to redesignate the existing text at § 414.1400(b)(3)(vii) to at § 414.1400(b)(3)(vii)(A) and add the heading participation plan for third party intermediary not submitting data at § 414.1400(b)(3)(vii).

We request public comment on these proposals.

d. Proposal to Update Qualified Posting

Every year, CMS publishes a qualified posting on the CMS website containing a list of all CMS-approved third party intermediaries that have self-nominated to submit data on behalf of

MIPS eligible clinicians for the MIPS performance period. This list is updated to account for withdrawals, remedial action, or termination of third party intermediaries. The qualified posting contains information about approved third party intermediaries such as organization details, information about remedial action or termination, supported performance categories, specialty focus, a description of services they provide and associated costs, reporting options (MVP versus traditional MIPS) and participation options (individual clinician, group, subgroup, virtual group, APM entity) supported, and measures they are approved to support. MIPS eligible clinicians can refer to information in the qualified posting to identify and select a third party intermediary.

In the CY 2017 Quality Payment Program final rule (81 FR 77367 through 77369 and 77384 through 77385), we established that QCDRs and qualified registries must sign a document that verifies their name, contact information, cost for MIPS eligible clinicians or groups to use the qualified registry, services provided, and the specialty-specific measure sets the qualified registry intends to report. As technology progressed, we no longer needed third party intermediaries to sign a document and instead required an attestation. We became aware that this requirement was no longer consistent with our established policy in describing the manner in which the QCDR or qualified registry documents this information. To align with current processes, we finalized in the CY 2024 PFS final rule to add § 414.1400(b)(3)(xiv), which required that QCDRs and qualified registries attest that the information listed on the qualified posting is accurate (88 FR 79385). Additionally, we also finalized in the CY 2024 final rule, at § 414.1305, to define qualified posting as the document made available by CMS that lists QCDRs or qualified registries available for use by MIPS eligible clinicians, groups, subgroups, virtual groups, and APM Entities (88 FR 79385). We noted that we had used the term qualified posting since the inception of the Quality Payment Program but had not previously defined the term.

We have recently been made aware that certain third party intermediaries are making changes to the information that was provided for their qualified posting after receiving CMS

approval of the qualified posting. Examples of changes include updates to costs, services that are included in the initial cost, and other administrative changes. This creates an increased administrative burden for CMS, who must identify and rectify such changes, and it creates confusion amongst clinicians who contract with the third party intermediary as to what they will pay for the cost of the third party intermediary's services. Subsequently, we must make additional updates to the qualified posting, which increases the administrative burden on us. Hence, in efforts to reduce administrative burden for both clinicians and CMS, we propose to update § 414.1400(b)(3)(xiv) by adding a requirement that changes to information (for example, cost, services included) on the qualified posting must be included and finalized during the qualified posting review period. We propose specifying in regulatory text that third party intermediaries will not be permitted to make changes after the qualified posting is publicly posted on the Quality Payment Program Resource Library page.

We request public comments on these proposals.

e. Proposal to Update CMS Data Submission Requirements for Third Party Intermediaries

In the CY 2017 Quality Payment Program final rule, we finalized at § 414.1400(b)(3)(x) and (b)(3)(x)(A) that a QCDR or a qualified registry must be able to submit to CMS data for at least six quality measures including at least one outcome measure and if no outcome measure is available, a QCDR or qualified registry must be able to submit to CMS results for at least one other high priority measure (81 FR 77368).

However, in section IV.A.4.d.(1)(c) of this proposed rule, we are proposing to remove the high priority designation from MIPS quality measures beginning in the CY 2027 performance period/CY 2029 MIPS payment year. Additionally, we are also proposing to remove the requirement to report an outcome measure and require reporting a MIPS core measure. Hence, under the new proposal, MIPS eligible clinicians participating through traditional MIPS must submit data on at least six measures, including at least one MIPS core measure.

To align third party intermediaries' requirements with the MIPS core measure set and high priority designation for MIPS quality measures proposals, we propose to revise § 414.1400(b)(3)(x)(B) to state that beginning in the CY 2027 performance period/ 2029 MIPS payment year, a QCDR or qualified registry must be able to submit to CMS, data for at least six quality measures including at least one MIPS core measure. We also propose to revise § 414.1400(b)(3)(x) and (b)(3)(x)(A) so that the requirement for a QCDR or qualified registry to be able to submit an outcome measure and if the outcome measure is not available, then a high priority measure can be submitted, concludes with the CY 2026 performance period/CY 2028 MIPS payment year.

We request public comment on these proposals.

4. Remedial Action and Termination of Third Party Intermediaries

a. Background

We refer readers to § 414.1400(e), the CY 2017 Quality Payment Program final rule (81 FR 77548) the CY 2019 PFS final rule (83 FR 59908 through 59910), the CY 2020 PFS final rule (84 FR 63077 through 63080), the CY 2021 PFS final rule (85 FR 84947), the CY 2022 PFS final rule (86 FR 65542 and 65550), and the CY 2023 PFS final rule (87 FR 70106 through 70108) for previously finalized policies for remedial action and termination of third party intermediaries.

b. Proposed Termination of a Third Party Intermediary that does not Submit Data for 1 Year

In the CY 2023 PFS final rule, we established that we will terminate QCDRs and qualified registries that are required to submit participation plans during the applicable self-nomination period under § 414.1400(b)(3)(viii) because they did not submit any MIPS data for either of the 2 years preceding the applicable self-nomination period, and continue to not submit MIPS data to CMS for the applicable performance period (87 FR 70107 through 70108). We believe that timely termination of third party intermediaries that are not submitting data is

important to minimize unnecessary operational and administrative tasks for both CMS and third party intermediaries. Maintaining third party intermediaries that do not actively participate does not provide a benefit to the MIPS program, rather it creates confusion for interested parties by including these third party intermediaries in our qualified postings (86 FR 65545).

We note that the policy for termination of third party intermediaries not submitting data would be impacted by the proposed requirement to submit a participation plan for third party intermediaries that do not submit data for one year in section IV.C.3.c. of this proposed rule. This proposed policy means that we would terminate QCDRs and qualified registries that were required to submit participation plans during the applicable self-nomination period under § 414.1400(b)(3)(viii) because they did not submit any MIPS data for 1 year (rather than 2 years) preceding the applicable self-nomination period, and continue to not submit MIPS data to CMS for the applicable performance period. However, because the data submission period lasts for one year following the performance period, there is a delay in CMS being made aware of whether a third party intermediary submitted data for a given year. Therefore, currently, CMS does not have a mechanism to acquire the necessary knowledge to appropriately terminate a third party intermediary until the year after the applicable performance period.

Currently, if a third party intermediary does not submit data for the performance period for which they submitted a self-nomination participation plan, they will be terminated. However, CMS does not become aware of the third party intermediary's failure to submit data for a given MIPS performance period until the year following the performance period. For example, under the current policy, if a third party intermediary self-nominated for the 2024 performance period and was required to submit a self-nomination participation plan but does not submit data for the 2024 performance period, CMS would not know the third party intermediary did not submit MIPS data for the 2024 performance period until the end of the submission period in March 2025. Therefore, the third party intermediary can continue to participate for the 2025 MIPS performance period as if they were already approved and posted as a 2025 CMS-approved third

party intermediary. Hence, to shorten the timeline of when CMS is aware that the third party intermediary does not submit any data and when CMS appropriately terminates the third party intermediary, we propose to update our policy such that CMS would request documentation that the third party intermediary has contracted with Quality Payment Program's participants who will submit MIPS data for the given MIPS performance period. CMS's query for documentation would occur before the end of the calendar year for the given MIPS performance period. If the appropriate documentation cannot be provided by the date specified by CMS, the third party intermediary would be terminated. This proposal would provide the information needed to be able to terminate a third party intermediary during the applicable performance period year instead of having to wait until the following year to terminate them.

Specifically, we propose to add a new requirement for third party intermediaries to submit documentation about intent to submit MIPS data and to terminate a third party intermediary if they do not submit the appropriate documentation by the date specified by CMS. We also propose to add at § 414.1400(e)(5)(ii) that beginning with the CY 2027 performance period/2029 MIPS payment year, a QCDR or qualified registry that submits a participation plan as required under § 414.1400(b)(3)(viii), but does not submit MIPS data for the applicable performance period for which they self-nominated under § 414.1400(b)(3)(viii), will be queried by CMS before the end of the calendar year of the given MIPS performance period for documentation that they have contracted with Quality Payment Program participants who will submit data for the given MIPS performance period. If the appropriate documentation cannot be provided, the third party intermediary would be terminated. We also propose to redesignate the existing text at § 414.1400(e)(5) to § 414.1400(e)(5)(i). We also propose to add the heading "Termination for Third Party Intermediary not submitting data." at § 414.1400(e)(5).

We request public comment on this proposal.

D. Calculating Final Score

1. Background

For a description of the statutory basis of and our previously finalized policies for calculating the final score for each MIPS eligible clinician, including performance category weights and reweighting the performance categories, we refer readers to § 414.1380(c) and the discussion in the CY 2017 and CY 2018 Quality Payment Program final rules, and the CY 2019, CY 2020, CY 2021, CY 2022, CY 2023, and 2025 PFS final rules (81 FR 77319 through 77329, 82 FR 53769 through 53785 and 53895 through 53900, 83 FR 59868 through 59878, 84 FR 63020 through 63031, 85 FR 84908 through 84917, 86 FR 65509 through 65527, 87 FR 70093 through 70096, 89 FR 98455 through 98459 respectively).

As described in more detail in the following sections, we propose to change the data source that CMS uses to determine eligibility for reweighting under the automatic extreme and uncontrollable circumstances (EUC) policy beginning with the CY 2027 performance period/2029 MIPS payment year. We also propose to change the deadline by which clinicians must request reweighting where data for a MIPS eligible clinician are inaccessible or unable to be submitted due to circumstances outside of the control of the clinician because the MIPS eligible clinician delegated submission of the data to their third party intermediary.

Section 1848(q)(5)(A) of the Act requires the Secretary to develop a methodology for assessing the total performance of each MIPS eligible clinician according to the performance standards for the applicable measures and activities for each performance category applicable to such clinician for a performance period and, using the methodology, provide for a final score (using a scoring scale of 0 to 100) for each MIPS eligible clinician for the performance period.

Additionally, section 1848(q)(5)(E) of the Act specifies how we must weigh the scores for each performance category in our calculation of the MIPS eligible clinician's final score. We have codified these weights at § 414.1380(c)(1). Meanwhile, section 1848(q)(5)(F) of the Act provides that, if there are not sufficient measures and activities applicable and available to each

type of MIPS eligible clinician involved, the Secretary shall assign different scoring weights (including a weight of 0). We also have finalized at § 414.1380(c)(2) several policies addressing the basis for reweighting one or more performance categories, and how those weights will be redistributed to the remaining performance categories.

2. Proposal to Use Alternative Data Sources to Determine Clinician Eligibility for the Automatic EUC

For the quality, cost, and improvement activities performance categories, under the current reweighting policies at § 414.1380(c)(2)(i)(A)(6) through (8), and for the Promoting Interoperability performance category, under the reweighting policies at § 414.1380(c)(2)(i)(C)(*2*) and (3), performance category weights may be redistributed to another performance category or categories in circumstances where MIPS eligible clinicians are subject to, or located in an area affected by, an EUC. This includes MIPS eligible clinicians with an approved application-based EUC reweighting request (83 FR 59871 through 59874 and 82 FR 53680 through 53687) or an automatic reweighting for a clinician identified as located in a CMS designated region affected by an EUC such as a Federal Emergency Management Agency (FEMA)-designated major disaster or a public health emergency (as determined by the Secretary of Health and Human Services) (82 FR 53895 through 53900). The automatic EUC policy for quality, cost, and improvement activities performance categories is described at § 414.1380(c)(2)(i)(A)(8) and the automatic EUC policy for the Promoting Interoperability performance category is described at § 414.1380(c)(2)(i)(C)(3). Additionally, we previously finalized at § 414.1380(c) that MIPS eligible clinicians scored on fewer than two performance category scores will receive a final score equal to the performance threshold, which will result in a neutral payment adjustment (81 FR 77326 through 77328 and 82 FR 53778 through 53779). We noted in the CY 2018 Quality Payment Program final rule that we anticipate the types of events that could trigger the automatic EUC policy would be events designated as a FEMA

major disaster or a public health emergency declared by the Secretary, although we will review each situation on a case-by-case basis (82 FR 53897).

In the CY 2018 Quality Payment Program final rule, we specified that CMS will determine if an individual MIPS eligible clinician is located in an area affected by an EUC as identified by CMS based on the practice location address listed in the Provider Enrollment, Chain and Ownership System (PECOS) (82 FR 53898). Since adopting a policy to use PECOS data, recent clinician reweighting requests have increasingly identified clinicians who were incorrectly excluded from the automatic EUC policy because PECOS address data may be inaccurate or outdated in some cases. For example, individual MIPS eligible clinicians impacted by an EUC may not be identified by CMS in circumstances where a clinician has not updated their PECOS data or in circumstances where a clinician begins providing services in an additional geographic location or zip code. In order to ensure the accurate identification of impacted clinicians for subsequent performance periods, we propose that beginning with the CY 2027 performance period/2029 MIPS payment year CMS will use the most current and reliable data available to determine if an individual MIPS eligible clinician is located in an area that has been identified as being affected by an EUC. For example, we may use the zip codes on billed claims, that identify the location of service, to make this determination. This data source may be used in addition to or in lieu of the zip codes included in PECOS address data to achieve our goal of accurately identifying all impacted clinicians. This proposal will ensure that all individual MIPS eligible clinicians affected by natural disasters and public health emergencies are accurately identified by CMS.

We request public comment on this proposal.

3. Proposal to Update the Deadline for Clinicians to Inform CMS that Third Party Intermediary Did Not Submit Data Due to Reasons Outside the MIPS Eligible Clinician's Control

We previously finalized at § 414.1380(c)(2)(i)(A)(10) and (c)(2)(i)(C)(12) that beginning with the CY 2024 performance period/2026 MIPS payment year, we may reweight one or more of the quality, improvement activities, and Promoting Interoperability performance categories

where we determine, based on documentation submitted to us through a reweighting request on or before November 1st of the year preceding the relevant MIPS payment year, that data for a MIPS eligible clinician are inaccessible or unable to be submitted due to circumstances outside of the control of the clinician because the MIPS eligible clinician delegated submission of their data to a third party intermediary, evidenced by a written agreement between the MIPS eligible clinician and the third party intermediary, and the third party intermediary did not submit the data for the performance category(ies) on behalf of the MIPS eligible clinician in accordance with applicable deadlines (89 FR 62096). We previously finalized that this reweighting policy is available only for the quality, improvement activities, and Promoting Interoperability performance categories because a MIPS eligible clinician may delegate data submission to a third party intermediary for these three performance categories, and not the cost performance category. MIPS eligible clinicians do not submit data separately for measures for the cost performance category; we score cost measures based solely on administrative claims data (89 FR 98455 through 98455).

As specified in the CY 2025 PFS final rule, we would only approve reweighting requests with evidence of a written agreement between the MIPS eligible clinician and a third party intermediary. Such written agreement must provide that the MIPS eligible clinician delegated submission of their data to the third party intermediary, and that the third party intermediary agreed to submit data on their behalf in accordance with applicable deadlines, for the performance category or performance categories in question. We review requests and make determinations to reweight based on our assessment that data were not submitted due to reasons outside the control of the MIPS eligible clinician (89 FR 62096). Under this reweighting policy, the MIPS eligible clinician must submit reweighting requests beginning with the close of a relevant performance period's data submission period, only after it is confirmed that no data has been submitted in accordance with applicable deadlines. MIPS eligible clinicians must then submit reweighting requests on or before November 1st of the year preceding the associated

MIPS payment year in order to allow time for CMS to re-calculate their final score and MIPS payment adjustment factor (89 FR 62096).

We propose to adjust the deadline by which clinicians would be able to submit reweighting requests for the quality, improvement activities, and Promoting Interoperability performance categories due to scenarios where a third party intermediary did not submit data on their behalf in accordance with the applicable data submission deadlines. Specifically, we propose that beginning with the CY 2025 performance period/2027 MIPS payment year, MIPS eligible clinicians would be able to submit reweighting requests on or before December 31st of the year preceding the relevant MIPS payment year. We also propose to codify this updated deadline at § 414.1380(c)(2)(i)(A)(10) for the quality and improvement activities performance categories and at § 414.1380(c)(2)(i)(C)(12) for the Promoting Interoperability performance category. Under this proposed reweighting policy, the MIPS eligible clinician must submit reweighting requests beginning with the close of a relevant performance period's data submission period, only after it is confirmed that no data has been submitted in accordance with applicable deadlines. Under this proposed deadline, MIPS eligible clinicians would still be able to submit reweighting requests before the beginning of the associated MIPS payment year.

The deadline for MIPS eligible clinicians to submit reweighting requests before the beginning of the associated MIPS payment year is aligned with the requirements finalized in the CY 2020 PFS final rule for clinicians to request reweighting in circumstances where data are inaccurate, unusable, or otherwise compromised. Under this policy, we apply reweighting only in cases when we learn of the compromised data before the beginning of the associated MIPS payment year (84 FR 63023 through 63026). We intend for this policy to offer increased flexibility to impacted clinicians and note that this timeline will encourage MIPS eligible clinicians and their third party intermediaries to inform us of these concerns in a timely manner so we can update our data sets while minimizing the impacts to other interested parties who

utilize MIPS data. The proposed deadlines will still allow CMS to re-calculate final scores and MIPS payment adjustments factor in a timely manner.

We request public comment on these proposals.

E. Public Reporting

1. Background

Public reporting of Merit-based Incentive Payment System (MIPS) eligible clinician performance information on the Compare Tool on medicare.gov (here after referred to as the "Compare Tool") is authorized under section 10331(a)(1) and (2) of the Affordable Care Act (ACA). Section 10331(a)(1) of the ACA established a physician compare website for the public reporting of clinician performance information.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) amended the Social Security Act by adding Section 1848(q)(9), which requires the Secretary to continue to make publicly available, on the Compare Tool and in an easily understandable format, information regarding the performance of individual MIPS eligible clinicians and groups (81 FR 77391).

For previous discussions and established policies regarding public reporting on the Compare Tool, we refer readers to § 414.1395 as well as, the CY 2016 PFS final rule (80 FR 71116 through 71123), the CY 2017 Quality Payment Program final rule (81 FR 77390 through 77399), the CY 2018 Quality Payment Program final rule (82 FR 53819 through 53832), the CY 2019 PFS final rule (83 FR 59910 through 59915), the CY 2020 PFS final rule (84 FR 63080 through 63083), the CY 2021 PFS final rule (85 FR 84947 through 84948), the CY 2022 PFS final rule (86 FR 65550 through 65554), the CY 2023 PFS final rule (87 FR 70109 through 70104), the CY 2024 PFS final rule (88 FR 79394 through 79401), and the CY 2026 PFS final rule (90 FR 49862). The Compare Tool is available at *https://www.medicare.gov/care-compare/* and in the Medicare Provider Data Catalog available at *https://data.cms.gov/provider-data/topics/doctors-clinicians*.

In this section of the proposed rule, we propose to remove the requirement preventing the public reporting of any performance data reported through a MIPS Value Pathway (MVP) on new improvement activities and Promoting Interoperability (PI) measures on the Compare Tools

for the first year the new measures and activities are included in such MVP. We also include a request for information (RFI) to obtain feedback on potential improvements to the current star rating assignment methodology for quality measure scores reported under the administrative claims collection type.

2. Proposal to Remove the Public Reporting Requirements for the MIPS Value Pathway (MVP) Requirement at § 414.1395(c)(2)

In the CY 2022 PFS final rule (86 FR 65550 through 65552), we finalized a policy under which we would not publicly report any MVP data, or MIPS performance data reported through an MVP, on a new improvement activity or PI measure, objective, or activity for the first year the new activity or measure is included in an MVP. For example, if a new improvement activity is finalized for inclusion in MIPS and an MVP for the CY 2027 performance period/CY 2029 MIPS payment year, under the current regulatory framework, we would not publicly report the first year of its data for MIPS eligible clinicians who report the new improvement activity through the MVP reporting framework. The purpose of this requirement was to encourage participation in the new MVP reporting framework and to provide participants with additional time to transition to MVPs before their performance on new measures or activities is publicly reported. However, we have determined that this requirement has not served as an effective incentive for MVP participation because most improvement activities and PI measures included in MVPs are not considered new and would be publicly reported, as they have been included in MIPS for over a year.

Consistent with section 1848(q)(9)(A)(i)(II) of the Act, we finalized in the CY 2017 Quality Payment Program final rule a decision to make all measures, objectives, or activities

under the MIPS quality, cost, improvement activities, and PI performance categories available for public reporting on the Compare tools (81 FR 77391 through 77396), using a phased approach for new performance information facilitated by Section 1848(q)(9)(A) and (D). In the CY 2018 PFS final rule (82 FR 53825 through 53827), we further finalized that the first

year of data for new improvement activities and PI measures would be publicly reported for MIPS eligible clinicians on the Compare tools if all other public reporting criteria established under § 414.1395(b) are met. Since we established § 414.1395(c)(2), the annual consumer testing conducted consistent with the requirements of § 414.1395(b) demonstrates that most patients and caregivers find the new improvement activities and PI information understandable and useful for their decision-making. Therefore, this information should be publicly reported. The purpose of the Compare Tools is to provide patients with the most timely, clear, and credible information on provider performance that is available for public reporting.

Since the adoption of the requirement to not publicly report the first year of new improvement activity or PI information for participants who report through the MVP reporting framework, we have observed that the policy does not apply to a sufficient number of MIPS eligible clinicians to encourage meaningful participation in MVPs. For example, during 2025, only four individual providers' performance information would not have been publicly reported for new improvement activities included in MVPs, and there were no new PI measures included in MVPs for 2025. This represented less than 1 percent of clinicians reporting the new improvement activities for that performance period. Similarly, we observed that this requirement applied to less than 1 percent of MIPS eligible clinicians reporting new improvement activities and PI information overall since MVPs became available as a reporting framework beginning with the CY 2023 performance period. There have not been a sufficient number of new PI measures or improvement activities included in MVPs, and there is not enough data to continue supporting this requirement.

We propose to remove the requirement at § 414.1395(c)(2) that we would not publicly report any MVP data on new improvement activity or PI measure, objective, or activity during the first year in which it is included in an MVP. Upon the removal of this requirement, we would revert to the original policy, finalized in the CY 2018 PFS final rule (82 FR 53825 through 53827), and would include all eligible performance information for new improvement

activities and new PI measures in public reporting on the Compare Tools during the first year in which the measures and activities are included in the program.

We request public comments on this proposal.

3. Request for Information: Star Rating Assignment Methodology for Administrative Claims Quality Measures

a. Background

MACRA requires the continuous public display of individual MIPS eligible clinician and groups performance information, in an easily understandable format, on the CMS Compare tool on Medicare.gov (81 FR 77391). Our process for the assignment of star ratings is set forth in § 422.166(b), which establishes the public reporting parameters of star ratings.

As finalized in the CY 2015 and CY 2016 PFS final rules (79 FR 67547 and 80 FR 70885, respectively), CMS continued to expand public reporting on the Compare Tool. This expansion included publicly reporting both individual eligible clinicians and groups starting with 2016 data available for public reporting in late 2017, as well as the inclusion of a 5-star rating based on a benchmark in late 2017 based on 2016 data (80 FR 71125 and 71129), among other additions.

b. Adjustments to the Star Rating Assignment Methodology for Administrative Claims Quality Measures

The goal of publicly reporting clinician performance information is to ensure that patients can easily understand how quality measure scores reflect each provider's performance. While the current system of benchmarking for public reporting has been in place for several years, we are currently seeking feedback on alternative options for distributing scores. We are investigating improvements to the star rating assignment methodology for quality measure scores collected under the administrative claims collection type (42 CFR 414.1305). Our intent is to provide a more easily understood distribution of the administrative claims quality measure scores on

clinician profile pages for patients via the Compare Tool on *https://www.medicare.gov/care-compare/.*

Administrative claims quality measures differ from other MIPS quality measure collection types as they are automatically calculated and risk-adjusted for groups and clinicians who meet measure requirements. The administrative claims quality measure scores have been found to form a more normal distribution. However, the existing quality measure score conversion calculations and supporting code for the current star rating assignment methodology may not optimally align with the standard deviation-based methodology employed by CMS to score administrative claims quality measures (42 CFR 414.1380(b)(2)(i)(B)). With more information, we can determine whether an alternative methodology for star rating assignments is more appropriate for administrative claims quality measures prior to the public reporting of these scores on clinicians' profile pages on the Medicare.gov Compare Tool. We have been investigating how to adjust these calculations so that measure-level scores are more representative of clinician performance and better understood by patients.

Currently, we calculate star rating cutoffs for the Achievable Benchmark of Care (ABC) 5-star methodology through the equal ranges method for a subset of Merit-based Incentive Payment System (MIPS) quality and promoting interoperability measures that meet the established public reporting standards and resonate with users (§ 414.1395(b)). The equal ranges method is based on the difference between an established ABC methodology benchmark and the lowest performance score for a given measure. This range is then used to assign star ratings of one to four stars. Clinicians who meet or exceed the ABC benchmark for the applicable measure receive 5 stars. [387]

We seek to investigate a new option that would assign star ratings using a standard-deviation-based approach for the administrative claims quality measure scores. The MIPS

[387] For more information about the equal ranges method and the ABC methodology, visit *https://www.cms.gov/files/document/2023-doctors-clinicians-star-ratings-fact-sheet-546-kb.pdf.*

benchmarking process employed by CMS for measures of this collection type applies a standard deviation-based approach for a 10-point scoring scale[388], which differs from the ABC methodology. We expect that using a similar standard deviation-based methodology for assigning star ratings, as is currently used in the MIPS benchmarking process, would be more straightforward and easier to understand. We also anticipate that this shift to using standard deviations for assigning star ratings to the administrative claims measures would avoid the clustering-around-the-mean issues observed under the ABC methodology, where virtually all scores result in 2, 3, or 4 stars.

In addition, the adoption of a standard-deviation-based methodology may be extended to the public reporting of cost measures on clinician profile pages. Given that cost measure scores are automatically calculated and risk-adjusted using administrative claims data, star rating cutoffs may also require a similar standard deviation-based framework. We also seek feedback on developing a similar standard deviation-based approach for cost measures. We plan to investigate more ways to publicly report cost measures in a manner that better reflects provider performance and is more readily understood by patients. We are considering proposing to adopt a standard deviation-based methodology in the CY 2028 PFS rule to improve the clarity and interpretability of the distribution of the administrative claims quality measure scores displayed on the clinician profile pages of the Medicare.gov Compare Tool. We request public comments on the following topics regarding adjustments to a star rating assignment methodology:

- The public reporting methodology used for star rating assignments on clinician profile pages has used the equal ranges method based off an established ABC benchmark for calculating star rating cutoffs for several years. We request feedback on the current star rating assignment methodology and whether we must adjust this process for administrative claims quality measures.

---

[388]For a more detailed explanation of the standard deviation approach to the MIPS 10-point scale, please visit *MIPS Cost scores are coming — what to know for 2024 and prepping for 2025.*

- We request feedback on the statistical framework for transitioning the current star rating assignment methodology to a standard deviation-based methodology for administrative claims quality measures.

- We also request feedback on expanding the standard deviation-based adjustments for the administrative claims star rating assignment methodology to the public reporting of cost measures on clinician profile pages of the Medicare.gov Compare Tool in future program years. We seek to ensure that the display of cost measure performance more accurately reflects provider performance and can be understood by patients.

- We also request feedback on whether there are any unintended consequences or impacts to providers or patients that we must acknowledge before proposing any adjustments to the star rating assignment methodology for the administrative claims collection type.

5. Advanced APMs

a. Overview

The Quality Payment Program provides incentives for eligible clinicians to engage in value-based, patient-centered care under Medicare Part B via MIPS and Advanced APMs. The structure of the Quality Payment Program enables us to advance accountability and encourage improvements in care. Our vision for increased clinician participation in Advanced APMs is aimed at integrating individuals' clinical needs across a spectrum of providers and settings to improve patient care and population health. As we continue to make improvements to the Quality Payment Program, we seek to develop, propose, and implement policies that encourage broad and meaningful clinician participation in Advanced APMs.

In the CY 2026 PFS final rule (90 FR 50012), we finalized an update to our methodology to add an individual-level calculation to Qualifying APM Participant (QP) determinations, as set forth in §§ 414.1425(b)(3) and (c)(3), for all eligible clinicians participating in an Advanced APM, such that each eligible clinician would receive both APM Entity-level calculation and an individual-level calculation. Second, we finalized a policy at §§ 414.1435 and 414.1305 to perform QP determinations using both an E/M services approach and a Covered Professional Services approach.

Together with the addition of individual calculations and the use of specific services in our calculation, our methodology provides flexibility to ensure that participants receive incentives across model design and clinical specialty. However, we continue to identify misalignment between Advanced APM participation and the incentive structure of QPP, specifically in the application or the QP status to all of an eligible clinician's Tax Identification Number (TIN) reassignments irrespective of whether the TIN in question is participating in an Advanced APM. We also recognize the need for improvements and updates for technical or legislative reasons. The following policy proposals aim to address this misalignment and to make various improvements.

b. QP Determination

(1) General

In the CY 2017 Quality Payment Program final rule (81 FR 77439 through 77445), we finalized our policy for QP determinations at § 414.1425. We perform QP determinations for eligible clinicians three times during the QP Performance Period using claims data for services furnished from January 1 through each of the respective QP determination snapshot dates. An eligible clinician can be determined to be a QP only if the eligible clinician appears on the Participation List on a snapshot date that we use to determine the APM Entity group and to make QP determinations as described at § 414.1425.

In the CY 2017 Quality Payment Program final rule (81 FR 77433 through 77440) we established a process to calculate Partial QP status at § 414.1425(d). While to date our Partial QP policies have impacted only a small number of eligible clinicians, and thus we have not focused our discussion on this specific policy, we note that any changes to QP determinations at § 414.1425 also would likely require conforming changes to the policies for Partial QPs for consistency across the program.

(2) Applying QP Determinations at the TIN/NPI Level

When we initially established our policy in the CY 2017 Quality Payment Program final rule to make most QP determinations at the APM Entity level, we also specified that we would apply QP status at the NPI level (81 FR 77440). In other words, for a given eligible clinician (NPI), were one of their TIN/NPI relationships to be determined a QP, that QP status has applied all of their TIN/NPI relationships, both for purposes of being excluded from MIPS as well as for the application of QP financial incentives. Given the complexity of the program, we believed it was the best approach at the time to create one QP status result for a clinician at all of their billing organizations. However, we did not intend for the policy to create conflicting incentives to participation in Advanced APMs. We realized that an NPI being a QP at all of their TINs also meant that they would receive the financial incentives of QP status, at the time the APM

Incentive Payment, across all of those TINs, irrespective of whether those TINs were participating with Advanced APMs. However, we believed that the significance of that incentive would serve to increase clinician participation in Advanced APMs, and that the application of the QP thresholds would ensure that the clinician was appropriately incented to try to increase their individual Advanced APM participation. Further, we also had finalized at § 414.1450(c)(1) that we would pay the entire APM Incentive Payment amount to the TIN associated with the QP's participation in the Advanced APM Entity through which QP status had been attained (81 FR 77555), and we believed that by directing the lump sum entirely to the TIN participating with the Advanced APM Entity, we would reward the clinician without also rewarding non-participating TINs.

Upon gaining early experience implementing the APM Incentive Payments, we learned that for a variety of reasons (clinician movement, changes to a practice's TINs), we were not always able to send payment to the TIN associated with the APM Entity. We revised § 414.1450(c) in the CY 2021 PFS (88 FR 85035) to establish a hierarchy we would apply when determining where to send the APM Incentive Payments, which still prioritized TINs participating in Advanced APMs but allowed for payment to be sent to other, non-participating TINs if that was the only place we could find the clinician active at the time of payment. Still, we were satisfied that our prioritization of the lump-sum APM Incentive Payment to TINs that had Advanced APM participation remained a protection against providing non-participating TINs significant windfalls.

However, section 1848(d)(1)(A) of the Act establishes that, beginning with payment year 2026, QPs will receive a higher qualifying conversion factor update than non-QPs on their covered professional services claims. While the APM Incentive Payment has been extended multiple times as described in section XXX of this proposed rule, the implementation of the QP conversion factor means that a QP financial incentive goes directly to TINs in the form of claims payment. Particularly as the QP conversion factor grows and constitutes a larger proportion of

the QP incentive structure over time, we are concerned that a significant proportion of incentives paid for QP status will be paid to TINs that are not part of an Advanced APM, creating a disincentive for these TINs to join an Advanced APM and meaningfully engage in risk-bearing value-based care.

As such, we propose adding new provisions at §§ 414.1425(c)(8) and (d)(5) to apply QP status and Partial QP status, respectively, strictly to an eligible clinician as such term is defined at § 414.1305, specifically as a TIN/NPI combination, and that meets the definition at § 414.1305 of Qualifying APM participant (QP) or Partial QP, respectively, by participating in an Advanced APM during the QP performance period. Under the proposal, QP status and Partial QP status would therefore only apply to the clinician at the TIN that is participating with the APM Entity in the Advanced APM. Therefore, the financial incentives in the form of both the APM Incentive Payment and the QP conversion factor would apply to the NPI's claims only with those TINs, as would the ability of a Partial QP to opt into or out of MIPS.

For an eligible clinician who is participating in multiple APM Entities, the proposal's effects would be based on how the clinician becomes a QP or Partial QP. Section 414.1435(h)(2) specifies that CMS assigns to the eligible clinician the score that results in the greater QP status. In accordance with this provision, if an eligible clinician attains QP status at the individual level from participation in multiple APM Entities, under the proposal we would assign the QP status at each of the clinician's TINs participating across those APM Entities. If, however, the eligible clinician did not attain QP status at the individual level and did attain QP status as part of a specific APM Entity-level determination, we would assign QP status to the clinician at only the TIN(s) that are associated with the APM Entity or Entities that collectively attained QP status. If the eligible clinician did not attain any QP status through any determination but did attain Partial QP status, this same preference for the highest status would apply for Partial QP status. This approach maintains the longstanding policy within QPP to give the clinician the highest possible outcome available to them.

This proposal would mean that QP status would no longer apply to a clinician as a whole and we recognize the possibility of this being perceived as introducing complexity into an eligible clinician's QPP experience, for example because under the proposal some eligible clinicians would be a QP with one TIN and participating in MIPS with another. We want to emphasize that for the majority of clinicians in Advanced APMs, this policy will not change their participation in QPP, because they are already participating with an APM Entity in an Advanced APM with all of their TIN reassignments. In these cases, the eligible clinician's QP status would apply at each of their TINs under the proposal. For the clinicians who are not already participating in an Advanced APM across all of their TIN reassignments, we believe that this policy would provide a meaningful incentive to increase their participation in an Advanced APM. Participation in Advanced APMs across Original Medicare continues to grow and we expect this policy to support our progress.

We note further that our proposal aligns with MIPS, which already operates on a TIN/NPI basis, meaning that QPP internal operations and communications would be the same for all clinicians. Under our current policy, we receive a significant number of inquiries from billing organizations where clinicians have been excluded from MIPS as a result of QP status with another billing organization where that organization is participating in an Advanced APM. In these cases, organizations have made a significant investment to report MIPS but do not receive a MIPS final score and MIPS payment adjustment for these clinicians. Our proposed policy would ensure that these billing organizations are in control of how MIPS eligibility criteria apply to clinicians that have been reassigned to their organizations.

In addition to programmatic alignment, our operational experience tells us that, when a TIN has any clinicians who are subject to MIPS, it most often simply reports on all of its clinicians, as including everybody is easier than removing clinicians before reporting. As such, we believe that in the relatively few situations where the proposal would result in an eligible clinician with QP status at one TIN being subject to MIPS at one or more other TINs, reporting

is in many cases is already being done for that clinician, meaning that neither the clinician nor their MIPS-participating TIN(s) would bear any new burden as a consequence of the proposed policy. Further, as it was established at the outset operational experience indicates that MIPS eligible clinicians' experience has not been significantly impaired by the TIN/NPI operation of that portion of the program.

Finally, we recognize that this proposal would decrease the dollar value of the financial incentives available for affected QPs. However, we believe that assigning QP status at the TIN/NPI level will serve to prevent an increasing windfall for TINs that do not participate in Advanced APMs, particularly given that the higher qualifying conversion factor update that is now part of the physician fee schedule is baked in to the amount Medicare pays on claims and therefore always is paid to the TIN through which the service was furnished without regard to whether that TIN is part of the Advanced APM that conferred QP status to the clinician. We believe that this proposal would prevent waste and potential for abuse, and that these matters outweigh concerns around complexity or reduced incentives. Notably, under current law the QP conversion factor will compound to a greater degree each year relative to the non-QP conversion factor. In addition, because payment of the claims is made directly to the TINs through which the services were billed means that CMS has no mechanism of directing these incentives to Advanced APM participating TINs in the way we have done with the APM Incentive Payment. As such, while relatively few QPs would be affected by this proposal, CMS anticipates the amount of the resulting windfall flowing directly to non-participating TINs under the current framework will increase over time, with little benefit to the clinician and no benefit to the practices that are doing the work of Advanced APM participation.

With respect to Partial QP status, the proposal would maintain programmatic alignment within QPP and would provide for the application of the ability to opt out of MIPS at the TIN/NPI level. While there are not financial incentives for these eligible clinicians in the same manner that there are for QPs, we believe that applying the opt-out flexibility at the TIN/NPI

level similarly confers the burden reduction of Partial QP status only to those TINs that are affiliated with the APM Entity participating in the Advanced APM.

We propose amending §414.1425(c) to add new subparagraph (8) to apply QP status strictly to the eligible clinician as such term is defined at § 414.1305, specifically as a TIN/NPI combination, and that meets the definition of Qualifying APM participant (QP) as defined at § 414.1305 by participating in an Advanced APM during the QP performance period. We also propose amending §414.1425(d) to add new paragraph (5) to establish the same policy with respect to the application of Partial QP status.

We seek public comments on this proposal.

6. APM Entity Terminations

a. Overview

In the CY 2017 Quality Payment Program final rule (81 FR 77446 through 77447), we finalized for the timing of QP determinations that a QP Performance Period runs from January 1 through August 31 of the calendar year that is 2 years prior to the payment year. We finalized that during the QP Performance Period, we will make QP determinations at three separate snapshot dates (March 31, June 30, and August 31), each of which will be a final determination for the eligible clinicians who are determined to be QPs. The QP Performance Period and the three separate QP determinations apply similarly for both the group of eligible clinicians on a Participation List and the individual eligible clinicians on an Affiliated Practitioner List.

In the CY 2017 Quality Payment Program final rule, we finalized at §§ 414.1425(c)(5) and 414.1425(d)(3) that an eligible clinician is not a QP or Partial QP for a year, respectively, if the APM Entity group voluntarily or involuntarily terminates from an Advanced APM before the end of the QP Performance Period (81 FR 77446 through 77447). We also finalized at §§ 414.1425(c)(6) and 414.1425(d)(4) that an eligible clinician is not a QP or Partial QP for a year if one or more of the APM Entities in which the eligible clinician participates voluntarily or involuntarily terminates from the Advanced APM before the end of the QP Performance Period,

and the eligible clinician does not achieve a Threshold Score that meets or exceeds the QP or Partial QP payment amount threshold or QP or Partial QP patient count threshold based on participation in the remaining non-terminating APM Entities (81 FR 77446 through 77447).

b. APM Entity Terminations Before Financial Risk was Borne

In the CY 2020 PFS final rule (84 FR 63087 through 63089), we finalized revisions to § 414.1425(c)(5) to add § 414.1425(c)(5)(i) and (ii) to state, beginning with the 2020 QP Performance Period, that an eligible clinician is not a QP for a year if: (1) The APM Entity voluntarily or involuntarily terminates from an Advanced APM before the end of the QP Performance Period; (2) or the APM Entity voluntarily or involuntarily terminates from an Advanced APM at a date on which the APM Entity would not bear financial risk under the terms of the Advanced APM for the year in which the QP Performance Period occurs. We also finalized conforming revisions in § 414.1425(d)(3) with respect to Partial QP status. In addition, we finalized revisions to our regulation at § 414.1425(c)(6) and add §§ 414.1425(c)(6)(i) and (ii) to state, beginning with the 2020 QP Performance Period, that an eligible clinician is not a QP for a year if: (1) One or more of the APM Entities in which the eligible clinician participates voluntarily or involuntarily terminates from the Advanced APM before the end of the QP Performance Period, and the eligible clinician does not achieve a Threshold Score that meets or exceeds the QP payment amount threshold or QP patient count threshold based on participation in the remaining non-terminating APM Entities; or (2) one or more of the APM Entities in which the eligible clinician participates voluntarily or involuntarily terminates from the Advanced APM at a date on which the APM Entity would not bear financial risk under the terms of the Advanced APM for the year in which the QP Performance Period occurs, and the eligible clinician does not achieve a Threshold Score that meets or exceeds the QP payment amount threshold or QP patient count threshold based on participation in the remaining non-terminating APM Entities. We also finalized conforming revisions in § 414.1425(4)(3) with respect to Partial QP status.

When we finalized the revisions in the CY 2020 PFS, due to a clerical error we inadvertently included language in the text of § 414.1425(c)(5)(ii) that we believe is unnecessary and has potential to cause confusion. Specifically, § 414.1425(c)(5)(ii) states that an eligible clinician is not an QP for a year when an APM Entity termination occurs "at a date on which the APM Entity would not bear financial risk for that QP performance period under the terms of the Advanced APM*, even if such termination date occurs within such QP Performance Period*" (emphasis added). The inclusion of the emphasized language was a clerical error. This language did not appear in the CY 2020 PFS proposed rule regulation text for § 414.1425(c)(5)(ii) (84 FR 40929) nor does it appear in the companion finalized regulation for Partial QP status at § 414.1425(d)(3)(ii). What's more, in the CY 2020 PFS final rule, we indicated that we were finalizing these policies "without modification" (84 FR 63089), but the addition of this clause would have constituted a modification that we would have discussed if intentionally made. Further, we believe the language is unnecessary because § 414.1425(c)(5)(i) already addresses terminations within the QP performance period. Therefore, we believe that the clause not only serves no meaningful purpose, but also that it could result in confusion because it could appear to be filling a regulatory gap that in fact does not exist. However, we do not believe any clarifying language is necessary. The principal reasons that cause us to change proposed regulatory text in final are to address public comments or fix an error or address an issue that we recognized only after the proposal was made. We had not received any comments that indicated any confusion regarding the applicable timeframe for the proposed version of § 414.1425(c)(5)(ii) (that again, did not include the relevant clause), and we had not independently identified any problems with the proposed text, so we did not have any reason to believe we needed to clarify the applicable timing. Furthermore, we have not experienced any problems in the implementation of the companion regulation with respect to Partial QP status, which also does not contain this additional clause.

Therefore, to align the QP regulation text at § 414.1425(c)(5)(ii) with the Partial QP regulation text at § 414.1425(d)(3)(ii), and to remove any potential for confusion with respect to the intended timeframe for APM Entity terminations before financial risk is borne in the Advanced APM, we now propose to amend the text of § 414.1425(c)(5)(ii) to remove ", even if such termination date occurs within such QP Performance Period." Under this proposal, the text of § 414.1425(c)(5)(ii) will read "The APM Entity voluntarily or involuntarily terminates from an Advanced APM at a date on which the APM Entity would not bear financial risk for that performance period under the terms of the Advanced APM." This proposed change will make the text of § 414.1425(c)(5)(ii) read as we always intended and will remove both the misalignment with the text of the Partial QP regulation and any confusion that the unnecessary clause might cause.

c. Clarification for APMs without a Participation List

The definition of "Participation List" was first established in the CY 2017 QPP final rule, (81 FR 77008). In that rule, we codified the definition of "Participation List" at § 414.1305 as the mechanism by which CMS identifies the eligible clinicians associated with a given APM Entity for purposes of QP determinations and related QPP functions (81 FR 77246 through 77257). The definition has remained substantively unchanged since its initial adoption in the CY 2017 QPP final rule, though the regulatory provisions that rely upon it—including those governing QP determination methodology under § 414.1425, APM Entity group composition under § 414.1317, and APM Performance Pathway eligibility under § 414.1367—have been refined through subsequent annual rulemaking. The existing regulatory definition of "Participation List" does not expressly address the circumstance in which an APM does not require or generate a Participation List for its APM Entities. This gap has the potential to create interpretive ambiguity—particularly as CMS considers the design of future episode-based, mandatory, and other APMs under which Participation Lists may not be a structural feature of APM participation. To enhance regulatory clarity and ensure that the framework governing QP

determinations and MIPS APM scoring can accommodate the full range of APM designs CMS may implement, we are proposing a clarification to ensure that in cases where a participation list is not operationally practicable, we would not include these APMs for MIPS scoring or QP determinations.

We seek public comments on this proposal.

d. APM Incentive Payment

(1) Overview

Section 1833(z)(1) of the Act establishes an incentive payment for participation in eligible alternative payment models, which originally ran from payment years 2019-2024. As such, when we established the definition of "APM Incentive Payment" at § 414.1305 in the CY 2017 Quality Payment Program final rule (81 FR 77008) we included in the definition that the payment would be made from payment year 2019 through payment year 2024. We also established at § 414.1450(b)(1) that the amount of the APM Incentive Payment was “equal to 5 percent of the estimated aggregate payments for covered professional services as defined in section 1848(k)(3)(A) of the Act furnished during the calendar year immediately preceding the payment year” (81 FR 77554).

(2) APM Incentive Payment Extension

The incentive payment originally was extended as part of the Consolidated Appropriations Act, 2023, which provided for a 3.5 percent payment in payment year 2025. In the CY 2023 PFS final rule (88 FR 79539), we finalized revisions to § 414.1450(a)(1)(i) to make reference payment years 2019 through 2025 and to § 414.1450(b)(1) to codify the legislative extension. The Consolidated Appropriations Act, 2024 provided an additional payment of 1.88 percent in payment year 2026, and in the CY 2024 PFS final rule (89 FR 98564) we again made conforming updates to §§ 414.1450(a)(1)(i) and (b)(1) to incorporate that extension. As such, currently, in §§ 414.1450(a)(i) and (b)(1), the lump sum APM Incentive Payment is available for payment years 2019 through 2026, with the applicable percentage varying by year

in accordance with the statute: 5 percent for payment years 2019 through 2024, 3.5 percent for payment year 2025, 1.88 percent for payment year 2026.

The Consolidated Appropriations Act, 2026, now has provided for a 3.1 percent APM Incentive Payment in payment year 2028. Accordingly, we are proposing to codify this extension for 2028 into §§ 414.1450(a)(1)(i) and (b)(1). We also recognize that with several extensions of this payment now having occurred, and each extension having a new and unique applicable percentage, the current single-paragraph structure of the regulation at § 414.1450(b)(1) is beginning to get unwieldy and becoming harder to follow. Specifically, the relevant percentages and years have been listed within a single sentence at § 414.1450(b)(1) that describes the amount of the incentive payment. With each extension, this set of clauses has grown longer, creating greater distance between the concept of a percentage applying and the description of what the percentage in question applies to. Adding the most recent extension will make this sentence longer still.

Therefore, we are proposing a technical restructuring of § 414.1450(b)(1), which would not change the policies of this paragraph but, we believe, simply make it easier to read in light of now having three years of extensions at different percentages. Under the proposal, we would pull out the references to percentages and years from the first sentence of (b)(1) into a new list of subparagraphs, mirroring the way that the QP and Partial QP thresholds are listed in § 414.1430. Specifically, we propose to amend § 414.1450(b)(1) by: (1) remove all of the language in the first sentence that references percentages and payment years and begin the sentence "The amount of the APM Incentive Payment is"; (2) insert after "is" the phrase "the applicable percentage established for the payment year"; (3) add at the end of the subparagraph "The applicable percentage is the following value for the indicated payment years:"; and (4) create new subparagraphs (i) through (iv) to list the specific applicable percentages, including the extension for 2028. The proposed revised paragraph would read:

“(1) The amount of the APM incentive payment is the applicable percentage established for the payment year of the estimated aggregate payments for covered professional services as defined in section 1848(k)(3)(A) of the Act furnished during the calendar year immediately preceding the payment year. CMS uses the paid amounts on claims for covered professional services to calculate the estimated aggregate payments on which CMS will calculate the APM Incentive Payment. The applicable percentage is the following value for the indicated payment years below.

- 2019 through 2024: 5 percent.
- 2025: 3.5 percent.
- 2026: 1.88 percent.
- 2028: 3.1 percent.”

We believe that this proposed revised structure is cleaner than the current single paragraph with its increasingly long detailing of years and percentages, and therefore will provide an easier-to-follow explanation of the APM Incentive Payment amount. These proposed technical structural changes would not modify the substantive policies of this provision. The only substantive change we are proposing is the codifying in new subparagraph § 414.1450(b)(1)(iv) of the 3.1 percent legislated for 2028.

(3) APM Incentive Payment Definition

As described in the overview, we established the definition of "APM Incentive Payment" at § 414.1305 in the CY 2017 Quality Payment Program final rule (81 FR 77008), we included language that specifically referenced payment years 2019 through 2024. However, when we revised § 414.1450 in the CY 2023 and CY 2024 PFS final rules to codify the legislative extensions of the APM Incentive Payment, we neglected to make conforming changes to the definition of "APM Incentive Payment" at § 414.1305 to reflect those subsequent legislative actions. As such, the current definition at § 414.1305 references only the original statutory payment years of 2019 through 2024, making it out-of-date. To address this, we are proposing to

update the definition to remove the references to specific years and instead refer to § 414.1450(b)(1). The revised definition would read: "*APM Incentive Payment* means the lump sum incentive payment for a year as described in section 414.1450(b)(1) and that is paid for an eligible clinician who is a QP for the applicable year." This proposal would allow for the APM Incentive Payment definition to automatically be inclusive of any year that may be added through future legislation and codified at § 414.1450(b)(1) without the need for a conforming change to the definition at § 414.1305 itself.

We seek public comment on this proposal.

(4) Summary

We are proposing to codify the most recent legislative extension of the APM Incentive Payment by: (1) revising § 414.1450(a)(1)(i) to include the payment amounts for 2019 through 2028; and (2) revising § 414.1450(b)(1) to make structural changes that include the applicable percentages for 2019 through 2024, 2025, 2026, and 2028, respectively at §§§§ 414.1450(b)(1)(i), (ii), (iii) and (iv). We note that the only substantive change involved in these modifications would be the addition of the 2028 extension. The proposed structural changes would not affect the policies of this provision but simply improve the readability of this paragraph.

We also are proposing to revise the definition of "APM Incentive Payment" at § 414.1305 to remove the current references to specific payment years and replace them with a reference to the years described in § 414.1450(b)(1).

We seek public comment on these proposals.

e. QP and partial QP thresholds

Section 1833(z)(2) of the Act specifies the thresholds for the level of participation in Advanced APMs required for an eligible clinician to become a QP for a year. The Medicare Option, based on Part B payments for covered professional services or counts of patients furnished covered professional services under Part B, has been applicable since payment year

2019 (performance period 2017). The All-Payer Combination Option, through which QP status is calculated using the Medicare Option in addition to an eligible clinician's participation in Other Payer Advanced APMs, has been applicable since payment year 2021 (performance period 2019). In the CY 2017 Quality Payment Program final rule (81 FR 77433 through 77439), we finalized our policy for QP and Partial QP Thresholds for the Medicare Option as codified at § 414.1430(a) and for the All-Payer Combination Option at § 414.1430(b). Section 304(a)(2) of Division G, Title I, Subtitle C, of the Consolidated Appropriations Act, 2024 (CAA, 2024) (Pub. L. 118-42, March 9, 2024) amended section 1833(z)(2) of the Act by extending for payment years 2025 and 2026 (performance periods 2023 and 2024) the applicable payment amount and patient count thresholds for an eligible clinician to achieve QP status. Specifically, section 304(a)(2) of the CAA, 2024, amended section 1833(z)(2) of the Act to continue the QP payment amount thresholds that applied in payment year 2025 (performance period 2023) to payment year 2026 (performance period 2024). Additionally, section 304(a)(2) of the CAA, 2024, amended section 1833(z)(2) of the Act to require that, for payment year 2026, the Secretary use the same percentage criteria for the QP patient count threshold that applied in payment year 2022. Section 304(b) of the CAA, 2024, also amended section 1848(q)(1)(C)(iii) of the Act to extend through payment year 2026 the Partial QP thresholds that were established beginning for payment year 2021 under the Medicare Option. Under the All-Payer Combination Option, the QP thresholds for payment year 2026 (performance period 2025) will remain at 50 percent for the payment amount method and 35 percent for the patient count method. The Partial QP thresholds for payment year 2026 (performance period 2024) will continue at 40 percent for the payment amount method and 25 percent for the patient count method. To become a QP through the All-Payer Combination Option, eligible clinicians must first meet certain minimum threshold percentages under the Medicare Option. For payment year 2026 (performance period 2024), the minimum Medicare Option threshold an eligible clinician must meet to be eligible for the All-Payer Combination Option is 25 percent for the payment amount method or 20 percent for the

patient count method. For Partial QP status, the minimum Medicare Option threshold an eligible clinician must meet to be eligible for the All-Payer Combination Option is 20 percent for the payment amount method or 10 percent for the patient count method.

To conform our regulation with the amendments made by the CAA, 2024, we propose to amend § 414.1430 by revising paragraphs (a) and (b) to reflect the statutory QP and Partial QP threshold percentages for both the payment amount and patient count under the Medicare Option and the All-Payer Option with respect to payment year 2026 (performance period 2024). Over the years, as legislative changes have been enacted, we have added new regulatory subsections. Additionally, we note that these thresholds all increased for payment year 2027 (performance period 2025), and were legislatively restored to lower levels for payment year 2028 (performance period 2026). To maintain relative structural simplicity in the regulation, we are proposing to condense the lists of applicable years and thresholds. The proposed structure would limit duplication in our description of the applicable thresholds.

We propose the following revisions to § 414.1430(a) and (b) for the Medicare Option and All-Payer Combination Option QP and Partial QP thresholds as follows:

- Paragraph (a)(1)(vi) to state that for 2027 the amount is 75 percent, and a new paragraph (a)(1)(vii) to state that for 2028, the amount is 50 percent, and a new paragraph (a)(1)(viii) to state that for 2029 and later, the amount is 75 percent.
- Paragraph (a)(2)(vi) to state that for 2027 the amount is 50 percent, and a new paragraph (a)(2)(vi) to state that for 2028 the amount is 40 percent, and a new paragraph that for 2028 and later, the amount is 50 percent.
- Paragraph (a)(3)(vi) to state that for 2027 the amount is 50 percent, and a new paragraph (a)(3)(vii) to state that for 2028, the amount is 35 percent, and a new paragraph (a)(3)(viii) to state that for 2029 and later, the amount is 50 percent.

- Paragraph (a)(4)(vi) to state that for 2027 the amount is 35 percent, and a new paragraph (a)(4)(vii) to state that for 2028, the amount is 25 percent, and a new paragraph (a)(3)(viii) to state that for 2029 and later, the amount is 35 percent.

- Paragraph (b)(1)(i)(B) to state that for 2027 the amount is 75 percent, and a new paragraph (b)(1)(i)(C) to state that for 2028, the amount is 50 percent, and a new paragraph (b)(1)(i)(D) to state that for 2029 and later, the amount is 75 percent.

- Paragraph (b)(2)(i)(B) to state that for 2027 the amount is 75 percent and a new paragraph (b)(2)(i)(C) to state that for 2027, the amount is 50 percent, and a new paragraph (b)(2)(i)(D) to state that for 2028 and later, the amount is 75 percent.

- Paragraph (b)(3)(i)(B) to state that for 2027 the amount is 50 percent, and a new paragraph (b)(3)(i)(C) to state that for 2028, the amount is 35 percent, and a new paragraph (b)(3)(i)(D) to state that for 2029 and later, the amount is 50 percent.

- Paragraph (b)(4)(i)(B) to state that for 2027 the amount is 35 percent, and a new paragraph (b)(4)(i)(C) to state that for 2028, the amount is 25 percent, and a new paragraph (b)(4)(i)(D) to state that for 2029 and later, the amount is 35 percent.

V. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), 44 U.S.C. 3501–3520, we are required to provide notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. Collection of information is defined under 5 CFR 1320.3(c) of the PRA''s implementing regulations. To fairly evaluate whether an information collection should be approved by OMB, 44 U.S.C. 3506(c)(2)(A) requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment (see section V.D. of this proposed rule) on each of the aforementioned issues for the following sections of this document that contain confirmed or potential information collection requirements (ICRs). Comments, if received, will be responded to within the subsequent final rule (CMS-1848-F, OMB 0938-1485).

A. Wage Estimates

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' (BLS) May 2025 National Occupational Employment and Wage Estimates for all salary estimates (*https://www.bls.gov/oes/tables.htm*). In this regard, Tables D-A1 and D-A2 present BLS' mean hourly wage, our estimated cost of fringe benefits and other indirect costs (calculated at 100 percent of salary), and our adjusted hourly wage. There are many sources of variance in the average cost estimates, both because fringe benefits and other indirect costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from

study to study. Therefore, we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

We note that the BLS data does not include median hourly wage rates for multiple physician occupation types listed in Table D-A2; in these cases, the BLS identifies that the median wage rate is equal to or greater than $115.00/hr or $239,200 per year. BLS data for prior years, such as the May 2022 and May 2023 data, provide similar notes for median wage rates for occupations that are above the same threshold ($115.00/hr or $239,200 per year for the May 2022 BLS data (*https://www.bls.gov/oes/2022/may/oes_nat.htm*) and May 2023 BLS data (*https://www.bls.gov/oes/2023/may/oes_nat.htm*)). Therefore, for consistency with previous years for estimating physician wage rates, we have continued to use mean hourly wage rates across our wage estimates.

TABLE D-A1: NATIONAL OCCUPATIONAL EMPLOYMENT AND WAGE ESTIMATES (EXCLUDING PHYSICIANS)

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefits and Other Indirect Costs ($/hr)	Adjusted Hourly Wage ($/hr)
Billing and Posting Clerks	43-3020	24.55	24.55	49.10
Business Operations Specialists	13-1000	44.63	44.63	89.26
Computer System Analysts	15-1211	55.10	55.10	110.20
General and Operations Managers	11-1021	64.87	64.87	129.74
Licensed Practical and Licensed Vocational Nurses	29-2061	32.24	32.24	64.48
Medical and Health Services Managers	11-9110	67.77	67.77	135.54
Software Quality Assurance Analysts and Testers	15-1253	53.60	53.60	107.20
Training and Development Managers	11-3131	71.33	71.33	142.66

For our purposes, BLS' May 2025 National Occupational Employment and Wage Estimates does not provide an occupation that we could use for "Physician" wage data. To estimate a Physician's costs, we used an average conglomerate wage of $307.74/hr as demonstrated in Table D-A2.

TABLE D-A2: NATIONAL OCCUPATIONAL EMPLOYMENT AND WAGE ESTIMATES (PHYSICIANS)

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefits and Other Indirect Costs ($/hr)	Adjusted Hourly Wage ($/hr)
Anesthesiologists	29-1211	173.35	173.35	346.70
Family Medicine Physicians	29-1215	122.99	122.99	245.98
General Internal Medicine Physicians	29-1216	128.46	128.46	256.92
Obstetricians and Gynecologists	29-1218	134.16	134.16	268.32
Orthopedic Surgeons, Except Pediatric	29-1242	179.60	179.60	359.20
Pediatric Surgeons	29-1243	241.37	241.37	482.74
Pediatricians, General	29-1221	101.98	101.98	203.96
Physicians, All Other	29-1229	125.98	125.98	251.96
Psychiatrists	29-1223	129.78	129.78	259.56
Surgeons	29-1240	175.17	175.17	350.34
Surgeons, All Other	29-1249	179.78	179.78	359.56
Total				3,385.24
Average Physician Wage (3,385.24/11)				307.74

Private Sector

To derive average costs, we used the most recently available data from the US Bureau of Labor Statistics (BLS), the May 2025 National Occupational Employment and Wage Statistics, for all salary estimates (*https://www.bls.gov/oes/tables.htm*). In this regard, Table D-A3 presents BLS' mean hourly wage, our estimated cost of fringe benefits and other indirect costs (calculated at 100 percent of salary), and our adjusted hourly wage.

TABLE D-A3: NATIONAL OCCUPATIONAL EMPLOYMENT AND WAGE ESTIMATES

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefits and Other Indirect Costs ($/hr)	Adjusted Hourly Wage ($/hr)
Billing and Posting Clerks	43-3021	24.55	24.55	49.10
Computer System Analysts	15-1211	55.10	55.10	110.20
General and Operations Managers	11-1021	64.87	64.87	129.74
Licensed Practical and Licensed Vocational Nurses	29-2061	32.24	32.24	64.48
Medical and Health Services Managers	11-9110	67.77	67.77	135.54
Physicians	29-1210	133.30	133.30	266.60
Software Quality Assurance Analysts and Testers	15-1253	53.60	53.60	107.20

As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and other indirect costs vary significantly from employer to employer, and because methods of estimating these

costs vary widely from study to study. Nonetheless, we believe that doubling the hourly wage to estimate the total cost is a reasonably accurate estimation method.

Wages for Individuals

We believe that the cost for beneficiaries undertaking administrative and other tasks on their own time is a post-tax wage of $24.05/hr.

The Valuing Time in U.S. Department of Health and Human Services Regulatory Impact Analyses: Conceptual Framework and Best Practices[389] identifies the approach for valuing time when individuals undertake activities on their own time. To derive the costs for beneficiaries, we used a measurement of the usual weekly earnings of wage and salary workers of $1,159[390] for 2024 and then divided by 40 hours to calculate an hourly pre-tax wage rate of $28.98/hr. This rate is adjusted downwards by an estimate of the effective tax rate for median income households of about 17 percent or $4.93/hr ($28.98/hr x 0.17), resulting in the post-tax hourly wage rate of $24.05/hr ($28.98/hr - $4.93/hr). Unlike our private sector wage adjustments, we are not adjusting beneficiary wages for fringe benefits and other indirect costs since the individuals' activities, if any, would occur outside the scope of their employment.

B. Proposed Information Collection Requirements (ICRs)

1. ICR Regarding Rebate Reduction Requests under Sections 11101 and 11102 (§§ 427.402, 428.302, and 428.303)

This ICR collects information from manufacturers of Part B rebatable biosimilar biological products and generic Part D rebatable drugs and biosimilars that are requesting rebate reductions to inform CMS' determinations regarding such rebate reduction requests pursuant to the policies adopted in the CY 2025 PFS final rule (89 FR 97710). The information collection requirements for the Rebate Reduction Requests under sections 11101 and 11102 of the IRA ICR currently approved under OMB Control Number 0938-1474 are scheduled to expire on July 31,

[389] https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//176806/VOT.pdf.
[390] https://fred.stlouisfed.org/series/LEU0252881500A.

2027. We intend to seek renewal of this collection from OMB prior to its expiration. The renewal will continue the currently approved requirements with technical updates to the forms, such as the email address to submit rebate reduction requests and references to relevant sections of the CY 2025 PFS final rule. No policy changes related to this collection are proposed in this rule. Consequently, we are not setting out any proposed burden estimates under this section of this proposed rule.

2. ICRs Regarding Clinical Laboratory Fee Schedule: Revised Data Reporting Period and Phase-in of Payment Reductions (§ 414.504)

As stated in section 1834A(h)(2) of the Act, chapter 35 of title 44 U.S.C., which includes such provisions as the PRA, does not apply to information collected under section 1834A of the Act. Consequently, we are not setting out any proposed burden estimates under this section of the proposed rule. Please refer to section VII.F.4. of this proposed rule for a discussion of the impacts associated with the proposed changes described in section III.C. of this proposed rule.

3. Ambulatory Specialty Model

In this proposed rule, we make several proposals related to the Ambulatory Specialty Model (ASM), which is tested under the authority of section 1115A of the Act. As stated in the CY 2026 PFS final rule (90 FR 49973), under section 1115A(d)(3) of the Act, Chapter 35 of title 44, United States Code, does not apply to the testing, evaluation, and expansion of models under section 1115A of the Act and, therefore, the information collection requirements associated with the ASM proposals in this rule are not subject to the PRA. Nevertheless, for transparency, we briefly describe the anticipated administrative effects of these proposals.

The proposed ASM revisions in this proposed rule would have limited impact on the collection of information overall. For example, within the quality ASM performance category, we propose to replace the Functional Status Change for Patients with Low Back Impairments (MIPS Q220) with the Functional Outcome Assessment (MIPS Q182) measure, which should not impact burden given we are removing one measure and replacing with another. The proposed

addition of the administrative claims-based quality measure would not entail additional data collection or submission requirements given there is no data submission for such measures. Similarly, remaining proposals should not impact the collection of information significantly.

4. ICRs Regarding Limiting Medicare Coverage of Certain Individuals

In accordance with section 1899C of the Act and in this proposed rule, we intend to update the Medicare initial enrollment forms to expand the response options to include specific types of citizenship and alien status data elements to support Medicare Part A enrollment eligibility determinations. This is a small change that will not increase the burden already accounted for in OMB control numbers 0938-0251 (CMS 18-F-5), 0938-0245 (CMS 4040), 0938-0251 (CMS-10797) and 0938-0080 (CMS 43).

Our estimate is that the addition of the citizenship section to the CMS-10797, the form used to apply for Medicare using a Special Enrollment Period for Exceptional Conditions, does not change the currently approved burden estimates accounted for in OMB Control Number 0938-0251. The majority of respondents are expected to be U.S. citizens or nationals who will spend no more than one minute on the citizenship section, which is considered negligible. The currently approved burden for this collection reflects 34,612 respondents generating 34,612 total annual responses at 0.25 hours per response, for a total of 8,653 burden hours (34,612 responses x 0.25 hr/response) at a cost of $208,105 (8,653 hours × $$24.05/hr), or $6.01 per respondent ($208,105/ 34,612 respondents). We request comment on the burden assumptions for the CMS-10797.

The addition of the new SEP category to the CMS-10797 creates additional burden for individuals who utilize the SEP to apply for re-enrollment in Medicare following a change in their citizenship, nationality, or immigration status. We do not have historical data on which to base a precise estimate of SEP utilization, as this is a newly proposed enrollment pathway with no prior utilization experience. OACT estimates that approximately 32,000 individuals will lose Medicare coverage beginning in 2027. For purposes of this burden estimate, we assume that

approximately 10 percent of individuals projected to lose Medicare coverage, approximately 3,200 (32,000 × 0.10) individuals annually, may utilize the SEP to re-enroll in Medicare following a change in their citizenship, nationality, or immigration status. This is a placeholder assumption, as there is no historical precedent on which to base the estimate. We estimate 3,200 total respondents annually at 0.25 hours per response, for a total additional burden of 800 hours (3,200 responses × 0.25 hr/response) at a total estimated additional cost of $19,240 (800 × $24.05/hr), or $6.01 per respondent ($19,240 / 3,200 respondents), beginning in CY 2027. We assume that the 0.25 hours per response applies to this proposed SEP, as the burden associated with reestablishing immigration status and updating documentation is outside the Medicare enrollment process and therefore this burden estimate only accounts for time to enroll in Medicare.

The updated total burden for OMB control number 0938-1426, inclusive of both the currently approved burden and the additional SEP burden, is 37,812 total respondents (34,612 + 3,200) and 9,453 total burden hours (8,653 + 800) at a total cost of $227,345 ($208,105 + $19,240).

All information impacts related to the procedural steps that MA and Part D plans must take to receive and process disenrollment transactions have already been accounted for under OMB control numbers 0938-0753 (CMS-R-267) and 0938-0964 (CMS-10141) and no additional burden is attributed to this provision for those activities as this change is small relative to the number of disenrollment transactions processed by MA and Part D plans annually.

We are seeking public comments on all aspects of the proposed changes to entitlement and eligibility rules for Parts A and B, the underlying burden assumptions, and the changes to limit coverage under Medicare cost plans, MA plans, and Part D plans.

5. ICR Regarding Medicare Prescription Drug Inflation Rebate (§ 428.203(c))

The following proposed changes will be submitted to OMB for review under control number 0938-1485 (CMS-10930).

In section III.G.3.c.2.c. of this proposed rule, we are proposing to require all providers and suppliers that are covered entities as defined under § 10.3 (hereinafter collectively "340B providers" unless otherwise noted) to submit data elements from their Part D 340B claims to the 340B repository for all covered Part D drugs billed to Medicare Part D by such covered entity or its contractor(s) beginning in 2027 for Part D claims with dates of service on or after January 1, 2027. To allow sufficient time for 340B providers to gather, validate, and submit the specified data to the 340B repository, we propose to require that 340B providers would be expected to report data on a quarterly basis (though they may choose to submit more frequently) to the 340B repository within one calendar quarter following the close of the relevant calendar quarter. For example, for claims with dates of service between October 1, 2027, through December 31, 2027, 340B providers would submit the data elements from Part D 340B claims to the 340B repository no later than March 31, 2028. 340B providers would submit this data directly to CMS to be included in the 340B repository. We propose that we would rely upon the completeness and accuracy of the data submitted by 340B providers to the 340B repository, consistent with the 340B provider requirement to certify the accuracy of such submissions, to consider all data elements received by the 340B repository to be associated with Part D 340B claims. We also propose, as part of every submission to require 340B providers (or an individual or contractor with the delegated authority as an authorized representative of the 340B provider to perform the certification) to certify that the data elements from all claims submitted to the 340B repository are from verified 340B claims and, to the best of the 340B provider's knowledge, its submissions include all Part D 340B claims for the 340B provider at the time of submission for the relevant period. 340B providers or their authorized representative would be required to certify the completeness and accuracy of the data submitted and to certify that the submitter is authorized to submit on behalf of the 340B provider. We would match the stored data elements in the 340B repository to PDE transactions for each Part D rebatable drug dispensed during the applicable

period and would evaluate 340B repository data for: (1) data integrity, and (2) submission frequency and completeness across covered entity types and geographies.

The information collected by CMS from 340B providers would provide CMS with information to assess the usability of the data received and feasibility of CMS removing 340B units from the total number of units used to calculate the total rebate amount in the future based on the data submitted. This data and information is necessary to implement statutory requirements of the Medicare Part D Drug Inflation Rebate Program at section 1860D-14B(b)(1)(B) of the Act, which requires that beginning with plan year 2026, we shall exclude from the total number of units for a Part D rebatable drug, with respect to an applicable period, those units for which a manufacturer provides a discount under the 340B Program. As stated earlier, we are proposing to require all 340B providers to submit data elements from their Part D 340B claims to the 340B repository for all covered Part D drugs billed to Medicare Part D beginning in 2027 for Part D claims with dates of service on or after January 1, 2027.

Based on internal CMS analyses of the unique 340B ID numbers in the OPAIS database that are active (that is, not terminated) with at least one contract pharmacy association listed, we estimate that approximately 14,000 340B providers would respond by submitting data 4 times per year (quarterly) to the 340B repository in the format and manner specified by CMS.

For a 340B provider or its third-party administrator (TPA), we estimate it would take 6 hours at $107.20/hr for a Software Quality Assurance Analyst and Tester sampling for each submission and 2 hours at $129.74/hr for a General and Operations Manager to review each submission. In addition to the recurring submissions, we estimate it would take a General and Operations Manager one hour at $129.74/hr to complete the one-time registration for the 340B repository.

In aggregate, we estimate an annual burden of 462,000 hours ([56,000 responses x 8 hr/response] + [14,000 340B providers x 1 hr/registration]) at a cost of $52,366,440 [(2 hr x

$129.74/hr x 56,000 responses) + (6 hr x $107.20/hr x 56,000 responses) + (1 hr x $129.74/hr x 14,000 registrations)]) (see Table D-A4).

TABLE D-A4: SUMMARY OF TOTAL ANNUAL BURDEN FOR ALL 340B PROVIDERS OR TPAS TO COMPLETE 340B REPOSITORY DATA ELEMENTS FORM IN 2026

Section(s) Under Title 42 of the CFR	OMB Control Number (CMS ID No.)	No. Respondents	Total Annual Responses	Time per Response (hours)	Total Annual Time (hours)	Labor Cost ($/hr)	Total Cost ($)
Regarding the Medicare Prescription Drug Inflation Rebate Program under Sections 11101 and 11102 of the Inflation Reduction Act	0938-1485 (CMS-10930)	14,000 340B Providers or TPAs	70,000 (14,000 registrations/ year + 56,000 responses/year	Varies	462,000	Varies	52,366,440

6. ICRs Regarding the Medicare Shared Savings Program

Section 1899(e) of the Act provides that chapter 35 of title 44 U.S.C., which includes such provisions as the PRA, shall not apply to the Shared Savings Program. Accordingly, we are not setting out Shared Savings Program burden estimates under this section of the rule. Please refer to the Regulatory Impact Analysis (section VII. of this proposed rule) for a discussion of the impacts associated with the proposed changes to the Shared Savings Program as described in section III.G. of this proposed rule.

7. ICRs Regarding the Quality Payment Program

a. Background

The following identifies proposed changes will be submitted to OMB for review under control number 0938-1314 (CMS-10621).

However, independent of this proposed rulemaking's changes, we also intend to merge the information collection requests in the Virtual Groups PRA package (OMB control number 0938-1343, CMS-10652) into OMB control number 0938-1314 (CMS-10621) in order to consolidate QPP-related ICRs into a single collection of information request to avoid duplication. For more detailed information on our proposed policies, we refer readers to section IV. of this proposed rule.

We apply the updated BLS wage rate data identified in section V.A. of this proposed rule. We refer readers to section VII.F.11.e. of this proposed rule for the Regulatory Impact Analysis for discussion of impacts to final scores and payment adjustments.

All changes to burden and information collections for Quality Payment Program ICRs due to changes associated with proposed policies will be submitted to OMB for review under control number 0938-1314 (CMS-10621). Non-rulemaking revisions, resulting from updated data and assumptions, will also be submitted to OMB. It is intended to focus our PRA score on the impact of this rule's proposed policy changes.

(1) Framework for Understanding the Burden of MIPS Data Submission

Across organizations permitted or required to submit data on behalf of clinicians, there can be variation across the types of data provided, and whether a clinician is a MIPS eligible clinician or other eligible clinician voluntarily submitting data, a MIPS Alternative Payment Model (APM) participant, or an Advanced APM participant. MIPS eligible clinicians and other clinicians voluntarily submitting data to MIPS for the quality, Promoting Interoperability, and improvement activities performance categories may submit data as the following participation types: individual; group; virtual groups (available only for traditional MIPS); subgroups (available only for MIPS Value Pathways (MVPs)); and APM Entities. Eligible clinicians who attain Partial Qualifying APM Participant (QP) status may be subject to data collection burden if they elect to participate in MIPS. MIPS eligible clinicians are not required to submit any data for the cost performance category, as CMS calculates performance on measures specified for this performance category based on claims-data. Virtual groups are subject to the same data submission requirements per performance category as groups, and therefore, we will refer only to groups for the remainder of this section, unless otherwise noted.

For the aforementioned participation types, we assessed the same burden per reporting option and assumed from our available data that all non-Medicare Shared Savings Program (Shared Savings Program) APM Entity submissions are assessed based on a single Taxpayer

Identification Number (TIN). Per section 1899(e) of the Act, the PRA does not apply to the Shared Savings Program, thus excluded submissions by Shared Savings Program APM Entities from our MIPS reporting estimates. The regulatory impact analysis in section VII.F.11.b. of this proposed rule discusses impacts to the Shared Savings Program from provisions associated with this proposed rule.

There are three MIPS reporting options: traditional MIPS, MVPs, and the APM Performance Pathway (APP). In section V.B.7.c.(1) of this proposed rule, we provide distinct estimates for the traditional MIPS and MVP reporting options for the quality performance category, focusing on changes to our currently approved burden estimates. As with the CY 2026 PFS final rule (90 FR 49942 through 49943), we have not separately estimated burden for traditional MIPS and MVPs for the Promoting Interoperability and improvement activity performance categories. Traditional MIPS and MVPs require reporting on all Promoting Interoperability performance category objectives and measures. Traditional MIPS reporting for the improvement activities performance category typically requires attestation to two improvement activities; however, clinicians, groups, and virtual groups with a special status designation are only required to attest to one improvement activity. All MVP participants are only required to attest to one improvement activity. For additional details on historic burden assumptions for the improvement activities performance category, we refer readers to the CY 2025 PFS final rule (89 FR 98492). In the related collection of information request (OMB control number 0938-1314, CMS-10621), we aggregate submissions across all reporting options. For additional burden historic frameworks, we refer readers to the CY 2024 PFS final rule (88 FR 79422 through 79424) and the CY 2025 PFS proposed rule (89 FR 62111 through 62114).

(2) Additional Data Considerations

The accuracy of our estimates of the total burden for data submission for MIPS performance categories may be impacted by several factors. First, we are unable to predict with

certainty the number of participants who will obtain a QP status, thus exempt from MIPS reporting, for the CY 2027 performance period/2029 MIPS payment year and later years. Eligible clinicians who do not achieve QP status for a given performance period may be required to participate in the Merit-Based Incentive Payment System (MIPS). Second, it is difficult to predict whether Partial QPs, who can elect to report to MIPS, will choose to participate in the CY 2027 performance period/2029 MIPS payment year or later years. Therefore, the actual number of Partial QP participants and whether they elect to submit MIPS data may differ from our estimates. However, we believe our methodology for assessing burden, as described in the preceding Framework for Understanding the Burden of MIPS Data Submission section, is most appropriate given all the limitations. We refer readers to section VII.F.11.e.(2) (b) of this proposed rule for a discussion of the potential but unquantifiable burden implications on MIPS-related burden of the proposal to modify the application of the QP and partial QP status, presented in section IV.F.2. of this proposed rule.

b. ICRs Regarding Third Party Intermediaries (§ 414.1400)

We refer readers to § 414.1400(d) for our previously established requirements for CMS-approved third party intermediaries that may submit data on behalf of MIPS eligible clinicians, groups, virtual groups, subgroups, and APM Entities. The following sections detail proposals that impact existing ICRs relevant to Third Party Intermediaries. Additionally, in section IV.C. of this proposed rule, we are proposing to (1) add a requirement that CMS-approved third-party intermediaries may be terminated after failure to submit data for 1 year ; and (2) add a new requirement for third party intermediaries to submit documentation about intent to submit MIPS data and to terminate a third party intermediary if they do not submit documentation by the date specified by CMS. We refer readers to section VII.F.11.e.(2)(c) of this proposed rule for additional discussion on the impact of these proposals for which burden is not quantifiable.

(1) Full and Simplified Self-Nomination for Qualified Clinical Data Registries (QCDRs) and Qualified Registries

As described in section IV.C. of this rule, we are proposing to: (1) further clarify that additional requirements for health IT vendors do not apply beginning with the CY 2025 performance period/2027 MIPS payment year because health IT vendors are no longer allowed to submit MIPS data as third party intermediaries starting in that year; (2) clarify the level at which performance feedback reports are provided; (3) update the existing sampling methodologies for data auditing purposes; and (4) update the policy so that third party intermediaries will not be permitted to make changes to the qualified posting after it is publicly posted on the Quality Payment Program resource library. We assume that there will be no impact on the time required to complete either the full or simplified self-nomination process due to these proposals. Additionally, related to our proposal to implement core measures in traditional MIPS and MVPs in section IV.A.4.d.(1)(c) of this proposed rule, we are proposing to revise the data submission requirement in which a QCDR or a qualified registry must be able to submit at least six qualified measures including at least one MIPS core measure, beginning with the CY 2027 performance period/2029 MIPS payment year. This proposal does not alter the minimum number of measures a qualified registry or QCDR is required to support; therefore, we assume no impact to the overall time estimated for qualified registries or QCDRs to submit their information at the time of self-nomination. We are not proposing revisions to our estimated responses and time per response for both the Full and Simplified Self-Nominations for Qualified Registries and QCDRs under OMB control number 0938–1314 (CMS–10621).

(2) Third Party Intermediary Plan Audits

We are proposing updates related to Third Intermediary Plan Audits, which include targeted audit requirements, participation plan submissions, and corrective action and termination processes for third party intermediaries.

(a) Participation Plans

In section IV.C.3.c. of this proposed rule, we are proposing to update the conditions for approval related to participation plans such that third party intermediaries that do not submit data

for 1 year would be required to submit a participation plan during self-nomination. Currently, third party intermediaries are required to submit a participation plan only after not submitting data for 2 consecutive years. We do not expect this proposal to affect the number of participation plans submitted during the self-nomination process and therefore do not anticipate an impact on burden; therefore, we are not proposing to modify our burden estimates under OMB control number 0938–1314 (CMS–10621).

c. ICRs Regarding Quality Data Submission

(1) Proposed Changes to Quality Performance Category Submissions

In section IV.A.4.a. of this proposed rule, we are proposing to add three new MVPs beginning with the CY 2027 performance period/2029 MIPS payment year. In section IV.A.3. of this proposed rule, we are also proposing that beginning in the CY 2029 performance period/2031 MIPS payment year, eligible clinicians participating in MIPS, and not reporting the APM Performance Pathway (APP/APP+), would be required to report the measures and activities in a selected MVP. Related to this proposal, we are proposing to include virtual groups in MVP reporting beginning in the CY 2029 performance period/2031 MIPS payment year. We refer readers to sections V.B.7.c.(1)(a) of this proposed rule for additional details regarding the quality data reporting estimates for both MIPS and MVPs due to these updated proposals.

The following proposed policies would not have impact on burden as they do not affect the minimum reporting requirements for the respective quality performance category submission:

In section IV.A.4.a.(2) of this proposed rule, we are proposing MVP maintenance updates to our MVP inventory that are aligned with the MVP development criteria (85 FR 84849 through 84854), in section IV.A.4.d.(1)(c)(iii) of this proposed rule, we are also proposing MIPS core measures in traditional MIPS and MVPs with an attestation process. In section IV.A.4.d(1)(e) of this proposed rule, we are also proposing MIPS quality measure inventory updates.

In section IV.A.4.d.(1)(c)(iii) of this proposed rule, we are proposing to establish a MIPS core measure attestation process whereby the clinician would be required to attest during the data

submission period that there was not an available and applicable MIPS core measure for them to report. We are not proposing revisions due to this proposal as we believe the currently approved burden for traditional MIPS and MVP quality measure submissions is sufficient to absorb the negligible effort of the attestation in lieu of reporting a quality measure.

In the following sections, we estimate the number of submissions for each collection type that require active reporting by individual clinicians, groups, subgroups (as applicable for MVP reporting), or non-Shared Savings Program APM Entities for the CY 2027 performance period/2029 MIPS payment year through CY 2029 performance period/2031 MIPS payment year per the policy proposals previously discussed. Available collection types include Medicare Part B claims measures (small practices only), MIPS Clinical Quality Measures (CQM), QCDR measures, and electronic Clinical Quality Measures (eCQMs). We do not assess burden for the administrative claims-based quality measures, as CMS automatically calculates scores for individual clinicians, groups, subgroups (as applicable for MVP reporting), or non-Shared Savings Program APM Entities that meet requirements to be scored. As there are no policy proposals related to the non-Shared Savings Program related APM Performance pathway, we assume no change to our currently approved burden estimates.

(a) CY 2027 Performance Period/2029 MIPS Payment Year and CY 2028 Performance Period/2030 MIPS Payment Year

The following section details the burden estimate for the proposal to add 3 new MVPs starting with the CY 2027 performance period/2029 MIPS payment year consistent with the proposals outlined in section V.B.7.c.(1)(a)(ii) of this rule. These burden estimates will also apply to the CY 2028 performance period/2030 MIPS payment year.

(i) Updated Data Assumptions for Quality Submissions

For the traditional MIPS and MVP Quality Performance Category ICRs, our currently approved estimates used submission data from the CY 2023 performance period/2025 MIPS payment year and estimated that: (1) 14 percent of quality submissions will submit as an MVP

based on the MVP inventory available in the CY 2026 performance period/2028 MIPS payment year; and (2) 20 subgroups (90 FR 49948 through 49949). At the time of this rulemaking, we have updated historic submission data for the CY 2024 performance period/2026 MIPS performance year, inclusive of individual, group, and non-Shared Savings Program APM Entities.

In Tables D-A5 and D-A6, we identify the updated response estimates by reporting option due to the availability of this updated data and add our estimate of 20 subgroup submissions currently approved under OMB control number 0938–1314 (CMS–10621). The response estimates for these ICRs apply our existing approach for estimating the impact of MVPs as a percentage of historic submissions, the currently approved estimate of 14 percent as established in the CY 2026 PFS Final Rule (90 FR 49949).

The impact on burden for each proposal discussed in the following sections use these updated active response estimates when calculating change in total time and cost. The updated estimates will be submitted to OMB for review under control number 0938-1314 (CMS-10621).

TABLE D-A5: RESPONDENT COUNTS FOR QUALITY PERFORMANCE CATEGORY AND MVP REGISTRATION ICRs

Reporting Option	Performance Category	Requirement	Currently Approved Responses*	Revised Responses **	Change Due to Updated Data
Traditional MIPS	Quality	Medicare Part B Claims Measure Collection Type Submission	8,350	7,307	(1,043)
Traditional MIPS	Quality	MIPS CQM and QCDR Measure Collection Type Submission	17,407	18,820	1,413
Traditional MIPS	Quality	eCQM Collection Type Submission	23,936	22,830	(1,106)
MVPs	N/A	MVP Registration	8,110	7,989	(121)
MVPs	Quality	Medicare Part B Claims Measure Collection Type Submission	1,359	1,189	(170)
MVPs	Quality	MIPS CQM and QCDR Measure Collection Type Submission	2,844	3,074	230
MVPs	Quality	eCQM Collection Type Submission	3,907	3,726	(181)

*Under OMB control number 0938-1314 (CMS-10621).
**Traditional MIPS updates calculated as updated submission data for CY 2024 performance period/2026 MIPS payment year submissions minus 14 percent (existing MVP submission rate). MVPs calculated as 14 percent of historic submissions plus estimated subgroup submissions (split evenly across the eCQM and MIPS CQM/QCDR measure collection types).

(ii) MVP Participation Estimate

We estimate the number of MVP submissions for the CY 2027 performance period/2029 MIPS payment year as a percent of the total traditional MIPS and MVP submissions from the CY 2024 performance period/2026 MIPS payment year (see Table D-A5). We assessed measure-level submission trends from the CY 2024 performance period/2026 MIPS payment

year data for the new MVPs as proposed in section IV.A.4.a. of this proposed rule. The total average of quality measure submissions for the proposed new MVPs was equivalent to approximately 6 percent of the total quality performance category submissions in the CY 2024 performance period/2026 MIPS payment year. With the existing 14 percent estimate previously finalized in the CY 2026 PFS final rule (90 FR 32789) plus the incremental change of an additional 6 percent due to the proposed new MVPs, we estimate that 20 percent of quality performance category submissions may report via MVPs for the CY 2027 performance period/2029 MIPS payment year (row b). While this approach to estimate MVP submissions as a function of historic traditional MIPS and MVP submissions, and not just MVP submissions from a given year, is used to estimate future reporting behaviors with an expect increased adoption due to the annual expansion of the MVP inventory, as summarized in section IV.A.4.a. of this proposed rule, there are limitations, such as lack of longitudinal data to appropriately assess behavior changes related to future adoptions or submissions in both new and existing MVPs. For example, the most recent submission data available is from the CY 2024 performance period/2026 MIPS payment year when the MVP inventory was composed of 16 MVPs, whereas for CY 2027 performance period/2029 MIPS payment year we are proposing an MVP inventory of 30 MVPs. Consistent with the past approach, we project any increase to our expected MVP participation rate reduces the number of estimated submissions for each quality performance category collection type via traditional MIPS.

Table D-A6 of this proposed rule identifies our methods to estimate the number of individual clinicians, groups, and non-Shared Savings Program APM Entities that may submit data via each collection type in the CY 2027 performance period/2029 MIPS payment year, separating traditional MIPS and MVP estimates. We identify estimated submissions per collection type from CY 2024 performance period/2026 MIPS payment year data (row a). Consistent with the policy finalized in the CY 2018 Quality Payment Program final rule that for MIPS eligible clinicians who collect measures via Medicare Part B claims, MIPS CQM/QCDR,

or eCQM collection types and submit more than the required number of measures (82 FR 53735 through 54736), we will score the clinician on the required measures with the highest assigned measure achievement points and thus, the same clinician may be counted as a respondent for more than one collection type. Therefore, our columns in Table D-A6 are not mutually exclusive. We assume that each response or submission per collection type for traditional MIPS includes six quality measures, and that each response or submission per collection type for MVPs includes four quality measures.

TABLE D-A6: ESTIMATED NUMBER OF SUBMISSIONS FOR QUALITY PERFORMANCE CATEGORY BY COLLECTION TYPE

	Medicare Part B Claims Measure	MIPS CQM/QCDR Measure	eCQM
Total 2027 Performance Period Quality Performance Category Submissions (Excludes QPs) (a)	8,496	21,894	26,556
2026 Performance Period Approved MVPs (14 percent) (b) = (a) × 0.14	1,189	3,065	3,718
2027 Performance Period Proposed MVPs (20 percent) (c) = (a) × 0.20	1,699	4,379	5,311
2027 Traditional MIPS Performance Period (Excludes QPs and Estimated MVP Submissions) (d) = (a) - (c)	6,797	17,515	21,245
Number of Submissions Moving to MVPs due to New MVPs (e) = (c) - (b)	510	1,313	1,593

* Estimates in the table are rounded to the nearest whole number, therefore the Number of Submissions Moving to MVPs due to New MVPs row may deviate from the provided formula due to rounding.

(iii) Traditional MIPS Quality Data Submission

The following estimates apply to requirements for the traditional MIPS reporting option and submissions by individual clinicians, groups, and non-Shared Savings Program APM Entities. For our most recent discussions of related burden, we refer readers to the CY 2024 PFS final rule (88 FR 70149 through 70151) and the CY 2025 PFS final rule (89 FR 98479 through 98483), and CY 2026 PFS final rule (90 FR 49946 through 49949). All estimates encompass time to review measure specifications unless otherwise noted.

(A) Medicare Part B Claims Measure Collection Type

The following estimates apply to requirements for the traditional MIPS reporting option and submissions by individual clinicians from a small practice with less than 15 clinicians. We acknowledge a range of times for computer system analysts to submit quality measure data

(minimum, mean, and maximum burden estimates) for this collection type. We continue to apply the maximum burden in our total burden estimates.

For the CY 2027 performance period/2029 MIPS payment year, we estimate a decrease of 510 submissions due to proposing three new MVPs in this proposed rule. When considering a range of Computer System Analyst response times (from 1.15 to 8.2 hr/response) we estimate a maximum total decrease of 7,242 hours and $883,105 as demonstrated in Tables D-A7 through D-A9.

TABLE D-A7: ESTIMATED INFORMATION COLLECTION BURDEN CHANGE FOR TRADITIONAL MIPS MEDICARE PART B CLAIMS MEASURE COLLECTION TYPE FOR CY 2027 PERFORMANCE PERIOD/2029 MIPS PAYMENT YEAR AND CY 2028 PERFORMANCE PERIOD/2030 MIPS PAYMENT YEAR

Range: Time/Cost	Time (hr) - Computer System Analyst	Time (hr) - Other Occupations	Total Time (hr)	Cost ($) - Computer System Analyst	Cost ($) - Other Occupations	Total Cost ($)
Minimum	(587)	(3,060)	(3,647)	(64,632)	(422,249)	(486,881)
Mean	(1,046)	(3,060)	(4,106)	(115,214)	(422,249)	(537,463)
Maximum	(4,182)	(3,060)	(7,242)	(460,856)	(422,249)	(883,105)

TABLE D-A8: ESTIMATED INFORMATION COLLECTION BURDEN RANGE FOR COMPUTER SYSTEM ANALYSTS IN TRADITIONAL MIPS MEDICARE PART B CLAIMS MEASURE COLLECTION TYPE FOR CY 2027 PERFORMANCE PERIOD/2029 MIPS PAYMENT YEAR AND CY 2028 PERFORMANCE PERIOD/2030 MIPS PAYMENT YEAR

Computer System Analyst	Wage ($/hr)		Time per Submission (hr)	Total Time (hr)	Total Cost ($)
Minimum	110.20	(510)	1.15	(587)	(64,632)
Mean	110.20	(510)	2.05	(1,046)	(115,214)
Maximum	110.20	(510)	8.2	(4,182)	(460,856)

TABLE D-A9: ESTIMATED INFORMATION COLLECTION BURDEN RANGE FOR OTHER OCCUPATIONS IN TRADITIONAL MIPS MEDICARE PART B CLAIMS MEASURE COLLECTION TYPE FOR CY 2027 PERFORMANCE PERIOD/2029 MIPS PAYMENT YEAR AND CY 2028 PERFORMANCE PERIOD/2030 MIPS PAYMENT YEAR

Other Occupations	Wage ($/hr)		Time per Submission (hr)	Total Time (hr)	Total Cost ($)
Billing Clerks	49.10	(510)	1	(510)	(25,041)
Licensed Practical Nurses (LPNs)	64.48	(510)	1	(510)	(32,885)
Medical and Health Service Managers	135.54	(510)	3	(1,530)	(207,376)

Physicians	307.74	(510)	1	(510)	(156,947)
Total	n/a	(510)	varies	(3,060)	(422,249)

(B) MIPS CQM and QCDR Measure Collection Types

For the CY 2027 performance period/2029 MIPS payment year, we estimate a decrease of 1,313 submissions due to proposing three new MVPs in this proposed rule. Multiplying the estimated change in submissions (1,313) by the time per submission by labor category, we estimate a decrease of 11,926 hours and $1,499,903 as demonstrated in Table D-A10.

TABLE D-A10: ESTIMATED INFORMATION COLLECTION BURDEN CHANGE FOR TRADITIONAL MIPS CQM AND QCDR MEASURE COLLECTION TYPES FOR CY 2027 PERFORMANCE PERIOD/2029 MIPS PAYMENT YEAR AND CY 2028 PERFORMANCE PERIOD/2030 MIPS PAYMENT YEAR

Other Occupations	Wage ($/hr)		Time per Submission (hr)	Total Time (hr)	Total Cost ($)
Computer System Analyst	110.20	(1,313)	4.083	(5,361)	(590,782)
Billing Clerks	49.10	(1,313)	1	(1,313)	(64,468)
Licensed Practical Nurses (LPNs)	64.48	(1,313)	1	(1,313)	(84,662)
Medical and Health Service Managers	135.54	(1,313)	2	(2,626)	(355,928)
Physicians	307.74	(1,313)	1	(1,313)	(404,063)
Total	N/A	(1,313)	Varies	(11,926)	(1,499,903)

(C) MIPS eCQM Collection Type

For the CY 2027 performance period/2029 MIPS payment year, we estimate a decrease of 1,593 submissions due to proposing three new MVPs in this proposed rule. Multiplying the estimated change in submissions by the time per submission by labor category, we estimate a decrease of 12,744 hours and $1,629,639 as demonstrated in Table D-A11

TABLE D-A11: ESTIMATED INFORMATION COLLECTION BURDEN CHANGE FOR TRADITIONAL MIPS eCQM COLLECTION TYPE FOR CY 2027 PERFORMANCE PERIOD/2029 MIPS PAYMENT YEAR AND CY 2028 PERFORMANCE PERIOD/2030 MIPS PAYMENT YEAR

Other Occupations	Wage ($/hr)	Respondents	Time per Submission (hr)	Total Time (hr)	Total Cost ($)
Computer System Analyst	110.20	(1,593)	3	(4,779)	(526,646)
Billing Clerks	49.10	(1,593)	1	(1,593)	(78,216)

Licensed Practical Nurses (LPNs)	64.48	(1,593)	1	(1,593)	(102,717)
Medical and Health Service Managers	135.54	(1,593)	2	(3,186)	(431,830)
Physicians	307.74	(1,593)	1	(1,593)	(490,230)
Total	N/A	(1,593)	Varies	(12,744)	(1,629,639)

(iv) MVP Registration: Individuals, Groups, Subgroups, and APM Entities

We estimate that the proposed addition of three new MVPs would result in an increase of 3,416 MVP registrations. Using the currently approved estimate of 0.25/hr per registration, we estimate an annual burden increase of 854 hours (+3,416 registrations × 0.25 hr/registration) at a cost of +$94,111 (+854 hr × $110.20/hr for a computer system analyst or equivalent).

(v) MVP Quality Performance Category Submission

We estimate a change to the number of annual MVP quality performance category submissions per collection type from our currently approved burden estimates, beginning with the CY 2027 performance period/2029 MIPS payment year. These estimates include the figures detailed in section V.B.7.c.(1)(a) of this proposed rule. These estimates aggregate individual clinician, group, subgroup, and non-Shared Savings Program APM Entity submissions. All estimates presume maximum submission time and encompass time to review measure specifications unless otherwise noted.

(A) Medicare Part B Claims Measure Collection Type

We estimate an increase of 510 submissions due to the proposed addition of three new MVPs. Multiplying the estimated change in submissions (+510) by the time per submission by labor category, we estimate a total increase of 4,816 hours at a cost of $587,143 as demonstrated in Table D-A12.

TABLE D-A12: ESTIMATED INFORMATION COLLECTION BURDEN CHANGE FOR MVP MEDICARE PART B CLAIMS MEASURE COLLECTION TYPE FOR CY 2027 PERFORMANCE PERIOD/2029 MIPS PAYMENT YEAR AND CY 2028 PERFORMANCE PERIOD/2030 MIPS PAYMENT YEAR

Occupation	Wage ($/hr)	Respondents	Time per Submission (hr)	Total Time (hr)	Total Cost ($)
Computer System Analyst	110.20	510	5.46	2,785	306,907
Medical and Health Service Managers	135.54	510	2	1,020	138,251
Licensed Practical Nurses (LPNs)	64.48	510	0.66	337	21,730
Billing Clerks	49.10	510	0.66	337	16,547
Physicians	307.74	510	0.66	337	103,708
Total	n/a	510	varies	4,816	587,143

(B) MIPS CQM and QCDR Measure Collection Type

We estimate an increase of 1,313 submissions due to the proposed addition of three new MVPs. Multiplying the estimated change in submissions (+1,313) by the time per submission by labor category, we estimate a total increase of 7,840 hours at a cost of $986,867 as demonstrated in Table D-A13.

TABLE D-A13: ESTIMATED INFORMATION COLLECTION BURDEN CHANGE FOR MVP CQM AND QCDR MEASURE COLLECTION TYPES FOR CY 2027 PERFORMANCE PERIOD/2029 MIPS PAYMENT YEAR AND CY 2028 PERFORMANCE PERIOD/2030 MIPS PAYMENT YEAR

Occupation	Wage ($/hr)	Respondents	Time per Submission (hr)	Total Time (hr)	Total Cost ($)
Computer System Analyst	110.20	1,313	2.66	3,493	384,929
Medical and Health Service Managers	135.54	1,313	1.33	1,746	236,653
Licensed Practical Nurses (LPNs)	64.48	1,313	0.66	867	55,904
Billing Clerks	49.10	1,313	0.66	867	42,570
Physicians	307.74	1,313	0.66	867	266,811
Total	N/A	1,313	Varies	7,840	986,867

(C) eCQM Collection Type

We estimate an increase of 1,593 submissions due to the proposed addition of three new MVPs. Multiplying the estimated change in submissions (+1,593) by the time per submission by labor category, we estimate a total increase of 8,442 hours at a cost of $1,079,350 as demonstrated in Table D-A14.

TABLE D-A14: ESTIMATED INFORMATION COLLECTION BURDEN CHANGE FOR MVP eCQM COLLECTION TYPE FOR CY 2027 PERFORMANCE PERIOD/2029 MIPS PAYMENT YEAR AND CY 2028 PERFORMANCE PERIOD/2030 MIPS PAYMENT YEAR

Occupation	Wage ($/hr)	Respondents	Time per Submission (hr)	Total Time (hr)	Total Cost ($)
Computer System Analyst	110.20	1,593	1.99	3,170	349,334
Medical and Health Service Managers	135.54	1,593	1.33	2,119	287,209
Licensed Practical Nurses (LPNs)	64.48	1,593	0.66	1,051	67,768
Billing Clerks	49.10	1,593	0.66	1,051	51,604
Physicians	307.74	1,593	0.66	1,051	323,435
Total	N/A	1,593	Varies	8,442	1,079,350

(vi) Summary of Quality Performance Category Estimated Information Collection Burden Change for CY 2027 Performance Period/2029 MIPS Payment Year and CY 2028 Performance Period/2030 MIPS Payment Year

Across the quality performance category collection types for Traditional MIPS and MVPs, we estimate that policy proposals would lead to a decrease in burden of 9,960 hours and a savings of $1,265,176 under OMB control number 0938-1314 (Table D-A15).

TABLE D-A15: SUMMARY OF QUALITY PERFORMANCE CATEGORY ESTIMATED INFORMATION COLLECTION BURDEN CHANGE FOR CY 2027 PERFORMANCE PERIOD/2029 MIPS PAYMENT YEAR AND CY 2028 PERFORMANCE PERIOD/2030 MIPS PAYMENT YEAR

Requirement	Change in Number of Respondents	Change in Time	Change in Cost ($)
Traditional MIPS Quality Submission	(3,416)	(31,912)	(4,012,647)
MVP Registration	3,416	854	94,111
MVP Quality Submission	3,416	21,098	2,653,360
Total	**0***	**(9,960)**	**(1,265,176)**

* Respondents moving from Traditional MIPS to MVPs need to complete MVP registration plus MVP Quality Submission, therefore the net number of new respondents will be 0.

(b) CY 2029 Performance Period/2031 MIPS Payment Year

The following section details the burden estimate for that beginning in the CY 2029 performance period/2031 MIPS payment year, eligible clinicians participating in MIPS, and not

reporting the APP, would be required to report the measures and activities in a selected MVP as detailed in section IV.A.3. of this proposed rule.

(i) Traditional MIPS Quality Data Submission

For the CY 2029 performance period/2031 MIPS payment year, we assume that no Quality Performance category submissions will occur via Traditional MIPS due the proposal that eligible clinicians participating in MIPS and not reporting the APP, would be required to report the measures and activities in a selected MVP.

(A) Medicare Part B Claims Measure Collection Type

The following estimates apply to requirements for the traditional MIPS reporting option and submissions by individual clinicians. For the CY 2029 performance period/2031 MIPS payment year, we estimate a decrease of 6,797 submissions due to the proposal to require selection of an MVP for quality performance category reporting. Multiplying the estimated change in submissions (-6,797) by the time per submission by labor category, we estimate a maximum total decrease of 96,517 hours and savings of $11,769,506 as demonstrated in Table D-A16.

TABLE D-A16: ESTIMATED INFORMATION COLLECTION BURDEN CHANGE FOR TRADITIONAL MIPS MEDICARE PART B CLAIMS MEASURE COLLECTION TYPE FOR CY 2029 PERFORMANCE PERIOD/2031 MIPS PAYMENT YEAR

Occupation	Wage ($/hr)	Respondents	Time per Submission (hr)	Total Time (hr)	Total Cost ($)
Computer System Analyst	110.20	(6,797)	8.2	(55,735)	(6,141,997)
Medical and Health Service Managers	135.54	(6,797)	3	(20,391)	(2,763,796)
Licensed Practical Nurses (LPNs)	64.48	(6,797)	1	(6,797)	(438,271)
Billing Clerks	49.10	(6,797)	1	(6,797)	(333,733)
Physicians	307.74	(6,797)	1	(6,797)	(2,091,709)
Total	N/A	(6,797)	Varies	(96,517)	(11,769,506)

(B) MIPS CQM and QCDR Measure Collection Types

For the CY 2029 performance period/2031 MIPS payment year, we estimate a decrease of 17,507 submissions due to the proposal to require selection of an MVP for quality

performance category reporting. Multiplying the estimated change in submissions (-17,507) by the time per submission by labor category, we estimate a decrease of 159,016 hours and savings of $19,999,053 as demonstrated in Table D-A17.

TABLE D-A17: ESTIMATED INFORMATION COLLECTION BURDEN CHANGE FOR TRADITIONAL MIPS CQM AND QCDR MEASURE COLLECTION TYPES FOR CY 2029 PERFORMANCE PERIOD/2031 MIPS PAYMENT YEAR

Occupation	Wage ($/hr)	Respondents	Time per Submission (hr)	Total Time (hr)	Total Cost ($)
Computer System Analyst	110.20	(17,507)	4.083	(71,481)	(7,877,206)
Medical and Health Service Managers	135.54	(17,507)	2	(35,014)	(4,745,798)
Licensed Practical Nurses (LPNs)	64.48	(17,507)	1	(17,507)	(1,128,851)
Billing Clerks	49.10	(17,507)	1	(17,507)	(859,594)
Physicians	307.74	(17,507)	1	(17,507)	(5,387,604)
Total	N/A	(17,507)	Varies	(159,016)	(19,999,053)

(C) MIPS eCQM Collection Type

For the CY 2029 performance period/2031 MIPS payment year, we estimate a decrease of 21,237 submissions due to the proposal to require selection of an MVP for quality performance category reporting. Multiplying the estimated change in submissions by the time per submission by labor category, we estimate a decrease of 169,896 hours and savings of $21,725,451 as demonstrated in Table D-A18.

TABLE D-A18: ESTIMATED INFORMATION COLLECTION BURDEN CHANGE FOR TRADITIONAL MIPS eCQM COLLECTION TYPE FOR CY 2029 PERFORMANCE PERIOD/2031 MIPS PAYMENT YEAR

Occupation	Wage ($/hr)	Respondents	Time per Submission (hr)	Total Time (hr)	Total Cost ($)
Computer System Analyst	110.20	(21,237)	3	(63,711)	(7,020,952)
Medical and Health Service Managers	135.54	(21,237)	2	(42,474)	(5,756,926)
Licensed Practical Nurses (LPNs)	64.48	(21,237)	1	(21,237)	(1,369,362)
Billing Clerks	49.10	(21,237)	1	(21,237)	(1,042,737)
Physicians	307.74	(21,237)	1	(21,237)	(6,535,474)
Total	N/A	(21,237)	Varies	(169,896)	(21,725,451)

(ii) MVP Registration: Individuals, Groups, Subgroups, and APM Entities

For the CY 2029 performance period/2031 MIPS payment year, we assume that the total number of individual clinicians, groups, non-Shared Savings Program APM Entities, and subgroups that will complete the MVP registration process is 56,946.

We estimate that the proposed transition to MVPs would result in an increase of 45,541 MVP registrations. Using the currently approved estimate of 0.25/hr per registration, we estimate an annual burden change of +11,385 hours (+45,541 registrations × 0.25 hr/registration) at a cost of +$1,254,627 (+11,385 hr × $110.20/hr for a computer system analyst or equivalent).

(iii) MVP Quality Performance Category Submission

We estimate an increase to the number of annual MVP quality performance category submissions per collection type from our currently approved burden estimates, for the CY 2029 performance period/2031 MIPS payment year due to the proposal to require selection of an MVP for quality performance category submission. These estimates include the figures detailed in section V.B.7.c.(1)(a) of this proposed rule plus our currently approved estimate of 20 subgroup submissions (split evenly across the eCQM and MIPS CQM/QCDR measure collection types). These estimates aggregate individual clinician, group, subgroup, and non-Shared Savings Program APM Entity submissions. All estimates encompass time to review measure specifications unless otherwise noted. Related to this proposal, we are proposing to include virtual groups in MVP reporting beginning in the CY 2029 performance period/2031 MIPS payment year. Because virtual groups are included as groups in the burden estimates there is no additional burden change beyond what is already calculated.

(A) Medicare Part B Claims Measure Collection Type

We estimate an increase of 6,797 submissions due to the proposed transition to MVPs in this proposed rule. Multiplying the estimated change in submissions (+6,797) by the time per submission by labor category, we estimate a total change of +64,164 hours at a cost of +$7,822,315 as demonstrated in Table D-A19.

TABLE D-A19: ESTIMATED INFORMATION COLLECTION BURDEN CHANGE FOR MVP MEDICARE PART B CLAIMS MEASURE COLLECTION TYPE FOR CY 2029 PERFORMANCE PERIOD/2031 MIPS PAYMENT YEAR

Occupation	Wage ($/hr)	Respondents	Time per Submission (hr)	Total Time (hr)	Total Cost ($)
Computer System Analyst	110.20	6,797	5.46	37,112	4,089,742
Medical and Health Service Managers	135.54	6,797	2	13,594	1,842,531
Licensed Practical Nurses (LPNs)	64.48	6,797	0.66	4,486	289,257
Billing Clerks	49.10	6,797	0.66	4,486	220,263
Physicians	307.74	6,797	0.66	4,486	1,380,522
Total	N/A	6,797	Varies	64,164	7,822,315

(B) MIPS CQM and QCDR Measure Collection Type

We estimate an increase of +17,507 submissions due to the proposed transition to MVPs in this proposed rule. Multiplying the estimated change in submissions (+17,507) by the time per submission by labor category, we estimate a total increase of 104,518 hours at a cost of $13,156,170 as demonstrated in Table D-A20.

TABLE D-A20: ESTIMATED INFORMATION COLLECTION BURDEN CHANGE FOR MVP CQM AND QCDR MEASURE COLLECTION TYPES FOR CY 2029 PERFORMANCE PERIOD/2031 MIPS PAYMENT YEAR

Occupation	Wage ($/hr)	Respondents	Time per Submission (hr)	Total Time (hr)	Total Cost ($)
Computer System Analyst	110.20	17,507	2.66	46,569	5,131,904
Medical and Health Service Managers	135.54	17,507	1.33	23,284	3,155,913
Licensed Practical Nurses (LPNs)	64.48	17,507	0.66	11,555	745,066
Billing Clerks	49.10	17,507	0.66	11,555	567,351
Physicians	307.74	17,507	0.66	11,555	3,555,936
Total	N/A	17,507	Varies	104,518	13,156,170

(C) eCQM Collection Type

We estimate an increase of +21,237 submissions due to the proposed transition to MVPs in this proposed rule. Multiplying the estimated change in submissions (+21,237) by the time per submission by labor category, we estimate a total change of +112,555 hours at a cost of +$14,390,821 as demonstrated in Table D-A21.

TABLE D-A21: ESTIMATED INFORMATION COLLECTION BURDEN CHANGE FOR MVP eCQM COLLECTION TYPE FOR CY 2029 PERFORMANCE PERIOD/2031 MIPS PAYMENT YEAR

Occupation	Wage ($/hr)	Respondents	Time per Submission (hr)	Total Time (hr)	Total Cost ($)
Computer System Analyst	110.20	21,237	1.99	42,262	4,657,272
Medical and Health Service Managers	135.54	21,237	1.33	28,245	3,828,327
Licensed Practical Nurses (LPNs)	64.48	21,237	0.66	14,016	903,752
Billing Clerks	49.10	21,237	0.66	14,016	688,186
Physicians	307.74	21,237	0.66	14,016	4,313,284
Total	N/A	21,237	Varies	112,555	14,390,821

(iv) Summary of Quality Performance Category Estimated Information Collection Burden Change for CY 2029 Performance Period/2031 MIPS Payment Year

Across the quality performance category collection types (Medicare Part B claims, CQM/QCDR, eCQMs) for Traditional MIPS and MVPs, we estimate that policy proposals will not change number of total respondents but will lead to a decrease in burden of 132,807 hours and a savings of $16,870,077 under OMB control number 0938-1314 (Table D-A22).

TABLE D-A22: SUMMARY OF QUALITY PERFORMANCE CATEGORY ESTIMATED INFORMATION COLLECTION BURDEN CHANGE FOR CY 2029 PERFORMANCE PERIOD/2031 MIPS PAYMENT YEAR

Requirement	Change in Number of Respondents	Change in Time	Change in Cost ($)
Traditional MIPS Quality Submission	(45,541)	(425,429)	(53,494,010)
MVP Registration	45,541	11,385	1,254,627
MVP Quality Submission	45,541	281,237	35,369,306
Total	**0**	**(132,807)**	**(16,870,077)**

* Respondents moving from Traditional MIPS to MVPs need to complete MVP registration plus MVP Quality Submission, therefore the net number of new respondents will be 0.

d. ICRs Regarding Reporting the MIPS Promoting Interoperability Performance Category

We refer readers to § 414.1375 for our previously established policies regarding reporting requirements for the MIPS Promoting Interoperability performance category. We also refer readers to § 414.1305 for the definition of attestation, § 414.1325 for data submission requirements, and §§ 414.1380(b)(4) and 414.1365(d)(3)(iv) for MIPS Promoting Interoperability performance category scoring. For historic assumptions on reporting

requirements for the MIPS Promoting Interoperability performance category, we refer readers to the CY 2024 PFS final rule (88 FR 79449 through 79451).

In the CY 2026 PFS final rule (90 FR 49952), our burden estimates represent an assumed number of 20,881 respondents, which is based on submission data from the CY 2023 performance period/2025 MIPS payment year. In this proposed rule, we updated our burden estimates to represent an assumed number of respondents to 19,325, which is based on submission data from the CY 2024 performance period/2026 MIPS payment year.

In the following paragraphs, we outline the proposed changes to the MIPS Promoting Interoperability performance category reporting requirements discussed in section IV.A.4.d.(4) of this proposed rule. For the first three policy proposals, there are similar proposed policies for the Medicare Promoting Interoperability Program in the FY 2027 Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment Systems (IPPS/LTCH PPS) proposed rule (91 FR 19620 through 19629). Our burden assumptions for the MIPS Promoting Interoperability performance category proposals in this proposed rule are consistent with the burden assumptions for the Medicare Promoting Interoperability Program as described in the FY 2027 IPPS/LTCH PPS proposed rule (91 FR 19760 through 19763). For the fourth policy proposal, we propose to change the burden for the MIPS Promoting Interoperability performance category due to the proposed addition of a new required measure. Lastly, we discuss the historical approach for estimating burden for this performance category and propose a reduction in the burden estimate for the proposal to remove the Security Risk Analysis measure.

First, beginning with the CY 2027 performance period/2029 MIPS payment year, we are proposing modifications to the MIPS Promoting Interoperability performance category Certified Electronic Health Record Technology (CEHRT) definition at 42 CFR 414.1305 to align with proposals to remove certain certification criteria from the Office of the National Coordinator for Health IT (ONC Health IT) Certification Program as detailed in Table C-G1 and as outlined in

the Assistant Secretary for Technology Policy (ASTP)/ONC (Health Data, Technology, and Interoperability) HTI-5 proposed rule. As these proposed changes will not impact reporting burden for the MIPS Promoting Interoperability performance category, we are not proposing to modify our burden estimate for this proposal.

Second, beginning with the CY 2026 performance period/2028 MIPS payment year, we are proposing to remove the required ONC Direct Review attestation and the optional ONC-Authorized Certified Bodies (ACB) Surveillance attestation from the MIPS Promoting Interoperability performance category to reduce administrative burden. CY 2024 submission data show that 79 percent of MIPS eligible clinicians elect to report this optional ONC-ACB Surveillance attestation. If the proposal to remove the required ONC Direct Review attestation is finalized, we estimate that the removal would decrease burden by 1 minute (0.0167 hr). Therefore, we estimate that removing this attestation would result in an annual decrease in total cost of $35,595 for all responses (-0.0167 hr per response x 19,325 responses) [391] x $110.20 /hr for a computer systems analyst to submit Promoting Interoperability data. Similarly, should the proposal to remove the optional ONC-ACB Surveillance attestation be finalized, we estimate that eligible clinicians who elect to submit the optional ONC-ACB Surveillance attestation would experience a decrease in burden of 1 minute (0.0167 hr) which is consistent with the CY 2027 IPPS/LTCH PPS proposed rule (91 FR 19761). Therefore, we estimate that removing this attestation would result in an annual decrease in total cost of $35,595 for all responses (-0.0167 hr per response x 19,325 responses)[392] x $110.20 /hr for a computer systems analyst to submit Promoting Interoperability data.

Third, we are proposing to modify the Electronic Prior Authorization measure to an optional (bonus) measure for the CY 2027 performance period/2029 MIPS payment year and a required measure starting with the CY 2028 performance period/2030 MIPS payment year. This

[391] This figure is rounded to whole number.
[392] This figure is rounded to whole number.

measure was established in the CMS Interoperability and Prior Authorization final rule (89 FR 8758) and was referenced in the CY 2026 PFS final rule (90 FR 49952). Initially, the implementation of this measure as a requirement of the MIPS Promoting Interoperability performance category was specified starting with the CY 2027 performance period/2029 MIPS payment year. In this proposed rule, we are updating the burden estimates for such measure to reflect the proposal to require the reporting of such measure starting with CY 2028 performance period/2030 MIPS payment year. The proposal to require the use of specific Fast Healthcare Interoperability Resources (FHIR)-enabled ONC-certified health IT modules within CEHRT to complete at least one prior authorization request and determination for at least one medical item or service (excluding prescription drugs) would not impact reporting burden. Under OMB control number 0938-1278 (CMS-10552) the currently approved burden estimate for this measure is 0.5 minutes (0.0083 hours) per eligible MIPS eligible clinicians. Because we are unable to estimate the number of MIPS eligible clinicians who may attest to this as a bonus measure in CY 2027, we are not proposing to modify our burden estimates for CY 2027. If the proposal to require the Electronic Prior Authorization measure starting with CY 2028 performance period/2030 MIPS payment year is finalized, we estimate that the requirement to attest "Yes"/"No" to this measure would increase burden by 0.5 minutes (0.0083 hours). Therefore, we estimate the proposal to modify this measure would result in an annual increase in total cost of $17,632 for all responses (+0.0083 hours per response x 19,325 responses)[393] x $110.20/hr for a computer systems analyst to submit Promoting Interoperability data.

Fourth, we are proposing to require a new measure, Electronic Prior Authorization for Prescription Drugs, which would require the use of specific FHIR-enabled health IT modules within CEHRT to complete at least one prior authorization request and determination for prescription drugs and medications starting with the CY 2028 performance period/2030 MIPS payment year. If the proposal is finalized to require the reporting of the Electronic Prior

[393] This figure is rounded to whole number.

Authorization for Prescription Drugs measure starting with the CY 2028 performance period/2030 MIPS payment year, we estimate that the requirement to attest "Yes"/"No" to this measure would increase burden by 0.5 minutes (0.0083 hours). Therefore, we estimate the proposal to add this measure would result in an annual increase in total cost of $17,632 for all responses (+0.0083 hr per response x 19,325 responses)[394] x $110.20 /hr for a computer systems analyst to submit Promoting Interoperability data.

Lastly, starting with the CY 2027 performance period/2029 MIPS payment year, we are proposing to remove the Security Risk Analysis measure from the MIPS Promoting Interoperability performance category to reduce burden. While the Security Risk Analysis measure has been required and included in the aggregate estimate for reporting burden for the MIPS Promoting Interoperability performance category (renamed from the Advancing Care Information performance category in the CY 2019 PFS final rule (83 FR 59719)) since the inception of MIPS under the Quality Payment Program as described in the CY 2017 Quality Payment Program final rule (81 FR 77014), we do not have a historic burden estimate attributed to this measure alone.

With the 2015 Medicare EHR Incentive Program final rule serving as the basis for developing the requirements and structure for the Advancing Care Information performance category under MIPS (81 FR 28215 through 28230), we reviewed how burden was historically estimated. We found that the 2015 Medicare EHR Incentive Program estimated burden by objective as follows: 10 minutes to attest to objectives with measures requiring a numerator and denominator to be generated, 1 minute to attest to objectives with measures with "Yes"/"No" attestations, and 6 hours to attest the Security Risk Analysis measure (80 FR 62918). The Security Risk Analysis measure requires providers to attest that they are protecting electronic health information which involves conducting or reviewing a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the security (to include

[394] This figure is rounded to a whole number.

encryption) of data created or maintained by CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), implement security updates as necessary, and correct identified security deficiencies as part of the provider's risk management process.

In developing the Advancing Care Information performance category under MIPS in the CY 2017 Quality Payment Program final rule, we streamlined the submission requirements that were outlined in the 2015 Medicare EHR Incentive Program final rule and removed two objectives and their associated measures, thereby reducing burden from nearly seven hours in the Medicare EHR Incentive Program final rule to three hours for the MIPS Advancing Care Information performance category (81 FR 77510). In the CY 2026 PFS final rule (90 FR 49952), our finalized burden estimate for the reporting requirements to submit Promoting Interoperability data is 2.7 hours (162 minutes). Applying the same burden assumptions used in the 2015 Medicare EHR Incentive Program final rule of 10 minutes of burden per objectives with measures requiring the generation of a numerator/denominator and 0.5 to 1 minute of time for measures requiring "Yes"/"No" attestations to our currently approved requirements for reporting Promoting Interoperability data establishes a burden estimate of 36 minutes, we deduce that the remainder of time (126 minutes) can be attributed to the Security Risk Analysis measure. If the proposal to remove the required Security Risk Analysis measure is finalized, we estimate that the removal would decrease burden by 2.1 hours (126 minutes). Therefore, we estimate the proposal to remove this measure would result in an annual decrease in total cost of $4,472,247 for all responses (-2.1 hr per response x 19,325 responses)[395] x $110.20/hr for a computer systems analyst to submit Promoting Interoperability data beginning with the CY 2027 performance year/2029 MIPS payment year.

Tables D-A23 and D-A24 detail the estimated change in burden for each proposed measure/attestation change by performance year (CY 2027 performance year/2029 MIPS payment year and for the CY 2028 performance year/2030 MIPS payment year respectively)

[395] This figure is rounded to a whole number.

should the proposed policy changes be finalized. Each table includes an estimated total change in annual burden for submitting MIPS Promoting Interoperability performance category data.

TABLE D-A23: CHANGE IN ESTIMATED BURDEN FOR PROMOTING INTEROPERABILITY PERFORMANCE CATEGORY DATA SUBMISSION FOR CY 2027 PERFORMANCE PERIOD/2029 MIPS PAYMENT YEAR

Measure/Attestation	No. of Respondents	Total Annual Responses	Time per Response (hours)	Total Annual Time (hours)*	Labor Cost ($/hr)	Total Cost ($)*
Removal of ONC Direct Review Attestation+	19,325	19,325	(0.0167)	(323)	110.20	(35,595)
Removal of ONC-ACB Surveillance Attestation+	19,325	19,325	(0.0167)	(323)	110.20	(35,595)
Removal of Security Risk Analysis Measure	19,325	19,325	(2.1)	(40,583)	110.20	(4,472,247)
Total	19,325	19,325	(2.13)	(41,228)	110.20	(4,543,326)

*Total Annual Time estimates in the table are rounded to the hour and Total Cost estimates are rounded to the dollar, therefore the Total row may deviate from the sum of all rows.
+The proposals to remove the ONC attestations begin with the CY 2026 performance period/2028 MIPS payment year and will be updated under OMB control number 0938-1314.

If all policy proposals, as identified in Table D-A23 of this proposal rule, are finalized for the CY 2027 performance year/2029 MIPS payment year, we estimate a total reduction of 2.13 hours per response (0.0167 + 0.0167 + 2.1), resulting in an annual decrease in total hours of 41,228 (2.13 hr per response x 19,325 responses)[396] and total savings of $4,543,326 for all responses (-2.13 hr per response x 19,325 responses)[397] x $110.20/hr for a computer systems analyst to submit Promoting Interoperability data.

TABLE D-A24: CHANGE IN ESTIMATED BURDEN FOR PROMOTING INTEROPERABILITY PERFORMANCE CATEGORY DATA SUBMISSION FOR CY 2028 PERFORMANCE PERIOD/2030 MIPS PAYMENT YEAR

Measure/Attestation	No. of Respondents	Total Annual Responses	Time per Response (hours)	Total Annual Time (hours)*	Labor Cost ($/hr)	Total Cost ($)*
Add Electronic Prior Auth Measure	19,325	19,325	.0083	+161	110.20	+$17,632
Add Electronic Prior Auth for Prescription Drugs Measure	19,325	19,325	.0083	+161	110.20	+$17,632
Total	19,325	19,325	.0167	+323	110.20	+$35,595

*Total Annual Time estimates in the table are rounded to the hour and Total Cost estimates are rounded to the dollar, therefore the Total row may deviate from the sum of all rows.

[396] This figure is rounded.
[397] This figure is rounded.

If the two policy proposals, as identified in Table D-A24 of this proposed rule, are finalized starting with the CY 2028 performance year/2030 MIPS payment year, we estimate a total increase in 0.0167 hours per response (0.00833 + 0.00833), resulting in an annual increase in total hours of 323 (0.0167 hr x 19,325 responses)[398] and a cost of $35,595 for all responses (+0.0167 hr per response x 19,325 responses)[399] x $110.20/hr for a computer systems analyst to submit Promoting Interoperability data. The proposed changes relevant to the submission of Promoting Interoperability data requirements and burden will be submitted to OMB for review under control number 0938-1314 (CMS-10621).

e. ICRs Regarding Reporting for the Improvement Activities Performance Category

We refer readers to §§ 414.1355 and 414.1365(c)(3) for our previously established policies regarding reporting for the improvement activities performance category. We also refer readers to § 414.1305 for the definition of attestation, § 414.1360 for data submission requirements, and §§ 414.1380(b)(3) and 414.1365(d)(3)(iii) for improvement activities performance category scoring. For historic assumptions on reporting requirements for the improvement activities performance category, we refer readers to the CY 2024 PFS final rule (88 FR 79454 and 79455).

In section IV.A.4.d.(3) of this proposed rule, we are proposing changes to the Improvement Activities Inventory for the CY 2027 performance period/2029 MIPS payment year and subsequent years. Consistent with our assumptions in the CY 2023 PFS final rule (87 FR 70211), the CY 2024 PFS final rule (88 FR 79519), the CY 2025 PFS final rule (89 FR 98492), the CY 2026 PFS final rule (90 FR 49953), we believe clinicians performing improvement activities will continue to perform the same activities because previously finalized improvement activities continue to apply for the current and future years unless otherwise

[398] This figure is rounded.
[399] This figure is rounded.

modified via rulemaking (82 FR 54175). We refer readers to section VII.F.11.e.(2)(a) of this proposed rule for additional discussion.

Independent of these proposals, we are updating the number of submissions due to the availability of updated submission data from the CY 2024 performance period/2026 MIPS payment year. While not scored in this rule, the non-policy changes will be submitted to OMB under control number 0938-1314 (CMS-10621).

f. ICRs Regarding the Cost Performance Category

The cost performance category relies on administrative claims data. The Medicare Parts A and B claims submission process (OMB control number 0938–1197; CMS–1500 and CMS-1490S) is used to collect data on cost measures from MIPS eligible clinicians. MIPS eligible clinicians are not required to provide any documentation by Compact Disc or hardcopy. The proposal to update the Operational List of care episode and patient condition groups and codes beginning with the CY 2027 performance period/2029 MIPS payment year, detailed in section IV.A.4.d.(2) of this proposed rule, would not result in the need to add, revise, or delete any claims data fields. Consequently, we are not proposing changes under the aforementioned OMB control number.

g. ICRs Regarding Voluntary Participants Election to Opt Out of Performance Data Display on Compare Tools

As described in section IV.E.2. of this proposed rule, we are proposing to amend § 414.1395(c)(2) to remove the 1-year delay for publicly reporting new improvement activities and Promoting Interoperability measures, objectives, or activities included in a Merit-based Incentive Payment System Value Pathway (MVP), provided the data meet the public reporting standards at § 414.1395(b).

We are not updating our burden estimates under OMB control number 0938–1314 (CMS–10621) as this proposal affects the timing of public reporting for measures and activities included in MVPs but does not modify the existing process by which voluntary participants may

elect to opt-out of having their performance data publicly displayed on Care Compare tools, as established under § 414.1395.

h. ICRs Regarding the Virtual Group Election

As described in section IV.A.3.d. of this proposed rule, we are proposing to include Virtual Groups in MVP reporting starting with the CY 2029 performance year/2031 MIPS payment year as the option for Traditional MIPS reporting would no longer be available. We are not updating our burden estimates under OMB control number 0938–1314 (CMS–10621) as the operational details of this proposal have not yet been developed. We will seek OMB approval for changes in burden due to this policy, once implementation details are sufficiently developed.

C. Summary of Proposed Annual Burden Estimates

Tables D-A25 through D-A27 sets out the burden for this rulemaking's proposals that are subject to the PRA. It does not score burden adjustments that are strictly based on updated data and are unrelated to any of this rule's proposals. Table D-A27 sets out the burden for this rulemaking's proposed provisions that are subject to the PRA. It does not score burden adjustments that are strictly based on updated data and are unrelated to any of the provisions.

TABLE D-A25: PROPOSED ANNUAL REQUIREMENTS AND BURDEN ESTIMATES (CY 2027 PERFORMANCE PERIOD/2029 MIPS PAYMENT YEAR)

Section(s) Under Title 42 of the CFR	OMB Control Number (CMS ID No.)	No. Respondents	Total Annual Responses	Time per Response (hours)	Total Annual Time (hours)	Labor Cost ($/hr)	Total Cost ($)
§§ 414.802 and 414.804	0938-1921 (CMS-10110)						
§§ 414.802 and 414.804	0938-1921 (CMS-10110)						
§§ 414.1325, 414.1335, 414.1365, and 414.1375 Quality Payment Program (CY 2027 performance period/2029 MIPS payment year)	0938-1314 (CMS-10621)	3,416	3,416	Varies	(51,188)	Varies	(5,808,502)
TOTAL	n/a						

TABLE D-A26: PROPOSED ANNUAL REQUIREMENTS AND BURDEN ESTIMATES (CY 2028 PERFORMANCE PERIOD/2030 MIPS PAYMENT YEAR)

Section(s) Under Title 42 of the CFR	OMB Control Number (CMS ID No.)	No. Respondents	Total Annual Responses	Time per Response (hours)	Total Annual Time (hours)	Labor Cost ($/hr)	Total Cost ($)
§§ 414.1325, 414.1335, 414.1365, and 414.1375 Quality Payment Program (CY 2028 performance period/2030 MIPS payment year)	0938-1314 (CMS-10621)	0	0	Varies	323	Varies	35,595
TOTAL	n/a						

TABLE D-A27: PROPOSED ANNUAL REQUIREMENTS AND BURDEN ESTIMATES (CY 2029 PERFORMANCE PERIOD/2031 MIPS PAYMENT YEAR)

Section(s) Under Title 42 of the CFR	OMB Control Number (CMS ID No.)	No. Respondents	Total Annual Responses	Time per Response (hours)	Total Annual Time (hours)	Labor Cost ($/hr)	Total Cost ($)
§§ 414.1325, 414.1335, 414.1365, and 414.1375 Quality Payment Program (CY 2029 performance period/2031 MIPS payment year)	0938-1314 (CMS-10621)	45,541	45,541	Varies	(132,807)	Varies	(16,870,077)
TOTAL	n/a						

TABLE D-A28: ANNUAL REQUIREMENTS AND BURDEN ESTIMATES

Section(s) Under Title 42 of the CFR	OMB Control Number (CMS ID No.)	No. Respondents	Total Annual Responses	Time per Response (hours)	Total Annual Time (hours)	Labor Cost ($/hr)	Total Cost ($)
Limiting Medicare Coverage of Certain Individuals	0938-1426 (CMS 10797)	32,000	3,200	0.25	800	$24.05	19,240
§§ 427.402(c)(4) and (5), 428.302(c)(4) and (5), and 428.303(c)(4) and (5) (Regarding Rebate Reduction Requests Submitted Under Sections 11101 and 11102 of the Inflation Reduction Act)	0938-1474 (CMS-10858)	20	20	31	620	Varies	76,801.60
Regarding the Medicare Prescription Drug Inflation Rebate Program under Sections 11101 and 11102 of the Inflation Reduction Act	0938-TBD (CMS-10930)	14,000 340B Providers or TPAs	70,000 [(14,000 x 4 submissions per year) + 14,000 registrations]	Varies	462,000	Varies	52,366,440
TOTAL		46,020	59,220	39.25	449,420	Varies	50,054,762

D. Submission of PRA-Related Comments

We have submitted a copy of this proposed rule to OMB for its review of the rule's information collection requirements. The requirements are not effective until they have been approved by OMB.

To obtain copies of the supporting statement and any related forms for the proposed collections discussed previously, please visit the CMS website at

https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/pra-listing or call the Reports Clearance Office at 410-786-1326.

We invite public comments on these information collection, that is reporting, recordkeeping or third-party disclosure requirements, please submit your comments electronically as specified in the **DATES** and **ADDRESSES** sections of this proposed rule and identify the rule (CMS-1848-P), the ICR's CFR citation, and OMB control number.

VI. Response to Comments

Because of the large number of public comments, we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

VII. Regulatory Impact Analysis

A. Statement of Need

In this proposed rule, we are proposing payment and policy changes under the Medicare PFS. Our proposed policies in this rulemaking specifically address: changes to the PFS and other changes to Medicare Part B payment policies to ensure that payment systems are updated to reflect changes in medical practice, the relative value of services, and changes in the statute; modifications to the Medicare Shared Savings Program (Shared Savings Program); updates to the Quality Payment Program (MIPS and Advanced APMs); changes to payment policies for drugs and biological products paid under Medicare Part B; changes to the Clinical Laboratory Fee Schedule requirements; other changes to Medicare Part B payment policies for Rural Health Clinics and Federally Qualified Health Centers; and changes to the regulations associated with the Ambulance Fee Schedule. The policies reflect CMS' stewardship of the Medicare program and overarching policy objectives for ensuring equitable beneficiary access to appropriate and quality medical care.

1. Statutory Provisions

a. Clinical Laboratory Fee Schedule (CLFS) – Proposed Revisions Consistent with Recent Statutory Changes

In section III.C. of this proposed rule, we propose the conforming regulations text changes for CLFS data reporting requirements due to the enactment of section 6226 of the Consolidated Appropriations Act, 2026 (CAA, 2026) (Pub. L. 119-75, February 3, 2026). Specifically, section 6226 of the CAA, 2026 revised the next required data reporting period for CDLTs that are not ADLTs to be May 1, 2026 through July 31, 2026, and specified that the applicable data collection period is January 1, 2025 through June 30, 2025. Additionally, section 6226 of the CAA, 2026 amended section 1834A(b)(3) of the Act to specify that the applicable percent was 0 percent for all of CY 2026, meaning that the payment amount determined for a CDLT for CY 2026 shall not result in any reduction in payment as compared to the payment

amount for that test for CY 2025, and to extend the statutory phase-in of payment reductions resulting from private payor rate implementation by an additional year, that is, through CY 2029. Therefore, the applicable percent of up to 15 percent would apply for CYs 2027 through 2029.

2. Discretionary Provisions

a. Medicare Shared Savings Program

In section III.G. of this proposed rule, we are proposing modifications to the Shared Savings Program regulations that would accelerate accountable care service delivery, further CMS towards its goal of aligning spending and value in Original Medicare, and support achieving other related strategic objectives. The proposed changes to the Shared Savings Program include the following.

We are proposing changes to Shared Savings Program policies for determining beneficiary assignment, applicable for the performance year starting on January 1, 2028, and subsequent performance years, to exclude from assignment calculations allowed charges for primary care services billed through a non-ACO TIN by an ACO professional used in assignment and modify assignment eligibility criteria and prospective assignment exclusion criteria based on Medicare enrollment status. We are also proposing to revise the definition of primary care services for the performance year starting on January 1, 2027, and subsequent performance years, to align with payment policy proposals and include, among other services for purposes of beneficiary assignment, services for Screening, Brief Intervention, and Referral to Treatment, Vaccine Adverse Effects Management, and Advance Care Planning.

We are proposing to revise the quality performance standard and other quality reporting requirements, by extending the availability of the MIPS CQM collection type and the MIPS CQM reporting incentive for Shared Savings Program ACOs, extending the scoring of Shared Savings Program ACOs reporting Medicare CQMs using flat benchmarks, addressing ACOs' challenges with meeting the MIPS data completeness requirement, revising the Shared Savings Program scoring policy for excluded APP Plus measures and APP Plus measures that lack a

benchmark, and updating the APP Plus quality measure set. We are also proposing to simplify the Shared Savings Program CEHRT use requirements by sunsetting existing Shared Savings Program CEHRT use and public reporting requirements, providing new options for ACOs to meet the Shared Savings Program CEHRT use requirement, and requiring that they publicly report their selected option. We are also seeking comment on applying electronic prior authorization measures to ACOs participating in the Shared Savings Program in future years.

We are proposing changes to the Shared Savings Program's benchmarking and financial methodology to strengthen financial incentives for ACOs to participate in the program while mitigating selection issues and benchmark rebasing concerns. We are proposing the following changes that would be applicable to agreement periods beginning on January 1, 2027, and in subsequent years: increasing the sharing rate under Level E of the BASIC track, reducing the maximum weight on the regional adjustment for lower-spending ACOs under the ENHANCED track, modifying the prior savings adjustment to increase the scaling factor, risk adjusting the 5 percent cap on upward adjustments to the historical benchmark, and incentivizing new participation through a growth adjustment to the historical benchmark. We are also proposing to reform the ACPT component of the three-way blended benchmark update factor to improve accuracy and strengthen Shared Savings Program financial incentives.

To expand the tools available to ACOs to support beneficiary engagement, we are proposing to allow eligible Shared Savings Program ACOs that have submitted a Part B cost sharing support application and for which CMS has approved their application to reduce or eliminate Part B cost sharing for eligible beneficiaries. We are also proposing to discontinue availability of the option for prepaid shared savings.

We are proposing to modify the methodology for determining quarterly advance investment payment amounts (for eligible ACOs), by removing use of the area deprivation index and adding instead a rural criterion within an approach where we would use a flat per-beneficiary payment amount. We are also proposing revisions to the definitions of experienced and

inexperienced with performance-based risk Medicare ACO initiatives used in determining an ACO's eligibility for certain participation options. Finally, we are proposing to modify Shared Savings Program beneficiary notification requirements, by revising distribution timing of standardized written notices and removing the beneficiary follow-up notice.

b. Drugs and Biological Products Paid Under Medicare Part B

In section III.A.1. of this proposed rule, as part of our continued implementation of section 90004 of the Infrastructure Investment and Jobs Act (Pub. L. 117-58, November 15, 2021) (IIJA), which amended section 1847A of the Act to require manufacturers to provide a refund to CMS for certain discarded amounts from a refundable single-dose container or single-use package drug (hereinafter, refundable drug), we discuss one application received for increased applicable percentage.

c. Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

In section III.B.2. of this proposed rule, we are proposing changes to the payment of Diabetes Self-Management and Training (DSMT) and Medical Nutrition Therapy (MNT) services in RHCs. We are proposing to recognize DSMT and MNT services as qualified visits that are covered and paid as stand-alone billable visits under the RHC benefit. Consequently, we are also proposing to revise § 405.2463(a) and (b)(2) to reflect that DSMT and MNT services would be stand-alone billable visits in RHCs.

In section III.B.3 of this proposed rule, we are proposing to make conforming regulatory text changes at §§ 405.2463(b)(3) and 405.2469(d) since section 6209(d) of the CAA, 2026 extended the abeyance of the RHC and FQHC mental health in-person requirements through December 31, 2027. This provision, as proposed, would require that the in-person visit requirements not apply to any services furnished through to December 31, 2027. We are also proposing technical changes to §§ 405.2464(g) and 405.2469(d).

In section III.B.4 of this proposed rule, we discuss the proposed CY 2027 FQHC PPS market basket update. Section 1834(o)(2)(B)(ii) requires the FQHC PPS base rate be updated

annually by the percentage increase in a market basket of FQHC goods and services as issued through regulations, or if such an index is not available, by the percentage increase in the MEI (as defined in section 1842(i)(3) of the Act) for the year involved. For CY 2027, we are proposing to use an estimate of the 2022-based FQHC market basket to update payments to FQHCs based on the best available data. Consistent with CMS practice, we propose to use the update based on the most recent historical data available at the time of publication of the final rule.

d. Ambulatory Specialty Model (ASM)

In section III.D. of this proposed rule, we discuss proposals related to the Ambulatory Specialty Model (ASM), a mandatory alternative payment model that will be tested by the Innovation Center under the authority at section 1115A of the Act. Section 1115A of the Act authorizes the testing of innovative payment and service delivery models that reduce program expenditures while preserving or enhancing the quality of care furnished to Medicare, Medicaid, and CHIP beneficiaries.

Health care is becoming more fragmented as Medicare beneficiaries are increasingly seeing a greater number of specialists on a more regular basis. We believe there are opportunities to improve coordination between specialists and primary care providers (PCPs) and increase beneficiary engagement in care decisions, particularly with respect to preventing the onset and progression of chronic disease. ASM will evaluate select specialists that furnish a requisite volume of services related to heart failure or low back pain as measured by historic episode-based cost measure (EBCM) episode volume and test whether rewarding them based on measures of quality, cost, care coordination, and Promoting Interoperability results in enhanced quality of care and reduced costs through more effective upstream chronic condition management for ASM's targeted chronic conditions. We expect that a more targeted approach where specialists are evaluated: (1) on a set of relevant performance measures they are required to report; and (2) among specialists furnishing similar sets of services for similar chronic

conditions, will produce final scores and subsequent payment adjustments that are more reflective of clinician performance. A more targeted approach to measurement will also offer more insight into how clinical decisions and processes, such as care coordination, affect patient outcomes. We believe this insight is necessary to support and encourage accountable care, increasing beneficiary access to coordinated specialty care.

We believe that ASM's meaningful comparisons of performance to similar specialists furnishing a substantial volume of services related to ASM's targeted chronic conditions when matched with a payment methodology that creates impactful Medicare Part B payment adjustments will encourage quality improvements in specialty care and meaningful engagement with PCPs to both prevent and manage the onset of chronic conditions, all while achieving net savings to Medicare.

We finalized ASM through notice and comment rulemaking in CY 2026 PFS final rule (90 FR 49562 through 49720). The proposals within this proposed rule address policy gaps and make technical or conforming updates to ensure ASM has sound and well-developed technical, administrative, and operational policies.

B. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866, Regulatory Planning and Review, Executive Order 13563, "Improving Regulation and Regulatory Review;" Executive Order 14192, "Unleashing Prosperity Through Deregulation;" the Regulatory Flexibility Act (RFA) (Pub. L. 96-354); section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4); and Executive Order 13132, Federalism.

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits.

A regulatory impact analysis (RIA) must be prepared for regulatory actions that are significant under section 3(f)(1) of Executive Order 12866. Based on our estimates, OMB's Office of Information and Regulatory Affairs has determined this rulemaking is significant per section 3(f)(1)). Accordingly, we have prepared an RIA that, to the best of our ability, presents the costs and benefits of the rulemaking. The RFA requires agencies to analyze options for regulatory relief of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals, practitioners, and most other providers and suppliers are small entities, either by nonprofit status or by having annual revenues that qualify for small business status under the Small Business Administration standards. (For details, see the SBA's website at *https://www.sba.gov/document/support-table-size-standards* (refer to the 620000 series).) Individuals and States are not included in the definition of a small entity.

The RFA requires that we analyze regulatory options for small businesses and other entities. We prepare a regulatory flexibility analysis unless we certify that a rule would not have a significant economic impact on a substantial number of small entities. The analysis must include a justification concerning the reason action is being taken, the kinds and number of small entities the rule affects, and an explanation of any meaningful options that achieve the objectives with less significant adverse economic impact on the small entities.

Approximately 95 percent of practitioners, other suppliers, and providers are considered to be small entities, based upon the SBA standards. There are over 1 million physicians, other practitioners, and medical suppliers that receive Medicare payment under the PFS. Because many of the affected entities are small entities, the analysis and discussion provided in this section, as well as elsewhere in this proposed rule is intended to comply with the RFA requirements regarding significant impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare an RIA if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This

analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area for Medicare payment regulations and has fewer than 100 beds. Medicare does not pay rural hospitals for their services under the PFS; rather, Medicare payment is made under the PFS for physicians' services, which can be furnished by physicians and NPPs in a variety of settings, including rural hospitals. We did not prepare an analysis for section 1102(b) of the Act because we determined, and the Secretary certified, that this rulemaking will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2026, that threshold is approximately $193 million. This rule will impose no mandates on State, local, or tribal governments or on the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it issues a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has federalism implications. Since this rulemaking does not impose any costs on State or local governments, the requirements of Executive Order 13132 are not applicable.

We prepared the following analysis, which, together with the information provided in the rest of this rule, meets all assessment requirements. The analysis explains the rationale for and purposes of this rule; details the costs and benefits of this rulemaking; analyzes alternatives; and presents the measures we will use to minimize the burden on small entities. As indicated elsewhere in this rule, we discussed various changes to our regulations, payments, or payment policies to ensure that our payment systems reflect changes in medical practice and the relative value of services and to implement provisions of the statute. We provide information for each policy change in the relevant sections of this proposed rule. We are unaware of any relevant

Federal rules that duplicate, overlap, or conflict with this rule. The relevant sections of this rulemaking describe significant alternatives we considered, if applicable.

C. Executive Order 14192, "Unleashing Prosperity Through Deregulation"

Executive Order 14192, titled "Unleashing Prosperity Through Deregulation" was issued on January 31, 2025, and requires that "any new incremental costs associated with new regulations shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least 10 prior regulations."

D. Effects of the Proposed Changes in Relative Value Units (RVUs)

1. Resource-Based Work, PE, and MP RVUs

Section 1848(c)(2)(B)(ii)(II) of the Act requires that increases or decreases in RVUs may not cause the amount of Medicare Part B expenditures for the year to differ by more than $20 million from what expenditures would have been in the absence of these changes. If this threshold is exceeded, we make adjustments to preserve budget neutrality.

Our estimates of changes in Medicare expenditures for PFS services compare payment rates for CY 2026 with payment rates for CY 2027 using CY 2025 Medicare utilization. The payment impacts described in this rule reflect averages by specialty based on Medicare utilization. The payment impact for an individual practitioner could vary from the average and will depend on the mix of services they furnish. The average percentage change in total revenues will be less than the impact displayed here because practitioners and other entities generally furnish services to both Medicare and non-Medicare patients. In addition, practitioners and other entities may receive substantial Medicare revenues for services under other Medicare payment systems. For instance, independent laboratories receive approximately 83 percent of their Medicare revenues from clinical diagnostic laboratory tests that are paid under the Clinical Laboratory Fee Schedule (CLFS).

As required by section 1848(d)(1)(A) of the Act, beginning in CY 2026, there are two separate conversion factors (CFs): one for items and services furnished by a qualifying APM

participant as defined in section 1833(z)(2) of the Act (referred to as the qualifying APM conversion factor) and another for other items and services (referred to as the nonqualifying APM conversion factor), equal to the respective conversion factor for the previous year multiplied by the update established under section 1848(d)(20) of the Act for such respective conversion factor for such year. As specified by section 1848(d)(20) of the Act, the update to the qualifying APM conversion factor for CY 2027 is 0.75 percent while the update to the nonqualifying APM conversion factor for CY 2027 is 0.25 percent.

To calculate the estimated CY 2027 PFS conversion factors, we took the CY 2026 conversion factors without the payment increase of 2.50 percent provided by statute that applied to services furnished from January 1, 2026 through December 31, 2026 and multiplied them by the budget neutrality adjustment required as described in the preceding paragraphs, then multiplied by the qualifying APM and nonqualifying APM updates specified by section 1848(d)(20) of the Act. We estimate the CY 2027 PFS qualifying APM CF to be 33.1693 which reflects a 0.53 percent positive budget neutrality adjustment required under section 1848(c)(2)(B)(ii)(II) of the Act and the 0.75 percent update adjustment factor specified under section 1848(d)(20) of the Act. We estimate the CY 2027 PFS nonqualifying APM CF to be 32.8409 which reflects a 0.53 percent positive budget neutrality adjustment required under section 1848(c)(2)(B)(ii)(II) of the Act and the 0.25 percent update adjustment factor specified under section 1848(d)(20) of the Act. We estimate the CY 2027 anesthesia qualifying APM CF to be 20.4165 and the CY 2027 anesthesia nonqualifying APM CF to be 20.2143, reflecting the same overall PFS adjustments with the addition of anesthesia-specific PE and MP adjustments.

TABLE D-B1: CALCULATION OF THE CY 2027 PFS QUALIFYING APM CONVERSION FACTOR

CY 2026 Conversion Factor		33.5675
Conversion Factor without One Year 2.50% Increase		32.7488
CY 2027 Qualifying APM Update Factor	0.75 percent (1.0075)	
CY 2027 RVU Budget Neutrality Adjustment	0.53 percent (1.0053)	
CY 2027 Conversion Factor		**33.1693**

TABLE D-B2: CALCULATION OF THE CY 2027 PFS NON-QUALIFYING APM CONVERSION FACTOR

CY 2026 Conversion Factor		33.4009
Conversion Factor without One Year 2.50% Increase		32.5863
CY 2027 Non-Qualifying APM Update Factor	0.25 percent (1.0025)	
CY 2027 RVU Budget Neutrality Adjustment	0.53 percent (1.0053)	
CY 2027 Conversion Factor		**32.8409**

TABLE D-B3: CALCULATION OF THE CY 2027 ANESTHESIA QUALIFYING APM CONVERSION FACTOR

CY 2026 National Average Anesthesia Conversion Factor		20.5998
Conversion Factor without One Year 2.50% Increase		20.0974
CY 2027 Qualifying APM Update Factor	0.75 percent (1.0075)	
CY 2027 RVU Budget Neutrality Adjustment	0.53 percent (1.0053)	
CY 2027 Anesthesia Fee Schedule Practice Expense and Malpractice Adjustment	0.30 percent (1.0030)	
CY 2027 Conversion Factor		**20.4165**

TABLE D-B4: CALCULATION OF THE CY 2027 ANESTHESIA NON-QUALIFYING APM CONVERSION FACTOR

CY 2026 National Average Anesthesia Conversion Factor		20.4976
Conversion Factor without One Year 2.50% Increase		19.9976
CY 2027 Non-Qualifying APM Update Factor	0.25 percent (1.0025)	
CY 2027 RVU Budget Neutrality Adjustment	0.53 percent (1.0053)	
CY 2027 Anesthesia Fee Schedule Practice Expense and Malpractice Adjustment	0.30 percent (1.0030)	
CY 2027 Conversion Factor		**20.2143**

Table D-B5 shows the impact on PFS payment for physicians' services based on the proposed policies included in this rule. To the extent that there are year-to-year changes in the volume and mix of services provided by practitioners, the actual impact on total Medicare revenues will be different from those shown in Table D-B5 (CY 2027 PFS Estimated Impact on Total Allowed Charges by Specialty).

In recent years, we have received requests from interested parties to provide more granular information that separates the specialty-specific impacts by site of service. These interested parties have presented us with high-level information suggesting that Medicare payment policies are directly responsible for consolidating privately owned physician practices and freestanding supplier facilities into larger health systems. Their concerns highlight a need to update the information under the PFS to account for current trends in healthcare delivery,

especially concerning independent versus facility-based practices. We published an RFI in the CY 2023 PFS proposed rule to gather feedback on this issue and refer readers to the discussion in the CY 2023 PFS final rule (87 FR 69429 through 69438). As part of our holistic review of how best to update our data and offer interested parties additional information that addresses some of the concerns raised, we have recently improved our current suite of public use files (PUFs) by including a new file that shows estimated specialty payment impacts at a more granular level, specifically by showing ranges of impact for practitioners within a specialty. This file is available on the CMS website under "downloads" for the CY 2027 PFS proposed rule at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html*.

Some of the proposed policies in this rule are estimated to have differential effects depending on the site of service, therefore, we are publishing the impact tables that include a facility/non-facility breakout of payment changes, as we believed that displaying the total impact by specialty alone, without the setting of care context, could be misleading for interested parties. The following is an explanation of the information represented in Table D-B5.

- Column A (Specialty): Identifies the specialty for which data are shown.
- Column B (Setting): Identifies the facility or non-facility setting for which data are shown.
- Column C (Allowed Charges): The aggregate estimated PFS allowed charges for the specialty based on CY 2025 utilization and CY 2026 rates. That is, allowed charges are the PFS amounts for covered services and include coinsurance and deductibles (which are the financial responsibility of the beneficiary). These amounts have been summed across all services furnished by physicians, practitioners, and suppliers within a specialty to arrive at the total allowed charges for the specialty.

- Column D (Impact of Work RVU Changes): This column shows the estimated CY 2027 impact on total allowed charges of the changes in the work RVUs, including the impact of changes due to potentially misvalued codes.
- Column E (Impact of PE RVU Changes): This column shows the estimated CY 2027 impact on total allowed charges of the changes in the PE RVUs.
- Column F (Impact of MP RVU Changes): This column shows the estimated CY 2027 impact on total allowed charges of the changes in the MP RVUs.
- Column G (Combined Impact): This column shows the estimated CY 2027 combined impact on total allowed charges of all the changes in the previous columns. Column G may not equal the sum of columns D, E, and F due to rounding.

TABLE D-B5: CY 2027 PFS ESTIMATED IMPACT ON TOTAL ALLOWED CHARGES BY SPECIALTY

(A) Specialty	(B) Total: Non-Facility/Facility	(C) Allowed Charges (mil)				(D) Impact of Work RVU Changes	(E) Impact of PE RVU Changes	(F) Impact of MP RVU Changes	(G) Combined Impact
ALLERGY/IMMUNOLOGY	*TOTAL*	$154	0%	-1%	0%	0%			
	Non-Facility	$147	0%	-1%	0%	0%			
	Facility	$7	1%	0%	0%	1%			
ANESTHESIOLOGY	*TOTAL*	$1,656	0%	0%	0%	0%			
	Non-Facility	$332	0%	-1%	0%	-1%			
	Facility	$1,324	0%	0%	0%	0%			
AUDIOLOGIST	*TOTAL*	$81	1%	-4%	0%	-3%			
	Non-Facility	$78	1%	-4%	0%	-3%			
	Facility	$3	1%	-1%	0%	0%			
CARDIAC SURGERY	*TOTAL*	$146	1%	1%	0%	1%			
	Non-Facility	$30	0%	2%	0%	2%			
	Facility	$116	1%	0%	0%	0%			
CARDIOLOGY	*TOTAL*	$6,464	0%	0%	0%	1%			
	Non-Facility	$4,205	0%	1%	0%	1%			
	Facility	$2,259	0%	0%	0%	0%			
CHIROPRACTIC	*TOTAL*	$626	0%	2%	0%	2%			
	Non-Facility	$624	0%	2%	0%	2%			
	Facility	$2	0%	0%	0%	0%			
CLINICAL PSYCHOLOGIST	*TOTAL*	$729	3%	8%	0%	11%			
	Non-Facility	$593	3%	8%	0%	11%			
	Facility	$136	3%	5%	0%	8%			
CLINICAL SOCIAL WORKER	*TOTAL*	$974	4%	9%	0%	12%			

(A) Specialty	(B) Total: Non-Facility/Facility	(C) Allowed Charges (mil)				(D) Impact of Work RVU Changes	(E) Impact of PE RVU Changes	(F) Impact of MP RVU Changes	(G) Combined Impact
	Non-Facility	$857	3%	9%	0%		13%		
	Facility	$116	4%	7%	0%		11%		
COLON AND RECTAL SURGERY	*TOTAL*	$147	-1%	-3%	0%		-4%		
	Non-Facility	$57	-3%	-6%	0%		-9%		
	Facility	$90	0%	-1%	0%		-1%		
CRITICAL CARE	*TOTAL*	$348	0%	0%	0%		0%		
	Non-Facility	$65	1%	0%	0%		1%		
	Facility	$283	0%	-1%	0%		0%		
DERMATOLOGY	*TOTAL*	$3,881	-3%	-6%	0%		-9%		
	Non-Facility	$3,754	-3%	-6%	0%		-9%		
	Facility	$127	-3%	-4%	0%		-7%		
DIAGNOSTIC TESTING FACILITY	*TOTAL*	$999	0%	3%	0%		4%		
	Non-Facility	$997	0%	3%	0%		4%		
	Facility	$2	0%	1%	1%		2%		
EMERGENCY MEDICINE	*TOTAL*	$2,581	0%	0%	0%		1%		
	Non-Facility	$286	0%	0%	0%		0%		
	Facility	$2,294	0%	0%	0%		1%		
ENDOCRINOLOGY	*TOTAL*	$584	1%	1%	0%		2%		
	Non-Facility	$485	1%	1%	0%		2%		
	Facility	$99	1%	0%	0%		1%		
FAMILY PRACTICE	*TOTAL*	$5,976	1%	1%	0%		1%		
	Non-Facility	$4,927	1%	0%	0%		1%		
	Facility	$1,049	0%	2%	0%		3%		
GASTROENTEROLOGY	*TOTAL*	$1,327	0%	-1%	0%		-1%		
	Non-Facility	$538	0%	-1%	0%		-1%		
	Facility	$788	0%	-1%	0%		-1%		
GENERAL PRACTICE	*TOTAL*	$408	1%	1%	0%		2%		
	Non-Facility	$329	1%	0%	0%		1%		
	Facility	$79	1%	4%	0%		5%		
GENERAL SURGERY	*TOTAL*	$1,517	0%	0%	0%		0%		
	Non-Facility	$480	0%	1%	0%		0%		
	Facility	$1,037	0%	-1%	0%		-1%		
GERIATRICS	*TOTAL*	$203	1%	2%	0%		4%		
	Non-Facility	$131	1%	0%	0%		2%		
	Facility	$72	1%	6%	0%		7%		
HAND SURGERY	*TOTAL*	$278	-1%	-4%	0%		-5%		
	Non-Facility	$160	-2%	-4%	0%		-7%		
	Facility	$117	0%	-2%	0%		-3%		
HEMATOLOGY/ONCOLOGY	*TOTAL*	$1,571	1%	-1%	0%		0%		
	Non-Facility	$1,037	0%	0%	0%		0%		
	Facility	$534	1%	-1%	0%		1%		
INDEPENDENT LABORATORY	*TOTAL*	$380	0%	0%	0%		0%		

(A) Specialty	(B) Total: Non-Facility/Facility	(C) Allowed Charges (mil)				(D) Impact of Work RVU Changes	(E) Impact of PE RVU Changes	(F) Impact of MP RVU Changes	(G) Combined Impact
	Non-Facility	$371	0%	0%	0%	0%			
	Facility	$9	0%	0%	0%	0%			
INFECTIOUS DISEASE	*TOTAL*	$587	0%	0%	0%	0%			
	Non-Facility	$97	0%	-1%	0%	-1%			
	Facility	$490	0%	0%	0%	0%			
INTERNAL MEDICINE	*TOTAL*	$9,932	1%	1%	0%	1%			
	Non-Facility	$5,203	1%	0%	0%	1%			
	Facility	$4,728	0%	1%	0%	1%			
INTERVENTIONAL PAIN MGMT	*TOTAL*	$880	0%	-1%	0%	-2%			
	Non-Facility	$706	0%	-1%	0%	-2%			
	Facility	$174	0%	0%	0%	-1%			
INTERVENTIONAL RADIOLOGY	*TOTAL*	$545	0%	3%	0%	3%			
	Non-Facility	$361	0%	5%	0%	5%			
	Facility	$183	0%	1%	0%	1%			
MULTISPECIALTY CLINIC/OTHER PHYS	*TOTAL*	$164	-1%	-1%	0%	-2%			
	Non-Facility	$84	-2%	-2%	0%	-4%			
	Facility	$80	0%	0%	0%	0%			
NEPHROLOGY	*TOTAL*	$1,672	0%	0%	0%	0%			
	Non-Facility	$1,054	0%	0%	0%	1%			
	Facility	$619	1%	0%	0%	0%			
NEUROLOGY	*TOTAL*	$1,390	0%	-1%	0%	0%			
	Non-Facility	$923	0%	-1%	0%	-1%			
	Facility	$467	1%	-1%	0%	0%			
NEUROSURGERY	*TOTAL*	$652	0%	-2%	0%	-2%			
	Non-Facility	$128	0%	-1%	0%	-1%			
	Facility	$524	0%	-2%	-1%	-2%			
NUCLEAR MEDICINE	*TOTAL*	$50	0%	2%	0%	2%			
	Non-Facility	$21	0%	2%	0%	2%			
	Facility	$29	0%	1%	0%	2%			
NURSE ANES / ANES ASST	*TOTAL*	$1,130	0%	1%	0%	1%			
	Non-Facility	$19	0%	10%	0%	10%			
	Facility	$1,111	0%	1%	0%	1%			
NURSE PRACTITIONER	*TOTAL*	$7,775	0%	1%	0%	2%			
	Non-Facility	$5,263	0%	-1%	0%	0%			
	Facility	$2,512	0%	6%	0%	6%			
OBSTETRICS/GYNECOLOGY	*TOTAL*	$558	0%	-1%	0%	-1%			
	Non-Facility	$397	0%	-1%	0%	-1%			
	Facility	$162	0%	-1%	-1%	-2%			
OPHTHALMOLOGY	*TOTAL*	$4,548	0%	-3%	0%	-3%			
	Non-Facility	$3,373	0%	-3%	0%	-3%			
	Facility	$1,175	0%	-2%	0%	-2%			
OPTOMETRY	*TOTAL*	$1,498	0%	-2%	0%	-2%			

(A) Specialty	(B) Total: Non-Facility/Facility	(C) Allowed Charges (mil)				(D) Impact of Work RVU Changes	(E) Impact of PE RVU Changes	(F) Impact of MP RVU Changes	(G) Combined Impact
	Non-Facility	$1,457	0%	-2%	0%	-2%			
	Facility	$41	0%	-1%	0%	0%			
ORAL/MAXILLOFACIAL SURGERY	*TOTAL*	$34	0%	-1%	0%	-1%			
	Non-Facility	$24	0%	-1%	0%	-1%			
	Facility	$10	0%	-1%	0%	-1%			
ORTHOPEDIC SURGERY	*TOTAL*	$3,296	-3%	-4%	-1%	-7%			
	Non-Facility	$1,549	-2%	-4%	0%	-5%			
	Facility	$1,747	-4%	-4%	-1%	-8%			
OTHER	*TOTAL*	$39	0%	-2%	0%	-2%			
	Non-Facility	$29	0%	-3%	0%	-2%			
	Facility	$10	-1%	-1%	0%	-2%			
OTOLARYNGOLOGY	*TOTAL*	$1,199	-3%	-5%	0%	-9%			
	Non-Facility	$982	-4%	-6%	0%	-10%			
	Facility	$217	-1%	-2%	0%	-3%			
PATHOLOGY	*TOTAL*	$777	0%	-1%	0%	0%			
	Non-Facility	$412	0%	-1%	0%	-1%			
	Facility	$364	0%	0%	0%	0%			
PEDIATRICS	*TOTAL*	$61	1%	0%	0%	0%			
	Non-Facility	$42	0%	0%	0%	0%			
	Facility	$19	1%	0%	0%	1%			
PHYSICAL MEDICINE	*TOTAL*	$1,203	0%	1%	0%	1%			
	Non-Facility	$592	0%	-2%	0%	-2%			
	Facility	$611	0%	3%	0%	4%			
PHYSICAL/OCCUPATIONAL THERAPY	*TOTAL*	$4,372	0%	3%	0%	3%			
	Non-Facility	$4,370	0%	3%	0%	3%			
	Facility	$1	0%	0%	0%	0%			
PHYSICIAN ASSISTANT	*TOTAL*	$3,751	-1%	-2%	0%	-3%			
	Non-Facility	$2,699	-1%	-3%	0%	-5%			
	Facility	$1,052	0%	2%	0%	1%			
PLASTIC SURGERY	*TOTAL*	$268	0%	-2%	0%	-3%			
	Non-Facility	$131	-1%	-3%	0%	-4%			
	Facility	$138	0%	-1%	0%	-1%			
PODIATRY	*TOTAL*	$1,969	-2%	-2%	0%	-4%			
	Non-Facility	$1,762	-2%	-2%	0%	-4%			
	Facility	$207	-1%	1%	0%	0%			
PORTABLE **X**-RAY SUPPLIER	*TOTAL*	$76	0%	-2%	0%	-1%			
	Non-Facility	$72	0%	-2%	0%	-1%			
	Facility	$4	0%	-1%	0%	-1%			
PSYCHIATRY	*TOTAL*	$882	1%	1%	0%	3%			
	Non-Facility	$565	1%	2%	0%	3%			
	Facility	$317	1%	1%	0%	2%			
PULMONARY DISEASE	*TOTAL*	$1,266	1%	0%	0%	0%			

(A) Specialty	(B) Total: Non-Facility/Facility	(C) Allowed Charges (mil)				(D) Impact of Work RVU Changes	(E) Impact of PE RVU Changes	(F) Impact of MP RVU Changes	(G) Combined Impact
	Non-Facility	$599	1%	0%	0%	1%			
	Facility	$667	0%	0%	0%	0%			
RADIATION ONCOLOGY AND RADIATION THERAPY CENTERS	*TOTAL*	$1,541	0%	3%	0%	3%			
	Non-Facility	$1,054	0%	4%	0%	5%			
	Facility	$486	0%	-1%	0%	-1%			
RADIOLOGY	*TOTAL*	$4,706	0%	2%	0%	2%			
	Non-Facility	$2,075	0%	2%	0%	2%			
	Facility	$2,631	0%	1%	0%	1%			
RHEUMATOLOGY	*TOTAL*	$567	0%	-1%	0%	-1%			
	Non-Facility	$514	0%	-1%	0%	-1%			
	Facility	$53	1%	0%	0%	1%			
THORACIC SURGERY	*TOTAL*	$299	1%	1%	0%	1%			
	Non-Facility	$62	0%	2%	0%	2%			
	Facility	$237	1%	0%	0%	0%			
UROLOGY	*TOTAL*	$1,626	-1%	-1%	0%	-2%			
	Non-Facility	$1,178	-1%	-1%	0%	-2%			
	Facility	$448	0%	0%	0%	-1%			
VASCULAR SURGERY	*TOTAL*	$1,015	0%	3%	0%	3%			
	Non-Facility	$747	0%	4%	0%	4%			
	Facility	$268	0%	0%	0%	0%			
TOTAL	***TOTAL***	$91,355	0%	0%	0%	0%			
	Non-Facility	$59,028	0%	0%	0%	0%			
	Facility	$32,327	0%	1%	0%	1%			

* Column G may not equal the sum of columns D, E, and F due to rounding.

2. CY 2027 PFS Impact Discussion

a. Changes in RVUs

The most widespread specialty-level impacts of the RVU changes are generally related to the changes to RVUs for specific services resulting from the misvalued code initiative, including RVUs for new and revised codes. The proposals to update code valuation and improve the accuracy of the practice expense methodology would have a significant positive impact on clinical psychologists and clinical social workers, with smaller increases to physical and occupational therapists, interventional radiology, and vascular surgery. To a lesser degree, projected increases for some specialties would result from the proposed changes to HCPCS code G2211 and the fourth and final year of the behavioral health work update. Increases would also

result from proposed increases in valuation for particular services after considering the recommendations from the American Medical Association's (AMA) Relative Value Scale Update Committee (RUC) and CMS review, and increased payments resulting from supply and equipment pricing updates. For independent laboratories, it is important to note that these entities receive approximately 83 percent of their Medicare revenues from services that are paid under the Clinical Lab Fee Schedule.

Specialties that would see a significant decrease include dermatology, otolaryngology, orthopedic surgery, and hand surgery, and to a smaller extent, ophthalmology, podiatry, audiologists, neurosurgery, portable x-ray suppliers, and plastic surgeons. These changes can largely be attributed to the proposed changes to modifier -25 and the proposal to remove the Indirect Practice Cost Index (IPCI) from the calculation of the PE RVUs, although the effects on PE are mitigated by the proposed PE stabilization adjustment. The estimated impacts also reflect decreased payments due to continued implementation of previously finalized code-level reductions that are being phased in over several years.

The proposal to reduce payment when a separately identifiable office/outpatient E/M visit is furnished by the same physician (or a physician in the same group practice) on the same day as a 0-, 10-, or 90-day global procedure and identified on the claim with modifier -25 would have the largest negative impact on otolaryngology, dermatology, and podiatry, and to a smaller extent, hand surgery, physicians assistant, and colon and rectal surgery. These specialties frequently report E/M services with modifier -25 in conjunction with a 0-, 10-, or 90-day global procedure. Most other specialties receive a small increase due to the redistribution of those RVUs. Our utilization estimates for this proposal are reflected in the file titled "CY 2026 PFS Proposed Rule 2025 Utilization Data Crosswalked to 2027" available under "downloads" for the CY 2027 PFS proposed rule on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html.*

The proposal to replace HCPCS code G2211 with a modifier (MOD1) that is set to 16 percent of the total RVUs for the E/M service on the claim is expected to have minimal impact given that the volume previously reported using HCPCS code G2211 would now be reported with the modifier, and that was accounted for using the weighted average of the percent increase for G2211 utilization and adjusted for budget neutrality. The proposal to pay for services furnished in an ACO using a modifier (MOD2) that pays 32 percent of the total RVUs for the E/M service on the claim is expected to increase payment for practitioners that furnish a higher percentage of their services in ACOs. Our utilization estimates for MOD1 and MOD2 are reflected in the file titled "CY 2026 PFS Proposed Rule 2025 Utilization Data Crosswalked to 2027" available under "downloads" for the CY 2027 PFS proposed rule on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html*.

We often receive comments regarding the changes in RVUs displayed on the specialty impact table (Table D-B5), including comments received in response to the valuations. We remind interested parties that although the estimated impacts are displayed at the specialty level, typically, the changes are driven by the valuation of a relatively small number of new and potentially misvalued codes. The percentage changes in Table D-B5 are based upon aggregate estimated PFS allowed charges summed across all services furnished by physicians, practitioners, and suppliers within a specialty to arrive at the total allowed charges for the specialty and compared to the same summed total from the previous calendar year. Therefore, they are averages and may not necessarily represent what is happening to the particular services furnished by a single practitioner within any given specialty.

As previously discussed, we have reviewed our suite of PUFs and have worked on new ways to offer interested parties' additional information that addresses concerns about the lack of granularity in our impact tables. To illustrate how impacts can vary within specialties, we created a PUF that models the expected percentage change in total RVUs per practitioner. We also note

the code level RVU changes are available in the Addendum B PUF available on the CMS website under "downloads" for the CY 2027 PFS proposed rule at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html.*

The specialty impacts displayed in Table D-B5 reflect changes within the pool of total RVUs. The specialty impacts table, therefore, includes any changes in spending that result from proposed policies that are subject to the statutory budget neutrality requirement at section 1848(c)(2)(B)(ii)(II) of the Act but does not include any changes in spending which result from proposed policies that are not subject to the statutory budget neutrality adjustment, and therefore, have a neutral impact across all specialties. The 0.75 percent and 0.25 percent updates to the CY 2027 and nonqualifying APM conversion factors, respectively, are statutory changes that take place outside of BN, and therefore, are not captured in the specialty impacts displayed in Table D-B5.

b. Impact

Column G of Table D-B5 displays the estimated CY 2025 impact on total allowed charges, by specialty, of all the RVU changes. A table showing the estimated impact of all of the changes on total payments for selected high-volume procedures is available under "downloads" on the CY 2027 PFS proposed rule website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html*. We selected these procedures for the sake of illustration from among the procedures most commonly furnished by a broad spectrum of specialties. The change in both facility rates and non-facility rates are shown. For an explanation of facility and non-facility PE, we refer readers to Addendum A on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/.*

E. Effects of the Proposed Changes Related to Telehealth Services

We are proposing the addition of several codes to the Medicare Telehealth Services List, including HCPCS codes GAPC1, GAPC2, GSMAS, GSLPP, and GADV1. We are proposing to revise the code descriptors for CPT codes G0508 and G0509. We are proposing to allow teaching physicians to bill for services involving residents when either the teaching physician or resident is in the same physical location as the beneficiary. These services, in addition to other Medicare Telehealth Services, are expected to substitute for in-person visits and as such would not have increase overall utilization of these services.

Section 6209(a) and (b) of the Consolidated Appropriations Act, 2026 (CAA, 2026) (Pub. L. 119-75, February 3, 2026) extends the flexibilities for Medicare telehealth services to remove the geographic restrictions, expand the list of acceptable originating sites, and expand the array of practitioners eligible to furnish telehealth services from January 30, 2026 to the extended date of December 31, 2027. Section 6209(d) of the CAA, 2026 delays the in-person visit requirements for mental health services furnished through telehealth from January 30, 2026 to the extended date of January 1, 2028. Section 6209(e) of the CAA, 2026 extends the flexibilities to allow audio-only Medicare telehealth services from January 30, 2026 to the extended date of January 1, 2028. Additionally, section 6209(g) of the CAA, 2026, requires CMS to establish modifiers for telehealth services in certain instances, effective January 1, 2027. We anticipate that our provisions will result in continued utilization of services that can be furnished as Medicare telehealth services during CY 2027 at levels comparable to observed utilization of these services during CY 2026.

F. Other Provisions of the Proposed Rule

1. Impacts Related to Technical Corrections of Comprehensive Outpatient Rehabilitation Facility (CORF) Services Regulations

As discussed in section II.F. of this proposed rule, we are proposing to amend the regulatory text at §§ 410.105 and 414.1105 for accuracy that we overlooked during CY 2008

PFS rulemaking when we amended § 410.100. As such, there are no impacts for the policies in section II.F. of this proposed rule.

2. Impacts Related to Drugs and Biological Products Paid Under Medicare Part B: Discarded Drugs

Section 90004 of the Infrastructure Investment and Jobs Act (Pub. L. 117-58, November 15, 2021) amended section 1847A of the Act to require manufacturers to provide a refund to CMS for certain discarded amounts from a refundable single-dose container or single-use package drug. The refund amount is either as noted in section 1847A(b)(1)(B) of the Act in the case of a single source drug or biological or as noted in section 1847A(b)(1)(C) of the Act in the case of a biosimilar biological product, multiplied by the amount of discarded drug that exceeds an applicable percentage, which is required to be at least 10 percent, of total charges (subject to certain exclusions) for the drug in a given calendar quarter. In the CY 2023, 2024, and 2025 PFS final rules, we finalized several policies to implement the provision. In December of 2025, CMS sent discarded drug refund reports for CY 2023 "updated refund quarters" and CY 2024 "new refund quarters," as defined at § 414.902. The total refunds owed for these quarters amount to over $173 million, which was deposited into the Supplementary Medical Insurance trust fund, as required by law. In section III.A.1 of this proposed rule, we discuss one application (CMS 10835, OMB 0938-1435) for increased applicable percentage which will have no impact on Medicare spending.

3. Impacts Related to Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

In section III.B.2.c. of this proposed rule, to improve access to preventive services in RHCs, we propose changes to the payment of Diabetes Self-Management and Training (DSMT) and Medical Nutrition Therapy (MNT) services in RHCs. We are proposing to recognize DSMT and MNT services as qualified visits that are covered and paid as stand-alone billable visits under the RHC benefit. A national claims-based analyses of evaluation and management billing

patterns indicated that a nominal volume of DSMT and MNT services were bundled within payments to RHCs during 2025.

Since utilization of DSMT and MNT services are generally underutilized by the Medicare population, we believe that increase to Medicare Part B expenditures due to the proposal would be negligible. As discussed in section III.B.2.c of this proposed rule, an analysis of Medicare claims data from 2024 indicate that utilization of DSMT and MNT in RHC settings is substantially lower than in comparable care settings. In CY 2024, DSMT services were furnished to approximately 125 RHC beneficiaries, representing 0.005 percent of the total RHC beneficiary population of approximately 2.3 million. MNT services were furnished to approximately 439 RHC beneficiaries, representing 0.019 percent of the total RHC beneficiary population. On a claims basis, DSMT accounted for 0.002 percent and MNT for 0.007 percent of total RHC claims in CY 2024. By comparison, FQHCs, showed DSMT utilization rates approximately 22 times higher and MNT utilization rates approximately 28 times higher than RHCs on a per-beneficiary basis. On a claim basis, FQHC utilization of DSMT and MNT exceeded RHC utilization by approximately 31 times and 32 times, respectively. Rural physician offices, which share the geographic and demographic characteristics of RHC patient populations, showed DSMT and MNT utilization rates approximately 17 times and 7 times higher than RHCs, respectively, on a per-beneficiary basis. The analysis further demonstrated that within the PFS setting where DSMT and MNT are most readily identifiable in claims data, these services represent a very small share of total Medicare spending — less than 0.01 percent and 0.02 percent of total PFS line payments, respectively, in CY 2024. We believe that while our proposal would support an increase in the furnishing DSMT and MNT at RHCs, we do not expect a significant increase for CY 2027 since RHCs would need to determine potential changes to their care delivery and staffing which may impact timing for uptake.

4. Impacts Related to the Clinical Laboratory Fee Schedule (CLFS): CAA, 2026

In section III.D. of this proposed rule, we outline statutory amendments to section 1834A of the Act that revise the data reporting period, data collection period, and requirements for the phase-in of payment reductions under the CLFS. In accordance with section 6226 of the CAA, 2026, we are proposing to make certain conforming changes to the data reporting and payment requirements at 42 CFR part 414, subpart G. Specifically, we are proposing to revise § 414.502 to update the definitions of both the "data collection period" and "data reporting period," specifying that the data collection period is the 6-month period from January 1 through June 30, during which applicable information is collected and that precedes the data reporting period, and that the data reporting period for CDLTs that are not ADLTs is the 3-month period, May 1 through July 31, and for ADLTs is the 3-month period, January 1 through March 31, during which a reporting entity reports applicable information to CMS and that follows the preceding data collection period.. We are also proposing to revise § 414.504(a)(1) to indicate that initially, data reporting begins January 1, 2017, and is required every 3 years beginning May 1, 2026. In addition, we are proposing to make conforming changes to our requirements for the phase-in of payment reductions to reflect the amendments in section 6226 of the CAA, 2026. Specifically, we are proposing to revise § 414.507(d) to indicate that for CY 2026, payment may not be reduced by more than 0.0 percent as compared to the amount established for CY 2025, and for CYs 2027 through 2029, payment may not be reduced by more than 15 percent as compared to the amount established for the preceding year.

We recognize that private payor rates for CDLTs paid on the CLFS and the volumes paid at each rate for each test, which are used to determine the weighted medians of private payor rates for the CLFS payment rates, have changed since the first data collection period (January 1, 2016 through June 30, 2016) and data reporting period (January 1, 2017, through March 31, 2017). In addition, as outlined in section III.C. of this proposed rule, in the CY 2019 PFS final rule (83 FR 59671 through 59676), we amended the definition of applicable laboratory to include hospital outreach laboratories that bill Medicare Part B using the CMS-1450 14x Type of Bill.

As such, the CAA, 2026 amendments to the data reporting period will implement the use of updated private payor rate data to set revised CLFS payment rates for CDLTs that are not ADLTs.

Due to unforeseen changes in private payor rates due to shifts in market-based pricing for laboratory tests and the unpredictable nature of test volumes and their impact on calculating updated CLFS payment rates based on the weighted median of private payor rates, for purposes of this proposed rule, we are unable to estimate a budgetary impact. In other words, to assess the impact of implementation of updated CLFS rates, we will need to calculate weighted medians of private payor rates based on new data and compare the revised rates to the current rates. As such, we believe that we will only know the impact of the CAA, 2026 provisions after collecting actual updated applicable information from applicable laboratories and calculating the updated CLFS rates.

5. Ambulatory Specialty Model (ASM)

In section III.D. of this proposed rule, we discuss the Ambulatory Specialty Model (ASM) tested by the CMS Center for Medicare and Medicaid Innovation (hereinafter "Innovation Center") under the authority of section 1115A of the Act. Section 1115A of the Act authorizes the Innovation Center to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to Medicare, Medicaid, and Children's Health Insurance Program beneficiaries. ASM will test whether adjusting payment for eligible specialists who furnish services related to ASM's targeted chronic conditions (that is, heart failure and low back pain) based on performance across targeted measures of quality, cost, care coordination, and meaningful use of certified electronic health record (EHR) technology (CEHRT) results in enhanced quality of care and reduced costs through more effective upstream chronic condition management. By testing ASM, we aim to reduce avoidable hospitalizations and unnecessary procedures, improve patient experience and outcomes, and lower Original Medicare expenditures by incentivizing preventive care, more

effective management of chronic conditions, and enhanced coordination and collaboration among specialists and primary care providers. We finalized ASM's provisions in the CY 2026 PFS final rule (90 FR 49562 through 49720), including the framework for identifying ASM participants, performance evaluation, scoring, and payment adjustments.

a. Proposed Effects of the Ambulatory Specialty Model

Based on feedback we received from interested parties after the publication of the CY 2026 PFS final rule and our own internal review, we propose several technical refinements and adjustments to ASM, including but not limited to revising select definitions, revising and adding ASM participant exceptions from specific ASM requirements, adjusting data submission requirements, incorporating a rural scoring adjustment to final scores, adjusting provisions related to collaborative care arrangements under ASM, and making minor adjustments to specific ASM performance category policies in this proposed rule. We believe these proposals would improve the clarity, practicality, and alignment of ASM implementation. Further, our proposals would not modify the fundamental framework of ASM for identifying ASM participants over the course of the ASM test period, overall performance evaluation, scoring, or payment adjustments and continue to support CMS priorities related to reducing low-value care, promoting preventive care, enhancing management of chronic conditions, and improving coordination and collaboration among specialists and primary care providers.

Accordingly, we believe our proposals in this proposed rule would not increase federal costs or alter the estimated Medicare program savings described in the CY 2026 PFS final rule (90 FR 49969 through 49975). In the CY 2026 PFS final rule, we estimated an impact of $177 million in net savings to the Medicare program due to ASM from January 1, 2029 through December 31, 2033 (90 FR 49972). This estimate reflects relevant finalized provisions including the ASM test period, geographic scope, participant eligibility, ASM risk levels, the amount of ASM incentive pools distributed to ASM participants in the form of payment adjustments, and the estimated amount of Medicare Part B covered professional service payments subject to ASM

payment adjustments. We refer readers to the ASM section of the regulatory impact analysis of CY 2026 PFS final rule for additional information on our methodology and sensitivity analysis (90 FR 49969 through 90 FR 49975). Because we do not propose changes to key assumptions used to previously calculate the Medicare program savings estimate, we do not expect that the proposals in this proposed rule to materially affect the Medicare program savings estimates in the CY 2026 PFS final rule. For example, we do not anticipate that the proposed provisions related to ASM participant exceptions from specific ASM requirements would substantially affect the number of ASM participants meeting ASM requirements over the ASM test period because we believe any exceptions would be balanced by other participation provisions that allow for clinicians who newly meet the ASM participant eligibility criteria to be added as ASM participants over the course of the ASM test period. Therefore, ASM's previously estimated financial impact to the Medicare program remains unchanged from the CY 2026 PFS final rule.

6. Limiting Medicare Coverage of Certain Individuals

Section 71201 of the Working Families Tax Cut (WFTC) legislation, which added section 1899C to the Social Security Act (the Act), restricts Medicare eligibility to individuals who meet one of the following criteria: (1) U.S. citizens or nationals; (2) lawful permanent residents; (3) Cuban and Haitian entrants; or (4) individuals who lawfully reside in the United States in accordance with a Compact of Free Association. Individuals who do not meet these criteria and who were enrolled in Medicare on or before July 4, 2025, will have their coverage terminated effective February 1, 2027, which is the date that is 18 months after enactment of the WTFC legislation (July 4, 2025). As established in section 1899C(a) of the Act, individuals enrolled after July 4, 2025, who do not meet the eligibility requirements, are subject to denial or termination under the framework established at proposed §§ 406.14, 406.28 and 407.27.

Based on estimates from OACT, approximately 32,000 individuals are projected to lose Medicare coverage beginning in 2027, representing approximately 0.05 percent of the total Medicare-aged enrollment. OACT's estimate was derived from a 2025 Pew Research study on

race and ethnicity in the United States and by using a Congressional report authored by the Department of Homeland Security (DHS). In addition, citing research on lower health care utilization by immigrants, OACT assumes that affected individuals have average Medicare spending equal to approximately two-thirds of the average Medicare beneficiary, reflecting the generally healthier and younger age profile of this population, as well as lower utilization due to increased barriers in accessing health care including language barriers, limited familiarity with the U.S. health system, and concerns related to immigration status that may discourage enrollment and utilization even among those who are eligible. The population captured in this estimate is certain immigrants with temporary protections who no longer meet the revised eligibility requirements, including those with pending asylum applications, parolees, temporary protected status, and victims of crime and violence.

TABLE D-B6: ESTIMATED IMPACT ON MEDICARE SPENDING – LIMITING MEDICARE COVERAGE OF CERTAIN INDIVIDUALS ($ MILLIONS)

Year	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2027-2036 Total
FY Cash	-$220	-$390	-$420	-$450	-$490	-$520	-$560	-$600	-$640	-$680	-$4,970

Source: Office of the Actuary (OACT), May 1, 2026. Negative values indicate reductions in Medicare program outlays.

The financial impact of this provision is classified as a transfer — specifically, a reduction in Medicare program outlays that would otherwise have been paid to plans and providers on behalf of affected individuals. Based on OACT's estimates, the 10-year reduction in Medicare spending attributable to this provision is approximately $4.97 billion, ranging from approximately $220 million in 2027 to approximately $680 million in 2036 (see Table D-B6).

Disenrollments from Medicare Advantage, Part D, and Medicare cost plans resulting from loss of Part A or Part B entitlement will be processed automatically by CMS when SSA provides updated eligibility and entitlement records. Plans do not process these disenrollments and are not required to provide additional notification, as SSA provides a loss of entitlement notice directly to affected individuals. All information impacts related to the procedural steps plans must take to receive and process enrollment and disenrollment transactions have already

been accounted for under OMB control numbers 0938-0753 (CMS-R-267) and 0938-0964 (CMS-10141). The burden associated with the revision of Medicare initial enrollment forms to support eligibility determinations under this provision is described in the Collection of Information Requirements section of this rule.

Dahl and Forbes (2023) estimate that 46 percent of individuals are willing to pay $638 per person, in 2011 dollars—or approximately $873 when updated for inflation—to avoid switching medical providers (specifically, primary-care physicians).[400] For purposes of this regulatory impact analysis, it is assumed that $873 is a reasonable estimate of an average that includes the 46-percent of WTP amounts above it and the 54-percent below. Multiplying this $873 annual amount by 32,000 disenrollments yields a cost estimate of $28 million. This quantitative estimate is characterized by various forms of uncertainty, including:

- *Tendency toward underestimation.* Switching insurance plans, or newly lacking insurance coverage altogether, involves a more sweeping set of changes than just reestablishing a new primary-care physician, so WTP to avoid the latter probably understates WTP to avoid the former.

- *Tendency toward overestimation.* The relatively low level of churn associated with employer-sponsored insurance (ESI) may offer a greater opportunity to establish doctor-patient relationships than what is available to individuals affected by this provision (due to many of them having non-permanent immigration status), so extrapolating an ESI-derived estimate may overstate the WTP for continuity that would be relevant for this regulatory impact analysis.

7. Medicare Prescription Drug Inflation Rebate Program

In section III.F. of this proposed rule, as part of our continued implementation of the Inflation Reduction Act of 2022 (IRA), which established the Medicare Prescription Drug Inflation Rebate Program under sections 11101 and 11102 of the Act, we are proposing several

[400] Dahl, G.B. & Forbes, S.J. (2023). Doctor switching costs. *Journal of Public Economics*, *221*, 104858, https://doi.org/10.1016/j.jpubeco.2023.104858.

modifications. For the Medicare Part B Drug Inflation Rebate Program, this rulemaking proposes to modify the excluded product category for Part B rebatable drugs so that the exclusion applies only to certain skin substitute products and clarify what Consumer Price Index for all Urban Consumers (CPI-U) data CMS would use in the event CPI-U data are unavailable. Additionally, we propose to clarify the definition of "first marketed date" as used in the context of the Part B Drug Inflation Rebate Program. For the Medicare Part D Drug Inflation Rebate Program, this rulemaking proposes to clarify what CPI-U data CMS would use in the event CPI-U data are unavailable, a modification to the methodology finalized in the CY 2026 PFS final rule to account for 340B-eligible units for AIDS Drug Assistance Programs (ADAPs), and to require all providers and suppliers that are covered entities as defined under § 10.3 (hereinafter collectively "340B providers" unless otherwise noted) to submit data elements from their Part D 340B claims to the 340B repository beginning in 2027.

We do not expect the proposed policies regarding the Medicare Part B Drug Inflation Rebate Program and the Medicare Part D Drug Inflation Rebate Program to have a material impact on the calculation of total rebates in aggregate, as these proposals are refinements to regulatory requirements that improve program efficiency and do not otherwise change the current scope of rebatable drugs.

In section III.F.3.c.2.c. of this proposed rule, we are proposing to require all 340B providers to submit data elements from their Part D 340B claims for all covered Part D drugs billed to Medicare Part D by such covered entity or its contractor(s) beginning with claims with a date of service on or after in 2027. 340B providers would be required to follow the processes and requirements that CMS established for voluntary reporting starting in 2026 and the associated information collection currently approved under OMB control number 0938-1485. CMS would require that each 340B provider report data on a quarterly basis (though they may choose to submit more frequently) within 1 calendar quarter following the close of the relevant calendar quarter. CMS would consider all data elements received by the 340B repository to be associated

with Part D 340B claims; therefore, the 340B repository would rely on the accuracy and completeness of the submitted, certified data to the 340B repository to verify the 340B status of a claim, and CMS would analyze these data to determine if they could be used reliably in the future to remove 340B units from Part D inflation rebate calculations in accordance with section 1860D-14B(b)(1)(B) of the Act. Under this process, CMS would require, as part of every submission, 340B providers (or an individual or contractor with the delegated authority as an authorized representative of the 340B provider to perform the certification) to certify that the data elements from all claims submitted to the 340B repository are from verified 340B claims and, to the best of the 340B provider's knowledge, its submissions include all Part D 340B claims for the 340B provider at the time of submission for the relevant period. 340B providers, or their authorized representative, would be required to certify the completeness and accuracy of the data submitted and to certify that the submitter is authorized to submit on behalf of the 340B provider.

In section III.F.3.c.1. of this proposed rule, we are proposing a modification to the Prescriber-Pharmacy Methodology whereby all claims for Part D drugs dispensed to beneficiaries identified as having ADAP supplemental coverage would be treated as 340B-eligible and excluded from Part D inflation rebate calculations, with safeguards to prevent double-counting of units already identified under the existing methodology. This proposed modification addresses a limitation to the Prescriber-Pharmacy Methodology that may under-identify 340B units for drug claims associated with ADAPs that use pharmacies not registered in the OPAIS database as contract pharmacies. This change may result in some overestimation of 340B-eligible units associated with ADAPs, although it is expected to have minimal or no impact on the percentage of Part D units identified as 340B eligible for most drug classes with the exception of antiretroviral medications used in the treatment of HIV/AIDS. The proposed change would be effective for Rebate Reports issued for applicable periods beginning October 1, 2025 and subsequent applicable periods.

In sections III.F.2.c. and III.F.3.b. of this proposed rule, we are proposing to amend §§ 427.302, 428.20, and 428.202 to address gaps in monthly CPI-U data by establishing a methodology that uses the first available CPI-U data following any unavailable month. CMS calculates the inflation-adjusted payment amount for Part B rebatable drugs using benchmark and rebate period CPI-U data, with the benchmark period CPI-U determined based on a drug's FDA approval and first marketed date, and the rebate period CPI-U set as the greater of the benchmark CPI-U or the CPI-U from two calendar quarters prior to the applicable quarter. CMS calculates inflation-adjusted payment amount for Part D rebatable drugs using benchmark period and applicable period CPI-U data, with the benchmark period CPI-U determined based on a drug's FDA approval and first marketed date, and the applicable period CPI-U set as the CPI-U for the first month of the applicable period. However, it was necessary to account for situations in which a monthly CPI-U figure is unavailable. Alternative approaches, including the Treasury Department's inflation contingency index, a CMS-calculated inflation factor, or using the prior month's data were considered but not proposed as either less consistent with statutory requirements or administratively impracticable.

We do not anticipate our inflation rebate proposed policies will result in an incrementally significant financial impact on the Medicare program relative to a baseline that reflects the status quo in the absence of any modifications to inflation rebate regulations at parts 427 and 428 as these finalized policies are refinements to regulatory requirements.

8. Medicare Shared Savings Program

a. General Impacts

As of January 1, 2026, the Shared Savings Program has 511 ACOs with over 700,000 healthcare providers and organizations providing care to over 12.6 million assigned beneficiaries.[401] The policies in this proposed rule are designed, in part, to strengthen financial

[401] See CMS, "Shared Savings Program Fast Facts – As of January 1, 2026", available at *https://www.cms.gov/files/document/2026-shared-savings-program-fast-facts.pdf*.

incentives for ACOs to participate in the Shared Savings Program while mitigating selection issues and benchmark rebasing concerns, expand the population of Original Medicare beneficiaries for which ACOs are held accountable for quality and cost of care while minimizing gaming, advance ACO use of digital quality measures and reduce participant burden, and increase beneficiary engagement.

As we described in the CY 2026 PFS final rule (90 FR 32814), the ACOs in the program in PY 2023 combined to cover $128 billion in benchmark target spending. Actual ACO spending totaled approximately $123 billion – about $5.2 billion below combined benchmark. After accounting for $3.1 billion in net shared savings to ACOs, the remaining difference of $2.1 billion would represent federal savings from the program if benchmarks proved to be a perfect counterfactual in aggregate. The Regulatory Impact Analysis in the December 2018 final rule (see 83 FR 68044 through 68050) provided evidence that the benchmarks for PY 2016 combined to represent a lower spending target than the theoretical counterfactual for estimating what spending would have been in the total FFS Medicare Program had ACOs not been present that year. Evidence included all of the following:

- Lower combined market level spending trends observed for cohorts of Hospital Referral Regions (HRRs) with significant ACO formation relative to other HRRs without material ACO activity.
- Spillover effects on spending outside of ACO benchmarks, including non-assigned beneficiaries served by ACO providers and suppliers.
- Program design elements that restrained benchmark levels, including rebasing with agreement periods of only 3 years, feedback of communal ACO effects on national trends used to update benchmarks, and restrictions on risk adjustment.

The Regulatory Impact Analysis in the December 2018 final rule (83 FR 68048) estimated that ACOs may have been responsible for half of the 1.2 percent difference in spending trend observed between national average and the subset of HRRs with minimal ACO

activity through 2016. This scaled impact represented about four times the gross savings measured relative to benchmarks, or about 0.5 percent net savings across the entire FFS program after accounting for shared savings payments despite benchmarks only officially showing roughly equivalent overall reductions in spending relative to benchmark compared to total outlays from shared savings payments. Since 2016, changes to the Shared Savings Program have potentially moved the benchmarks closer to what the spending would have been in the absence of the program.

In the CY 2026 PFS final rule (90 FR 49975 through 49976), we explained that updating the earlier study to compare more recent trends for markets with varying levels of ACO activity requires updates to the initial study approach, as ACOs have become active in an increasing majority of markets across the nation. There no longer exists a sufficient number of HRRs with nominal ACO penetration in 2023 to construct a de facto counterfactual similar to the study in the December 2018 final rule. An alternate method, however, continued to show spending trends inversely correlated with ACO penetration over time. Roughly 5 percent of beneficiaries live in HRRs with ACO penetration consistently below the national average by 10 percentage points or more over the 2013 to 2023 time series ("Lagging"), while about 9 percent of beneficiaries live in HRRs with ACO penetration 10 percentage points or more above the national average over the same period ("Leading"). Relative to the 2011 base year immediately preceding the Shared Savings Program's introduction, growth in average unadjusted per capita spending in 2023 for Lagging and Leading markets was 4.3 percent higher and 3.9 percent lower than the national average. The divergence in spending growth was even wider after HCC risk adjustment: 5.3 percent higher for Lagging markets and 4.6 percent lower for Leading markets.

These market trends potentially overstate the impact that ACOs may have had on program spending in 2023. The portion of the difference in spending growth driven by risk adjustment may reflect efforts by ACOs to increase coding intensity. Leading markets may exhibit higher participation rates in CMMI models. ACO participation may naturally flock to

markets with lower trend for exogenous reasons. Still, conservatively assuming only 35 percent of the unadjusted trend gap is causally related to Shared Savings Program ACOs would roughly validate the $5.2 billion gross savings indicated by comparing aggregate program benchmarks to actual ACO spending in 2023, and the roughly $2 billion in net savings to FFS Medicare. A more optimistic estimate, assuming Shared Savings Program ACOs were responsible for 50 percent of the risk-adjusted spending growth difference (mirroring assumptions used in the December 2018 final rule), would imply net savings roughly 3 times greater, or roughly $6 billion net savings for FFS Medicare.

In the CY 2026 PFS final rule (90 FR 49976), we explained that a study of benchmark performance for cohorts of ACOs that participated in both PY 2022 and PY 2023 revealed that the BASIC track is the primary driver of net savings (as measured by program benchmark target spending less actual spending and shared savings payments). An updated analysis, summarized in Table D-B7, finds that ACOs remaining in the BASIC track continued to demonstrate roughly 50 percent higher net savings in PY 2024 (2.3 percent of benchmark) than ACOs that remained in the ENHANCED track over the same three year period (1.5 percent of benchmark) – where 'net savings' is calculated as the difference in combined cohort spending from combined cohort benchmark spending net of combined cohort shared savings outlays, expressed as percentage of combined cohort benchmark (column D in Table D-B7). Meanwhile, ACOs moving into the ENHANCED track from the BASIC track show a marked decline in net savings. Thirty-eight ACOs moved from the BASIC track in PY 2022 (with net savings of 2.5 percent) to the ENHANCED track by PY 2024 with net savings dropping to 1.7 percent of benchmark.

TABLE D-B7: WEIGHTED AVERAGE FINANCIAL PERFORMANCE BY ACO COHORT DEFINED BY PATH OF PARTICIPATION OVER PY 2022 TO PY 2024 ($ BILLIONS; NEGATIVE VALUES REPRESENT SAVINGS TO THE PROGRAM)

Participation Pathway From PY22 to PY24	ACO Count	Benchmark ($B) [A]	Gross Savings % of Benchmark [B]			Shared Savings % of Benchmark [C]			Net Difference % of Benchmark [D]		
			2022	2023	2024	2022	2023	2024	2022	2023	2024
BASIC All 3 Years	210	51	-3.1	-3.4	-4.1	1.3	1.4	1.8	-1.8	-2.0	-2.3
BASIC->ENHANCED	38	14	-4.5	-5.8	-6.3	2.0	3.5	4.6	-2.5	-2.4	-1.7

ENHANCED All 3 Years	123	50	-4.8	-5.1	-5.8	3.5	3.8	4.3	-1.2	-1.4	-1.5

Notes: "Participation Pathway" are the following groups of ACOs, identified by the track/level of their participation in PY 2022, PY 2023 and PY 2024: "BASIC All 3 Years" are ACOs that remained in the BASIC track (Level A, B, C, D, or E) for PY 2022, PY2023, and PY 2024; "BASIC->ENHANCED" are ACOs that participated in BASIC in PY 2022 and either (a) remained in BASIC in PY 2023 before then advancing to the ENHANCED track in PY2024, or (b) advanced to the ENHANCED track in PY 2023 and remained in the ENHANCED track in PY 2024; and "ENHANCED ALL 3 Years" are ACOs that remained in the ENHANCED track for PY 2022, PY 2023, and PY 2024.
"Benchmark" [A] is the total PY 2024 benchmark spending for each cohort, in billions of dollars.
"Gross Savings % of Benchmark" [B] is the percentage that a cohort's combined spending deviated from their combined benchmark spending (a negative percentage implies savings).
"Shared Savings % of Benchmark" [C] is the cohort's combined shared savings (and losses) paid to (from) ACOs expressed as a percentage of benchmark.
"Net Difference % of Benchmark" [D] is the sum of "Gross Savings % of Benchmark" [B] and "Shared Savings % of Benchmark" [C] and represents the portion of gross savings (as measured by program benchmarks) retained by the Trust Funds.

Favorable regional adjustments have helped selective ACOs maximize earnings in the ENHANCED track without taking on a high degree of real risk. Only about 2 percent of ENHANCED track ACOs owed losses in PY 2024 while 90 percent earned shared savings. The ENHANCED track has grown from including only 14 percent of ACOs in 2020 to 58 percent in 2026.

The first impact estimate in this section assesses the coordinated set of proposals to rebalance the incentives between the BASIC track and ENHANCED track. These proposals include reducing the maximum weight used in calculating the positive regional adjustment for lower-spending ACOs under the ENHANCED track from 50 percent to 35 percent, increasing the prior savings adjustment's scaling factor from 50 percent to 75 percent, and increasing the shared savings rate for BASIC track Level E from 50 percent to 60 percent. A stochastic modeling approach consistent with the regulatory impact analysis from previous rules was employed to simulate the impact this set of proposals would have on existing ACOs and potential new ACOs over the 10 year scoring period. The changes will reduce the propensity for ACOs to be able to passively earn shared savings at the highest sharing rate by solely relying on baseline efficiency through the regional adjustment to the benchmark and instead will place a stronger incentive on generating new efficiency over the agreement period. Such incentive for new efficiency will also be incentivized by the increase in the prior savings adjustment's scaling factor. That change, combined with the higher sharing rate in BASIC track Level E, will likely attract a greater number of new ACOs serving populations, often with high spending at baseline

relative to the regional average. The increase to the prior savings adjustment scaling factor would strengthen the degree that such higher spending ACOs would continue to share in savings originally made in their first agreement period despite then facing rebasing into a subsequent agreement period – a dynamic further enhanced by the proposal to risk adjust the cap on benchmark adjustments (currently defined as 5 percent of unadjusted national average assignable per capita spending). These proposals are together estimated to better allocate shared savings payments to ACOs creating new gains in efficiency as opposed to ACOs merely maintaining their historical baseline efficiency, resulting in $4.59 billion lower spending over 10 years, ranging from $6.42 billion lower spending to $2.88 billion lower spending at the 10th and 90th percentiles, respectively. The annual and 10-year total projections for the changes to Shared Savings Program participation options are detailed in Table D-B8.

TABLE D-B8: PROJECTED IMPACT OF FINANCIAL METHODOLOGY PROPOSALS TO REDUCE THE REGIONAL ADJUSTMENT WEIGHTING FOR ENHANCED TRACK ACOS, INCREASE SHARING RATE FOR BASIC TRACK LEVEL E, AND INCREASE THE PRIOR SAVINGS ADJUSTMENT PERCENTAGE ($ MILLIONS; NEGATIVE VALUES REPRESENT SAVINGS TO THE PROGRAM)

	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	Total
Impact Estimate	−580	−650	−720	−850	−980	−100	−140	−170	−190	−210	**−4,590**
Estimate Range:											
Low Estimate (10th Percentile)	−730	−810	−930	−1,150	−1,310	−300	−380	−420	−480	−510	**−6,420**
High Estimate (90th Percentile)	−450	−480	−510	−560	−680	100	70	70	70	100	**−2,880**

Note: Projections at the 10th and 90th percentiles are distinct at the annual level from the corresponding percentiles of the 10-year totals and therefore the sum of the annual percentiles will not necessarily match the corresponding percentiles of the 10-year totals.

The second area of material impact on program spending is for the creation of a growth adjustment to incentivize new participation among providers and suppliers that have not been part of a Medicare ACO within the past five years. As described in sections III.G.5.a and III.G.5.f of this proposed rule, participation in the Shared Savings Program has grown substantially since the program began in 2012, from approximately 3 million assigned beneficiaries assigned in its first year to more than 12 million assigned beneficiaries as of January 2026. This growth has occurred alongside strong program performance: We have

observed that when participation in the program increases, we see increases in both quality improvements for beneficiaries and increased savings to the Trust Funds. The Shared Savings Program has had eight consecutive years of generating savings for Medicare relative to benchmarks, with over $12 billion in total savings,[402] with an upward trend in savings year over year. (As noted previously in this discussion, these savings measured by benchmarks are reasonably substantiated by lower observed per capita spending trend in markets with early ACO adoption versus higher average per capita spending trend in markets with lagging ACO adoption.) Additionally, we have observed that ACOs in the Shared Savings Program have demonstrated improved quality over time and higher quality relative to other physician groups, suggesting that the Shared Savings Program is achieving savings while improving quality of care.

This historical experience supports our expectation that expanding participation would extend the program's quality benefits to additional beneficiaries and create further opportunities for Medicare savings. The growth adjustment is part of a complementary package of proposed modifications to the benchmark methodology intended to realign financial incentives and grow participation, thus expanding the reach of quality improvements demonstrated in the Shared Savings Program, and encourage further savings.

The proposed growth adjustment would be applied on top of the highest of the existing benchmark adjustments, including regional adjustment, prior savings adjustment, or population adjustment (if eligible), and would not exceed a risk adjusted 5 percent cap for consistency with the proposed approach to capping other upward adjustments to the historical benchmark. The proposal is estimated to have the greatest impact on new ACOs that would have the greatest potential to bring in beneficiaries who have not been previously assigned to ACOs. The growth adjustment proposal is projected to increase ACO shared savings payments by $5.3 billion over

[402] Additional information on past years Shared Savings Program Performance Year Finance and Quality Results is available at: *https://data.cms.gov/medicare-shared-savings-program/performance-year-financial-and-quality-results*.

10 years, but most of that cost would be offset by new savings on reduced benefit spending from bringing additional populations into care management under Shared Savings Program ACOs. As a result, the estimated net cost to the program is estimated to be considerably less than the increase in net sharing to ACOs. This proposal is estimated to result in a net increase in spending by $1.67 billion over 10 years, with the annual increase declining in later years as savings from increased participation grow while the effect of the growth adjustment on benchmarks eventually moderates. We have observed that beneficiaries receive higher quality of care (as evidenced by ACOs' quality performance) when assigned to ACOs in the Shared Savings Program, and increasing participation in the Shared Savings Program through the growth adjustment has the potential to broaden higher quality of care to additional Medicare FFS beneficiaries. The range of uncertainty spans costs of $1.13 billion to $2.28 billion at the 10th and 90th percentiles, respectively. The annual and 10-year total projections for these provisions are detailed in Table D-B9.

TABLE D-B9: PROJECTED IMPACT FOR GROWTH ADJUSTMENT INCENTIVE TO ENCOURAGE NEW PARTICIPATION ($ MILLIONS; NEGATIVE VALUES REPRESENT SAVINGS TO THE PROGRAM)

	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	Total
Impact Estimate	290	270	310	320	330	20	10	30	50	40	**1,670**
Estimate Range:											
Low Estimate (10th Percentile)	240	210	250	300	300	-60	-120	-100	-80	-70	**1,130**
High Estimate (90th Percentile)	330	270	380	370	420	140	120	120	150	160	**2,280**

Note: Projections at the 10th and 90th percentiles are distinct at the annual level from the corresponding percentiles of the 10-year totals and therefore the sum of the annual percentiles will not necessarily match the corresponding percentiles of the 10-year totals.

The third portion of our impact estimate is for the proposed changes to beneficiary assignment, including removing from assignment calculations allowed charges for primary care services billed through a non-ACO TIN by an ACO professional used in assignment, and modifying regulatory criteria that exclude from eligibility for assignment Medicare FFS beneficiaries with any months of Part A only or Part B only enrollment, or Medicare or group health plan enrollment (including MA) during the assignment window. These changes would marginally increase the number of beneficiaries assigned to a given ACO. More importantly,

they would improve the ability for the program to hold ACOs accountable for more of the patients actually served by ACO clinicians, including those with accentuated need for care management. The first proposal would reduce the ability for an ACO, through billings for primary care services by ACO professionals used in assignment, to 'lemon drop' – a potential form of gaming where patients with high needs are purposefully billed services through a TIN external to the ACO to engineer their assignment away from the ACO. The second proposal helps reduce a notable blind spot in the current assignment methodology. As enrollment in Medicare Advantage (MA) has grown over recent years, so has the number of beneficiaries switching back to OM from MA – a population that the proposed revised assignment criteria would more nimbly pick up for inclusion in ACO assignment. This proposal would also improve the symmetry in assignment for ACOs relative to the national and regional assignable populations because the Shared Savings Program does not currently employ the same exclusions based on Medicare enrollment status for identifying the assigned and assignable populations. Together these proposals are estimated to reduce program spending by $2.3 billion over 10 years, ranging from $2.97 billion to $1.69 billion savings at the 10th and 90th percentiles, respectively. Savings from these changes could effectively be materially higher if gaming of assignment were to otherwise significantly grow in popularity at baseline.

TABLE D-B10: PROJECTED IMPACT FOR CHANGES TO ASSIGNMENT METHODOLOGY ($ MILLIONS; NEGATIVE VALUES REPRESENT SAVINGS TO THE PROGRAM)

	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	Total
Impact Estimate	−380	−280	−220	−200	−200	−300	−230	−190	−160	−140	**−2,300**
Estimate Range:											
Low Estimate (10th Percentile)	−410	−330	−300	−300	−320	−410	−350	−320	−310	−290	**−2,970**
High Estimate (90th Percentile)	−350	−230	−140	−100	−80	−210	−120	−80	−10	−20	**−1,690**

Note: Projections at the 10th and 90th percentiles are distinct at the annual level from the corresponding percentiles of the 10-year totals and therefore the sum of the annual percentiles will not necessarily match the corresponding percentiles of the 10-year totals.

The last provision estimated to have a material impact on spending is the proposal to revise the methodology for the ACPT. The current policy includes a discretionary option for

CMS to reduce the weight on the ACPT's contribution to the three-way blended update to ACO benchmarks if unforeseen circumstances arise. The proposed changes would create uniform annual one-year growth projections common to ACOs in overlapping agreement periods – eliminating reliance on multi-year projections that the ACPT currently employs – and a policy that, for agreement periods beginning on or after January 1, 2027, would limit the effect of under-projection or over-projection as compared to actual retrospective national expenditure trend such that an effective ACPT trend (cumulatively from BY3 to a given performance year) is no more than one percentage point below (or no more than 1.5 percentage points above) national growth. The asymmetry of these guardrails preserves a limited degree of margin related to the ideal scenario where ACOs as a group cause national trend to slow relative to projected trend over the course of a given agreement period, but more importantly has several notable advantages relative to the current methodology with potential down-weighting. It protects the validity of benchmark updates by limiting how far the projected trend used in the ACPT portion of the three-way blended update factor would be allowed to deviate from observed national trend, and does so under an objective formula that eliminates the subjectiveness of the current down-weighting policy that would otherwise likely be invoked to a greater degree in years where down-weighting would favor ACOs as opposed to public pressure to maintain the one-third weighting in years where over-projection could favor ACOs. The proposal would also improve on the current down-weighting policy because it would preserve the role of national trend in the overall update, which can help preserve the incentive for neighboring ACOs to collectively lower spending in their overlapping service area (an outcome that down-weighting would penalize by increasing the effective weighting on regional trends in calculating benchmark updates). Despite estimating higher spending in 2027 and 2028 related partly to our separate proposal to only apply the lower 1.0 percentage point threshold for ACOs in existing agreement periods, the total impact over ten years is estimated to be a savings of $350 million, ranging from a $1.11 billion

savings to a $340 million cost at the 10th and 90th percentiles, respectively. The estimates are shown in table D-B11:

TABLE D-B11: PROJECTED IMPACT FOR CHANGES TO ACPT AND ASSOCIATED GUARDRAILS ($ MILLIONS; NEGATIVE VALUES REPRESENT SAVINGS TO THE PROGRAM)

	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	Total
Impact Estimate	130	70	−10	−50	−70	−80	−90	−90	−80	−70	**−350**
Estimate Range:											
Low Estimate (10th Percentile)	−60	−40	−90	−140	−200	−250	−290	−300	−200	−190	**−1,110**
High Estimate (90th Percentile)	350	200	80	10	20	30	30	40	20	30	**340**

Note: Projections at the 10th and 90th percentiles are distinct at the annual level from the corresponding percentiles of the 10-year totals and therefore the sum of the annual percentiles will not necessarily match the corresponding percentiles of the 10-year totals.

The remaining changes to the Shared Savings Program regulations, as described in section VII.A.2.a. of this proposed rule, are not estimated to have an impact on program spending at the aggregate level.

The proposals detailed above are expected to increase assignment to ACOs in the program by 0.5 to 1.0 million beneficiaries on average per year. The combined impacts from all Shared Savings Program provisions on federal spending are shown in Table D-B12. Because estimates are rounded to the nearest $10 million, and because the percentiles are independently sorted for each year and for the 10-year totals, the annual estimates may not sum to exactly match the total 10-year estimates. Together these proposals are estimated to reduce program spending by $5.5 billion over 10 years, ranging from $8.9 billion to $2.3 billion savings at the 10th and 90th percentiles, respectively.

TABLE D-B12: PROJECTED IMPACT OF MEDICARE SHARED SAVINGS PROGRAM PROVISIONS (INDIVIDUALLY SHOWN IN TABLES D-B8 THROUGH D-B11) ($ MILLIONS; NEGATIVE VALUES REPRESENT SAVINGS TO THE PROGRAM)

	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	Total
Impact Estimate	−580	−640	−690	−830	−960	−410	−400	−360	−330	−340	**−5,550**
Estimate Range:											
Low Estimate (10th Percentile)	−970	−1,010	−1,090	−1,280	−1,510	−920	−980	−970	−890	−910	**−8,870**
High Estimate (90th Percentile)	−180	−300	−300	−400	−420	40	80	130	160	190	**−2,310**

Note: Projections at the 10th and 90th percentiles are distinct at the annual level from the corresponding percentiles of the 10-year totals and therefore the sum of the annual percentiles will not necessarily match the corresponding percentiles of the 10-year totals.

The proposals are expected to both decrease and increase net shared savings payments across the overall distribution of ACOs. The mean projection is an overall increase in such payments by $1.05 billion over 10 years, ranging from a $2.6 billion decrease to a $4.63 billion increase at the 10th and 90th percentiles, respectively. The increase in shared savings payments to ACOs is driven by the proposed growth adjustment policy, and without this proposed policy the majority of savings to Medicare would be achieved through reductions in shared savings payments. Annual and total projections for the impact on shared savings net of shared losses are shown in Table D-B13.

TABLE D-B13: PROJECTED IMPACT OF MEDICARE SHARED SAVINGS PROGRAM PROVISIONS ON SHARED SAVINGS PAYMENTS TO ACOS ($ MILLIONS; POSITIVE VALUES REPRESENT INCREASED NET PAYMENTS TO ACOS)

	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	Total
Impact Estimate	−220	−230	−200	−260	−300	270	350	450	560	640	**1,050**
Estimate Range:											
Low Estimate (10th Percentile)	−620	−560	−580	−700	−900	−220	−210	−150	10	50	**−2,600**
High Estimate (90th Percentile)	210	130	200	180	230	720	850	990	1,060	1,180	**4,630**

b. Compliance with Requirements of Section 1899(i)(3) of the Act

Certain policies, including both existing policies and the new proposed policies described in proposed rule, rely upon the authority granted in section 1899(i)(3) of the Act to use other payment models that the Secretary determines will improve the quality and efficiency of items and services furnished under the Medicare program, and that do not result in program

expenditures greater than those that would result under the statutory payment model. The following proposed policies require the use of our authority under section 1899(i) of the Act: modifications to the ACPT component of the three-way blended benchmark update factor (described in section III.G.5.g of this proposed rule); discontinuing availability of the option for prepaid shared savings (described in section III.G.6.b of this proposed rule); and changes to the calculation methodology for quarterly advance investment payments (described in section III.G.7 of this proposed rule). When considered together, these changes to the Shared Savings Program are expected to improve the quality and efficiency of items and services furnished under the Medicare program by improving the accuracy of the benchmark update factor and strengthening financial incentives under the Shared Savings Program, decreasing administrative burden and conserving resources by discontinuing the availability of the prepaid shared savings option given low uptake and anticipated limited participation, and simplifying the calculation of quarterly amounts of advance investment payment (for eligible ACOs) while encouraging ACO formation in rural areas. These changes are not expected to result in a situation in which the payment methodology under the Shared Savings Program, including all policies we have adopted under the authority of section 1899(i) of the Act, results in more spending under the program than would have resulted under the statutory payment methodology in section 1899(d) of the Act.

In the CY 2023 PFS final rule (87 FR 70195 and 70196), we estimated that the projected impact of the payment methodology that incorporates all policies finalized by that final rule would result in $4.9 billion in greater program savings compared to a hypothetical baseline payment methodology that excluded the policies that we have enacted relying on the authority of section 1899(i)(3) of the Act. The marginal impact of the changes in the CY 2024 PFS final rule (88 FR 79496) were estimated to lower net spending by $330 million over the subsequent 10-year period (2024 through 2033) for all new policies combined. The marginal impact of the changes in the CY 2025 PFS final rule (89 FR 98527) were estimated to lower net spending by an additional $200 million in total through 2034. The marginal impact of the changes in the

CY 2026 PFS final rule (90 FR 49978) were estimated to be a $20 million reduction in net spending through 2035. The marginal impact of the changes in this proposed rule is estimated to be $5.5 billion reduction in net spending through 2036. The incremental changes have been estimated to improve program financial savings since the CY 2023 PFS final rule, and hence the cumulative impact of all policies (including those in this proposed rule) is estimated to result in more than the previously-estimated $4.9 billion in greater program savings compared to a hypothetical baseline payment methodology that excludes the policies we have enacted relying on section 1899(i)(3) of the Act as authority. Therefore, we estimate that program expenditures associated with the implementation of the provisions in this proposed rule, in combination with other policies associated with the statutory payment model and current policies we have adopted under the authority of section 1899(i)(3) of the Act, are expected to improve the quality and efficiency of items and services furnished under the Medicare program and would not be expected to increase program expenditures relative to those of the statutory payment model.

We will continue to reexamine this projection in the future to ensure that an alternative payment model does not result in additional program expenditures and so continues to satisfy the requirement under section 1899(i)(3)(B) of the Act. Additional Shared Savings Program data accumulating after the end of the PHE for COVID-19, along with emerging information on the characteristics of, and performance trends for, new entrants in the Shared Savings Program for agreement periods beginning on January 1, 2024, January 1, 2025, and January 1, 2026, are anticipated to gradually improve our ability to reevaluate program impacts in a comprehensive fashion. If we later determine that the payment model that includes policies established under section 1899(i)(3) of the Act no longer meets this requirement, we will undertake notice and comment rulemaking to adjust the payment model to ensure continued compliance with the statutory requirements.

9. Changes to the Regulations Associated with the Ambulance Fee Schedule

As outlined in section III.H.2. of this proposed rule, section 6203 of the Consolidated Appropriations Act, 2026 amended section 1834(l)(12)(A) and (l)(13) of the Act to extend the payment add-ons sets forth in those sections through December 31, 2027. The ambulance extender provisions are enacted through legislation that is self-implementing. We are proposing to revise dates at § 414.610(c)(1)(ii) and (c)(5)(ii) to conform the regulations to these self-implementing statutory requirements.

A plain reading of the statute requires only a ministerial application of the mandated rate increase and does not require any substantive exercise of discretion on the part of the Secretary. As a result, there are no policy proposals associated with these legislative provisions. We have estimated the cost of these provisions to be $260 million over the 10-year period and the Congressional Budget Office (CBO)'s estimated cost of these provisions was $52 million in FY 2026, $111 million in FY 2027, and $34 million in FY 2028 with minimal costs for the remaining 10 year period, resulting in a net effect of $197 million from FY 2026 to FY 2035 (*https://www.cbo.gov/system/files/2026-01/hr7148-CAA-2026.pdf, page 4)*.

As discussed in section III.H.4., of this proposed rule, we are proposing to make use of the revised OMB delineations as set forth in OMB's July 21, 2023 bulletin (No. 23-01) and the most recent modifications of the RUCA codes for purposes of payment under the AFS. If we adopt OMB's revised delineations and the updated RUCA codes, ambulance providers and suppliers that pick up Medicare beneficiaries in areas that would be Micropolitan or otherwise outside of MSAs based on OMB's revised delineations or in a rural census tract of an MSA based on the updated RUCA codes (but are currently within urban areas) may experience increases in payment for such transports because they may become eligible for the rural adjustment factors discussed previously, while those ambulance providers and suppliers that pick up Medicare beneficiaries in areas that would be urban based on OMB's revised delineations and the updated RUCA codes (but are currently in Micropolitan Areas or otherwise outside of MSAs,

or in a rural census tract of an MSA) may experience decreases in payment for such transports because they would no longer be eligible for the rural adjustment factors discussed previously.

The use of the revised OMB delineations and the updated RUCA codes would mean the recognition of new urban and rural boundaries based on the population migration that occurred over a 10-year period, between 2010 and 2020. As discussed previously in this section, we are proposing to use the updated 2020 RUCA codes to identify rural census tracts within MSAs, such that the census tracts falling at or above RUCA level 4.0 would continue to be designated as rural areas.

Based on our analysis, the geographic designations for approximately 95.87 percent of ZIP codes would be unchanged by using OMB's revised delineations and the updated RUCA codes. There are more ZIP codes that would change from urban to rural (1,172, or 2.73 percent) than rural to urban (602, or 1.40 percent). In general, it is expected that ambulance providers and suppliers in 1,172 ZIP codes within 47 States and Puerto Rico may experience payment increases if we adopt the revised OMB delineations and the updated RUCA codes, as these areas would be redesignated from urban to rural. The State of Maryland would have the most ZIP codes changing from urban to rural with a total of 49, or 7.78 percent. Ambulance providers and suppliers in 602 ZIP codes within 43 States may experience payment decreases if we adopt the revised OMB delineations and the updated RUCA codes, as these areas would be redesignated from rural to urban. The State of South Carolina would have the most ZIP codes changing from rural to urban (20, or 3.68 percent). Adoption of the revised OMB delineations and the updated RUCA codes would have no negative impact on ambulance transports in super rural areas, as none of the current super rural areas would lose their status due to the revised OMB delineations and the updated RUCA codes. We estimate that the adoption of the revised OMB delineations and the updated RUCA codes will have a minimal fiscal impact on the Medicare program.

10. Updates to the Quality Payment Program

In this section of the proposed rule, we estimate the impacts of the Quality Payment

Program policies. We estimate participation, final scores, and payment adjustments for eligible clinicians participating through MIPS the Advanced APMs, and MVPs. For Advanced APMs, we estimate the impacts on the number of Qualified Participants (QPs) that are associated with our proposed policies.

a. Overall Impact Modeling Approach and Data Assessment

(1) MIPS Impact Modeling Approach

For this proposed rule, we used a similar modeling approach as the CY 2026 PFS final rule (90 FR 49266 through 50481). We created two MIPS impact models: a baseline and a proposed policies model. Our baseline model includes previously finalized policies that are still in effect for the CY 2027 performance period/2029 MIPS payment year and in the absence of any of the new policies in this proposed rule. Examples of previously finalized policies included in the baseline model are revised administrative claims quality measure benchmarking methodology, modifications to the Total Per Capita Cost measure, and removal of the topped-out measure scoring cap and application of the defined topped out measure benchmarks to 19 quality measures identified for CY 2026 performance period/2028 MIPS payment year. Please refer to CY2026 PFS final rule for a comprehensive, detailed discussion of finalized policies (90 FR 49266).

The policies model builds on the baseline model and incorporates the new MIPS policies we are proposing for the CY 2027 performance period/2029 MIPS payment year included in this proposed rule. By comparing the baseline model to the proposed policies model, we are able to estimate the impact of the policies in this proposed rule.

Our modeling approach utilizes the same scoring engine that is used to determine MIPS payment adjustments. This approach enables our model to align as much as possible with actual MIPS scoring

(2) Data Used to Estimate Future MIPS Performance

In the CY 2026 PFS proposed and final rules, we used data from performance year 2023

to construct baseline and policies model simulations. For this proposed rule, we used data from performance year 2024. This is the most recent available data and reflects our most up-to-date information on program participation, final scores, and payment adjustments.

b. APM Incentive Payments to QPs in Advanced APMs and Other Payer Advanced APMs

Beginning with QP Performance Period 2017 (payment year 2019), through the Medicare Option, eligible clinicians who are determined to have a sufficient percentage of their Medicare Part B payments for covered professional services or Medicare patients through Advanced APMs are QPs for the applicable QP performance period and the corresponding payment year. In payment years 2019 through 2024, these QPs received a lump-sum APM Incentive Payment equal to 5 percent of their estimated aggregate paid amounts for covered professional services furnished during the base year (the calendar year immediately preceding the payment year). In payment year 2025, eligible clinicians who attained QP status for QP Performance Period 2023 will receive a lump-sum APM Incentive Payment equal to 3.5 percent of their estimated aggregate paid amounts for covered professional services furnished during CY 2024. In payment year 2026, eligible clinicians who attained QP status in QP Performance Period 2024 will receive a lump-sum APM Incentive Payment equal to 1.88 percent of their estimated aggregate paid amounts for covered professional services furnished during CY 2025. In payment year 2028, eligible clinicians who attained QP status in QP Performance Period 2026 will receive a lump-sum APM Incentive Payment equal to 3.1 percent of their estimated aggregate paid amounts for covered professional services furnished during CY 2027.

Beginning with QP Performance Period 2019 (payment year 2021), in addition to the Medicare Option, the All-Payer Combination Option also affords eligible clinicians an opportunity at QP status. The All-Payer Combination Option allows eligible clinicians to become QPs by assessing a combination of both Medicare Part B covered professional services furnished or patients through Advanced APMs and services furnished or patients through Other Payer Advanced APMs. Eligible clinicians who become QPs for a given QP Performance Period

are not subject to MIPS reporting requirements and payment adjustments for the contemporaneous MIPS performance period/payment year. Eligible clinicians who do not become QPs but meet a lower threshold requirement to become Partial QPs for the year may elect to (or not to) report to MIPS. If they elect to report, they are subject to MIPS scoring and payment adjustment. Partial QPs are not eligible to receive the APM Incentive Payment.

If an eligible clinician does not attain either QP or Partial QP status and is not excluded from MIPS on another basis, the eligible clinician will be subject to the MIPS reporting requirements and will receive the corresponding MIPS payment adjustment.

Separately from the APM Incentive Payment, beginning in payment year 2026, there are two separate PFS CFs—one for QPs for the year (the qualifying APM CF), and the other for all non-QP eligible clinicians and other suppliers paid under the PFS (the non-qualifying APM CF). The update to the qualifying APM CF for a year is 0.75 percent, whereas the update to the non-qualifying APM CF for a year is 0.25 percent. Such updates produce approximately a 0.5 percent difference in the two conversion factors each year.

The thresholds to achieve QP status in the 2027 QP Performance Period (2029 payment year) are set to 75 percent for the payment amount, and 50 percent for the patient count. Overall, we estimated that for the 2026 QP Performance Period, between 517,800 and 530,900 eligible clinicians will become QPs, and therefore will be excluded from MIPS reporting requirements and payment adjustments.

In the CY2026 PFS final rule, we finalized our proposal to use two new definitions, "Covered professional service attribution-eligible beneficiary" and "E/M attribution-eligible beneficiary" such that we conduct two determination calculations, one that includes any beneficiary who has received a covered professional service furnished by the eligible clinician (NPI) for whom we are making the QP determination and one that continues to use Evaluation and Management services furnished by the eligible clinician (NPI) for whom we are making the

QP determination. We also finalized our proposal to add a QP determination at the individual level for all Advanced APM participants, beginning with the 2026 QP Performance Period.

We project the number of eligible clinicians who will be QPs, and thus excluded from MIPS, using several sources of information. First, the projections are anchored in the most recently available public information on Advanced APMs. The projections reflect Advanced APMs that will be operating during the 2027 QP Performance Period. The following APMs are expected to be Advanced APMs for the 2027 QP Performance Period:

- Enhancing Oncology Model (EOM);
- Kidney Care Choices Model (Comprehensive Kidney Care Contracting Options, Professional Option and Global Option);
- Long Term Enhanced ACO Design (LEAD) Model;
- Medicare Shared Savings Program (Level E of the BASIC Track and the ENHANCED Track);
- States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model; and
- Transforming Episode Accountability Model (TEAM)

We used the Participation Lists and Affiliated Practitioner Lists, as applicable (see § 414.1425(a) for information on the APM Participant Lists used for QP determinations) for the 2024 QP performance period third snapshot QP determination date to estimate the number of QPs for the 2027 QP Performance Period. For models starting in the 2027 QP Performance Period we estimated performance based on projected participation. We examined the extent to which Advanced APM participants will meet the QP Thresholds of having at least 75 percent of their Part B covered professional services or at least 50 percent of their Medicare beneficiaries were attribution eligible thresholds.

c. Estimated Number of MIPS Eligible Clinicians in the CY 2027 Performance Period/2029 MIPS Payment Year

(1) Initial Population of Clinicians Included in the RIA Baseline and Proposed Policies Models

For this proposed rule, we applied the same assumptions as in the CY 2026 PFS final rule (90 FR 49980) to estimate our initial population of clinicians using 2024 performance data. Specifically, we used the CY 2024 final reconciled eligibility determination file, same as the 2023 file described in the CY 2026 PFS final rule (90 FR 49980). This file reconciles eligibility from two determination periods and aligns with the CY 2024 performance period submissions data on which we based this model. Our analysis included 1,984,786 clinicians with PFS claims in this initial population. This initial population of clinicians was used to determine eligibility using the methodology described in the following sections.

(2) Estimated Number of MIPS Eligible Clinicians after Applying Eligibility Assumptions

(a) Methods and Assumptions Used to Estimate Eligibility

After identifying the clinician population with PFS claims, we applied the same eligibility assumptions and determination process described in the CY 2026 PFS final rule (90 FR 49980). We did not propose any modifications to MIPS eligibility requirements and the same eligibility assumptions apply to both the baseline and proposed policies model.

For our impact analysis, we established the "required eligibility" category, which means the clinician exceeds the low-volume threshold in all three criteria (§§ 414.1305 and 414.1310(b)(1)(iii)) and is subject to a MIPS payment adjustment. We based this estimate on the CY 2024 performance period data described in this section of this proposed rule, which includes the three low-volume criteria.

Our next two eligibility assumptions concern clinicians participating in MIPS through groups. They may voluntarily participate in MIPS, but are not required to participate. First, our group eligibility, includes clinicians with a group submission, and their group exceeds all three low-volume threshold criteria. Second, we apply our opt-in eligibility assumptions. Individuals or groups who exceed the low-volume threshold in at least one criterion, but not all three, may elect to opt in. Based on the number of individuals who opted in to MIPS in performance year

2024, our model estimates that these clinicians will continue to opt in to MIPS in CY2027 performance period/2029 MIPS payment year.

Additionally, we estimate the number of "Potentially MIPS Eligible" clinicians. These clinicians are not included in our total number of MIPS eligible clinicians. These clinicians are potentially eligible because they are either opt-in eligible but did not opt-in or group eligible but did not report.

Finally, we estimate the number of clinicians who are neither MIPS eligible nor potentially MIPS eligible. They include clinicians who are below all three low-volume threshold criteria (both as an individual and as a group), QPs, and clinicians excluded from MIPS for other reasons, such as those with a non-MIPS-eligible clinician type or newly enrolled in Medicare

After applying these assumptions to our initial population, we estimate that there will be 586,925 MIPS eligible clinicians with ~$51.70 billion in allowed charges in the CY2027 performance period/2029 MIPS payment year.

(b) MIPS Eligibility Estimates

In our policies model, we estimate to have 586,925 MIPS eligible clinicians Table D-B14 summarizes our eligibility estimates for the policies model after applying our assumptions outlined in this section of this proposed rule.

TABLE D-B14: ESTIMATION OF MIPS ELIGIBILITY STATUS FOR CY 2027 PERFORMANCE PERIOD/2029 MIPS PAYMENT YEAR USING THE CY 2027 PFS PROPOSED RULE ASSUMPTIONS

Eligibility Status	Predicted Participation Status in MIPS Among Clinicians	Number of Clinicians	PFS allowed charges ($ in mil)[1]
MIPS Eligible Clinicians			
MIPS eligible (always subject to a MIPS payment adjustment because individual clinicians exceed the low-volume threshold in all 3 criteria)	Reported to MIPS	94,895	$28,668
	Did not Report to MIPS	36,898	$11,100
Group eligibility (only subject to payment adjustment because clinicians' groups exceed low-volume threshold in all 3 criteria)	Had a group submission	451,654	$11,710[2]
Subgroup Eligible	MVP Subgroup reporting	286	$14
Opt-In eligibility assumptions (only subject to a positive, neutral, or negative adjustment because the individual or group exceeds the low-volume threshold in at least 1 criterion but not all 3, and they elect to opt-in to MIPS)	Opted-in To MIPS	3,192	$204
Total Number of MIPS Eligible Clinicians and the associated PFS allowed charges		**586,925**	**$51,695**
Potentially MIPS Eligible Clinicians			
Potentially MIPS Eligible (not subject to payment adjustment for non-participation; could be eligible for one of two reasons: (1) meet group eligibility; or (2) opt-in eligibility criteria)	Opt-in Eligible; Do not opt-in	176,361	$5,594
	Group Eligible; Did not Report	497,433	$11,590
Total Number of Clinicians Potentially MIPS Eligible		673,794	$17,184
Not MIPS Eligible Clinicians			
Below the low-volume threshold (never subject to payment adjustment; both individual and group is below all 3 low-volume threshold criteria)	Not applicable	130,199	$807
Excluded for other reasons (Non-eligible clinician type, newly enrolled)	Not applicable	91,962	$635
Qualified Participant (QP)	Not applicable	501,906	$23,259
Total Number of Clinicians Not MIPS Eligible		1,**397,861**	**$41,885**
Total Number of Clinicians (MIPS and Not MIPS Eligible)		**1,984,786**	**$93,580**

[1]Allowed charges estimated in 2024 dollars and projected to 2029 dollars (payment year. Low-volume threshold is calculated using allowed charges. MIPS payment adjustments are applied to the paid amount.

[2]Most clinicians are represented by Group submissions yet are below LVT and have low allowed charges.

d. Modeling Approach and Methods for MIPS Value Pathways (MVPs) and Traditional MIPS

(1) Summary of Approach

In this proposed rule, we present several proposals that impact the measures and activities, the performance category scores, final scores, and MIPS payment adjustments for MIPS eligible clinicians. In section IV.A. of this proposed rule, we outline these changes in

more detail and describe our methodology to estimate MIPS payment adjustments for the CY 2027 performance period/2029 MIPS payment year. We then present the impact of the policies in the CY 2027 performance period/2029 MIPS payment year by comparing select metrics to the baseline model. By comparing model outputs between the baseline model and the proposed policies model, we are able to observe the impact of the policies proposed for the CY 2027 performance period/2029 MIPS payment year. MIPS eligible clinicians' final scores are calculated based on the clinicians' performance on measures and activities specified under the four MIPS performance categories: quality, cost, improvement activities, and Promoting Interoperability. MIPS eligible clinicians can participate in the four MIPS performance categories as an individual, group, virtual group, APM Entity, and via traditional MIPS, the APM Performance Pathway (APP), or MVP reporting options. MIPS APM participants who are ACOs participating in the shared saving program are required to report through the APP/APP+ measure set. The APP or APP+ reporting option only scored on three performance categories: quality, improvement activities, and Promoting Interoperability. Our simulation applies the proposed and baseline policies to the existing scoring engine.

(2) Methodology to Assess Impact for MIPS Value Pathways

At § 414.1365(b), we required MVP Participants (which can be a group, individual, subgroup, or APM entity) to register to report a particular MVP prior to submitting. We assessed whether to use 2024 MVP registration data to estimate MVP participation and policy impact but elected not to simulate the impact for MVP because we do not have sufficient MVP scoring data for modeling and simulation. Thus, modeling based on limited data is less reliable for impact assessment. As more MVP scoring data becomes available in the future, we will reassess our methodology for estimating MVP participation, final scores, and payment adjustments.

(3) Methodology to Assess Impact for Traditional MIPS

To estimate the impact of the policies on MIPS eligible clinicians, we use the data from performance year 2024, including data submitted for the quality, cost, improvement activities,

and Promoting Interoperability performance categories and claims data for the cost performance category.

We supplemented this information with the most recent data available for CAHPS for MIPS and CAHPS for ACOs, administrative claims data for certain quality measures, and other data sets. For the CY 2027 performance period/2029 MIPS payment year, we calculate hypothetical final scores for the baseline and policies models for each MIPS eligible clinician by applying appropriate measure level, performance category, and final scoring policies.

(a) Methodology to Estimate the Quality Performance Category Score

We used the CY 2026 PFS final rules as the starting point of our baseline model (90 FR 49982). This includes our policies regarding the new benchmark for Administrative Claims measures and scoring topped out measures impacted by limited measure choice. Please refer to the CY 2026 PFS final rule for a comprehensive, detailed discussion of finalized policies (90 FR 49266).

Our policies model incorporates the following policies from this proposed rule:

● In section IV.B.1.b.(3) of this proposed rule, to facilitate fairer scoring, we proposed to remove the scoring cap and change the benchmarking approach for additional topped out measures applicable to clinicians facing both limited measure choice and limited scoring opportunities as well as MIPS Core Measures. We do not simulate the addition or removal of quality measures outlined in section IV.A.4.d.(1) of this proposed rule because current data from the CY 2024 performance period do not include new measures, and we cannot estimate the impact of removing measures since we are not able to predict clinician response in measure selections.

In section IV.B.1.b.(1) of this proposed rule, we proposed to remove the requirement to submit one outcome or high priority measures and instead require the submission of a MIPS Core Measure. We propose that small practices with no more than 15 clinicians would be exempt from the MIPS Core Measure requirement. CMS internal analysis found 57 percent of the MVP

submissions in performance year 2024 did not contain any of the proposed MIPS Core measures. Modeling quality performance category score with insufficient historical submission data will introduce uncertainty and complexity to the modeling simulation. Working under this limitation, we believe the previous outcome/high-priority reporting requirement and scoring rules reflected in the performance year 2024 data can serve as a proxy for core measure reporting in the models. As a result, we do not simulate the MIPS Core Measure reporting proposal. We did, however, model the impact of the core measure exemption for small practices.

(b) Methodology to Estimate the Cost Performance Category Score

We estimate the cost performance category score using the same methodology as described in the CY 2026 PFS final rule (90 FR 49982) for the baseline and the proposed policies models.

We do not model the impact of the Acute Kidney Injury requiring New Inpatient Dialysis (AKI) measure because it was suppressed for the CY 2024 performance period/ 2026 MIPS payment year. Therefore, there was no performance data available in 2024 to model the impact of the Acute Kidney Injury requiring New Inpatient Dialysis (AKI) measure

(c) Methodology to Estimate the Promoting Interoperability Performance Category Score

We estimate the Promoting Interoperability performance category score using the same methodology as described in the CY 2026 PFS final rule (90 FR 49982) for the baseline model and the proposed models.

For the proposed policy model, we simulate the following changes:

In section IV.A.4.d.(4) of this proposed rule, we propose the removal of three attestations in the Promoting Interoperability performance category: ONC Direct Review, ONC-ACB Surveillance, and Security Risk Analysis.

(d) Methodology to Estimate the Improvement Activities Performance Category Score

For the baseline model, we use the same method to estimate the improvement activities performance category score as described in the CY 2026 PFS final rule (90 FR 49983), including

alignment with the clarification provided regarding IA automatic weighting for APM participants (89 FR 79366).

In section IV.A.4.d.(3) of this proposed rule, we propose updates to the Improvement Activities inventory, such as removing activities. There is no historical data reflecting IA inventory updates, such as activity removal, for us to estimate potential impact. Our RIA models cannot predict how clinicians will alter their behavior once activities are removed.

(e) Methodology to Estimate the Complex Patient Bonus Points

This proposed rule does not include proposals to modify the complex patient bonus. Therefore, for the baseline and proposed policies RIA model, we used the previously established method to calculate the complex patient bonus as described in the CY 2022 PFS final rule (86 FR 64996).

(f) Methodology to Estimate the Final Score

We do not propose any changes to how we calculate the MIPS final score. Our baseline and proposed policies models assign a final score for each TIN/NPI by multiplying each estimated performance category score by the corresponding performance category weight, adding the products together, multiplying the sum by 100 points, adding the complex patient bonus, and capping at 100 points.

For both models, after adding any applicable complex patient bonus, we reset any final scores that exceeded 100 points to equal 100 points. For MIPS eligible clinicians who were assigned a weight of zero percent for any performance category, we redistributed the weights according to § 414.1380(c).

For the purposes of this model, if a MIPS eligible clinician was approved for reweighting of one or more performance categories in the baseline model according to the data from the CY 2024 performance period/2026 MIPS payment year, we continue to apply that reweighting in our proposed policy model by assigning them a neutral score equal to the performance threshold if all categories were reweighted or assigning the applicable weights to the categories which

were reweighted. Although it is unlikely (but possible) that the exact same clinicians will apply for and receive reweighting in both the CY 2024 performance period/2026 MIPS payment year (which our data is based on) and the CY 2027 performance period/2029 MIPS payment year (which we are simulating), we believe that this assumption accurately reflects future clinician behavior for two reasons. First, while the exact same MIPS eligible clinicians may not receive reweighting in two different years, we believe that this assumption allows us to quantify the impact of the reweighting on a population level. In other words, even if the same clinicians do not apply for and receive reweighting in these two different years, the absolute number of reweighting and the characteristics of practices that receive reweighting are likely to remain similar. Secondly, if we were not to assign reweighting to those MIPS eligible clinicians, many of them would receive a very low final score because they did not submit data for one or more performance categories during the year in which they received reweighting. We do not believe that it is a realistic assumption that, in the absence of reweighting, those clinicians will continue not to submit data. For these reasons, we assume that clinicians who received reweighting in the CY 2024 performance period/2026 MIPS payment year are also approved for reweighting in the CY 2027 performance period/2029 MIPS payment year. These clinicians are assigned a score of the performance threshold (75) in our model because this corresponds with a neutral (0 percent) payment adjustment.

(g) Methodology to Estimate the MIPS Payment Adjustment

For the baseline and proposed policies models, we applied the hierarchy as finalized in the CY 2024 PFS final rule (86 FR 65536 through 65537) to determine which final score should be used for the payment adjustment for each MIPS eligible clinician when more than one final score is available. We then calculate the parameters of an exchange function in accordance with the statutory requirements related to the linear sliding scale, budget neutrality, and minimum and maximum adjustment percentages.

For the baseline model, we apply the performance threshold of 75 points finalized in the CY 2026 PFS final rule. In this proposed rule, we do not make any changes to the performance threshold. Therefore, for both the baseline and proposed policies models, we use a performance threshold of 75 to calculate the exchange function for MIPS payment adjustments. We note that the results of this exchange are not identical between the baseline and proposed policies models. This is because the scaling factor used to determine positive adjustments is dependent on the total dollar amount of negative payment adjustments, and those adjustments differ as final scores are not identical between both models.

For both the baseline and proposed policies models, we use these resulting parameters to estimate the positive or negative MIPS payment adjustment based on the estimated final score and the allowed charges for covered professional services furnished by the MIPS eligible clinician.

(4) Methodology to Assess Impact for APM Performance Pathways

Shared Savings Program Accountable Care Organizations, participating in MIPS through a MIPS APM are scored on performance in the quality, Promoting Interoperability, and Improvement Activities performance categories. We included the following previously finalized policies for SSP ACOs participating in a MIPS APM into the CY 2027 baseline model:

● In 2024, the CMS Web Interface continued to be a collection type available to Shared Savings Program Accountable Care Organizations (SSP ACOs) reporting under the Advanced Payment Pathway. Because our model simulation relies on data from performance year 2024, including CMS Web Interface submissions,, we are unable to predict which collection type SSP ACOs will adopt in lieu of the web interface for CY 2027 performance period/2029 MIPS payment year, given that the Web Interface collection type was no longer available after the CY 2025 performance period/2027 MIPS payment year.

We do incorporate the following proposals into the proposed model:

● In section IV.B.1.c.(1) of this proposed rule, we proposed to score all Medicare CQMs using flat benchmarks retroactively beginning in CY 2026.

(5) Simulation Results and Projected Impact to MIPS Eligible Clinicians

Based on the methodology described in section VII.F.11.d(3) of the proposed rule, we create a baseline and proposed policies simulation. Using this simulation, we estimate the impact of the policies of this proposed rule.

(a) Impact on Clinician Eligibility

In section VII.F.11.(c) of this proposed rule, we noted that we do not modify clinician eligibility and therefore there is no difference in the total number of MIPS eligible clinicians between our models.

(b) Impact on Clinician's Final Scores for Traditional MIPS

Table D-B15 shows the median final score by practice size and the percentage of MIPS eligible clinicians of each practice size with a positive, neutral, or negative adjustment.

TABLE D-B15: CY 2027 FINAL SCORE ESTIMATES BY PRACTICE SIZE

Practice Size[1]	Total Number of MIPS Eligible Clinicians	Median Final Score Estimate[2]	Percent Eligible Clinicians with Positive Payment Adjustment	Percent Eligible Clinicians with Neutral Payment Adjustment	Percent Eligible Clinicians with Negative Payment Adjustment
Baseline					
(1) Solo	15,427	75.00	34.98	26.27	38.75
(a) Reporting	7,326	89.61	73.66	9.00	17.35
(b) Non-Reporting[3]	8,101	24.7	0.00	41.90	58.10
(2) Small (2 to 15)	60,634	87.98	67.60	14.84	17.36
(a) Reporting	47,596	91.35	86.37	4.02	9.62
(b) Non-Reporting[4]	13,040	75	0.04	54.33	45.64
(3) Medium (16 to 99)	115,077	88.63	89.91	7.17	11.92
(4) Large (100+)	395,787	89.20	94.19	1.67	4.14
Overall	586,925	88.83	87.30	4.76	7.94
Proposed Policies					
(1) Solo	15,427	75.00	34.77	26.28	38.95
(a) Reporting	7,325	90.23	73.23	9.00	17.77
(b) Non-Reporting	8,101	24.70	0.00	41.90	58.10
(2) Small (2 to 15)	60,634	88.61	67.65	14.83	17.52
(a) Reporting	47,596	91.84	86.17	4.01	9.82
(b) Non-Reporting	13,040	75	0.04	54.33	45.64
(3) Medium (16 to 99)	115,077	89.14	81.08	7.14	11.78

(4) Large (100+)	395,787	89.48	94.80	1.63	3.57
Overall	586,925	89.21	87.73	4.72	7.55

[1]Practice size refers to the number of NPIs in a TIN

[2]The median final score includes clinicians who receive reweighting for all MIPS performance categories our policies at § 414.1380(c)(2). These clinicians who have all performance categories reweighted are assigned a score of 75 (neutral payment adjustment) in our model.

[3]52.51% of the solo practitioners did not report by not submitting any data

[4]21.51% of the small practice providers did not report by not submitting any data

MIPS performance and financial distribution remain stable with marginal improvements in the overall median final scores and slightly higher overall percentage of clinicians receiving a positive payment adjustment. The overall median final score is 88.83 in the baseline model and 89.21 in the proposed policies model, a slight increase for all practice sizes. About 87.3 percent of eligible clinicians receive a positive payment adjustment in the baseline model and 87.73 percent in the proposed policies model Overall, the percentage of eligible clinicians with negative payment adjustment will drop slightly, from 7.94 percent baseline to 7.55 percent proposed.

Table D-B16 shows the median quality category score for MIPS eligible clinicians who are scored on the quality performance category for the baseline and proposed policies model. Overall, the median quality performance category score showed a marginal increase from 83.16 to 83.72. Solo practitioners, who actively report, experience the most noticeable increase (+2.25) in median quality performance category score compared to those of other practice sizes

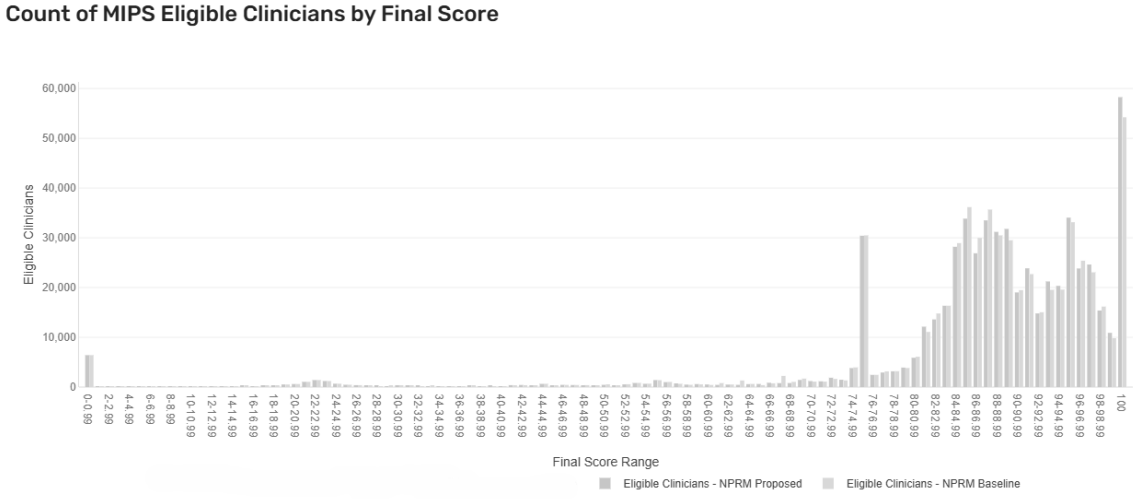
TABLE D-B16: CY 2027 QUALITY SCORE ESTIMATES BY PRACTICE SIZE

Practice Size	MIPS Eligible Clinicians Receiving Quality Score	Total Number of MIPS Eligible Clinicians	Percent of MIPS Eligible Clinicians Receiving Quality Score	Median Quality Score Estimate
Baseline				
Solo (1)	11,289	15,427	73.18	52.61
(a) Reporting	6,602	7,326	90.12	85.95
(b) Non-reporting	4,687	8,101	57.86	0
Small (2-15)	49,995	60,634	82.45	86.31
(a) Reporting	44,043	47,594	92.54	89.15
(b) Non-reporting	5,952	13,038	45.65	0
Medium (16-99)	97,892	115,077	85.07	81.89

Large (100+)	377,846	395,787	95.47	83.29
Overall	**537,022**	**586,925**	**91.50**	**83.16**
Proposed Policies				
Solo (1)	11,288	15,427	73.17	51.91
(a) Reporting	6,601	7,325	90.12	88.2
(b) Non-reporting	4,687	8,102	57.85	0
Small (2-15)	49,999	60,634	82.46	87.93
(a) Reporting	44,047	47,596	92.54	90.63
(b) Non-reporting	5,952	13,038	45.65	0
Medium (16-99)	97,926	115,077	85.10	83.13
Large (100+)	378,001	395,787	95.51	83.72
Overall	**537,214**	**586,925**	**91.53**	**83.72**

Figure D-B1 shows the distribution of final scores for all MIPS eligible clinicians. Note that there is a noticeable size of MIPS eligible clinicians with a final score of 75. MIPS eligible clinicians whom we approved for reweighting all MIPS performance categories in accordance with our reweighting policies at § 414.1380(c)(2) are assigned a final score of exactly the performance threshold (75). Overall, the distribution is left skewed, indicating that many more clinicians would receive final scores on the higher side.

FIGURE D-B1: Count of MIPS Eligible Clinicians by Final Score



(i) Impact to Small and Solo Practices

Across both the baseline and proposed policy models, approximately 15,427 MIPS-eligible clinicians are solo practitioners, accounting for 2.63 percent of all MIPS-eligible clinicians.

The median final score for solo practitioners who actively report data is 89.61 in the baseline model and 90.23 in the proposed policies model. However, the median final scores for solo practitioners who do not report data are substantially lower: 24.7 in both baseline and proposed policies models. The portion of all solo practitioners receiving a positive adjustment is starkly different between reporting and non-reporting solo practitioners. About 73.66 percent (baseline) and 73.23 percent (proposed) reporting solo practitioners will receive a positive payment adjustment; whereas 0 percent (both baseline and proposed) non-reporting solo practitioners will receive a positive payment adjustment.

Many solo practitioners do not actively submit data to MIPS despite being MIPS eligible clinicians. Based on the 2024 performance data, we estimate that about 52.51 percent of solo practitioners receiving a MIPS payment adjustment do not submit any data to MIPS.

Table D-B17 shows that, even among reporting solo practitioners, the percentage receiving a positive payment adjustment is lower than that of clinicians from small, medium, or large practices. Similarly, even for reporting solo practitioners, a higher proportion of them face negative payment adjustments compared to those in small, medium, and large practices Figure D-B2 shows the distribution of final scores for solo practitioners. Both baseline and proposed policies box plots show identical final score distributions, and both baseline and proposed policies models show a large distance between the lower and upper quartiles. Figure D-B3 shows the final score distribution for all MIPS eligible clinicians between the baseline and the proposed policies models. These box plots also show identical final score distributions; however, the distance between lower and upper quartiles is substantially narrower for all MIPS eligible clinicians than it is for solo practitioners.

FIGURE D-B2: Distribution of Final Scores for Solo Practitioners

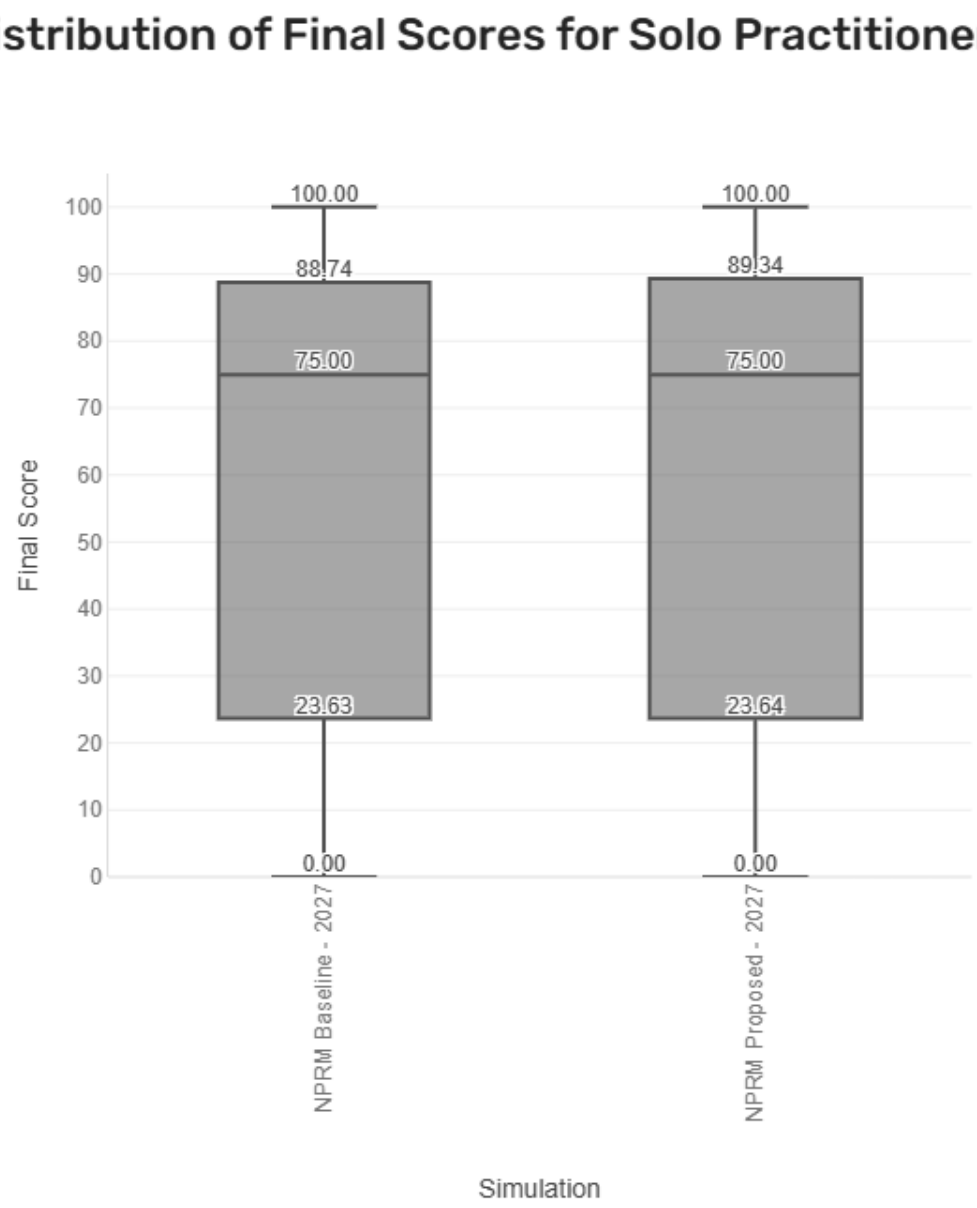
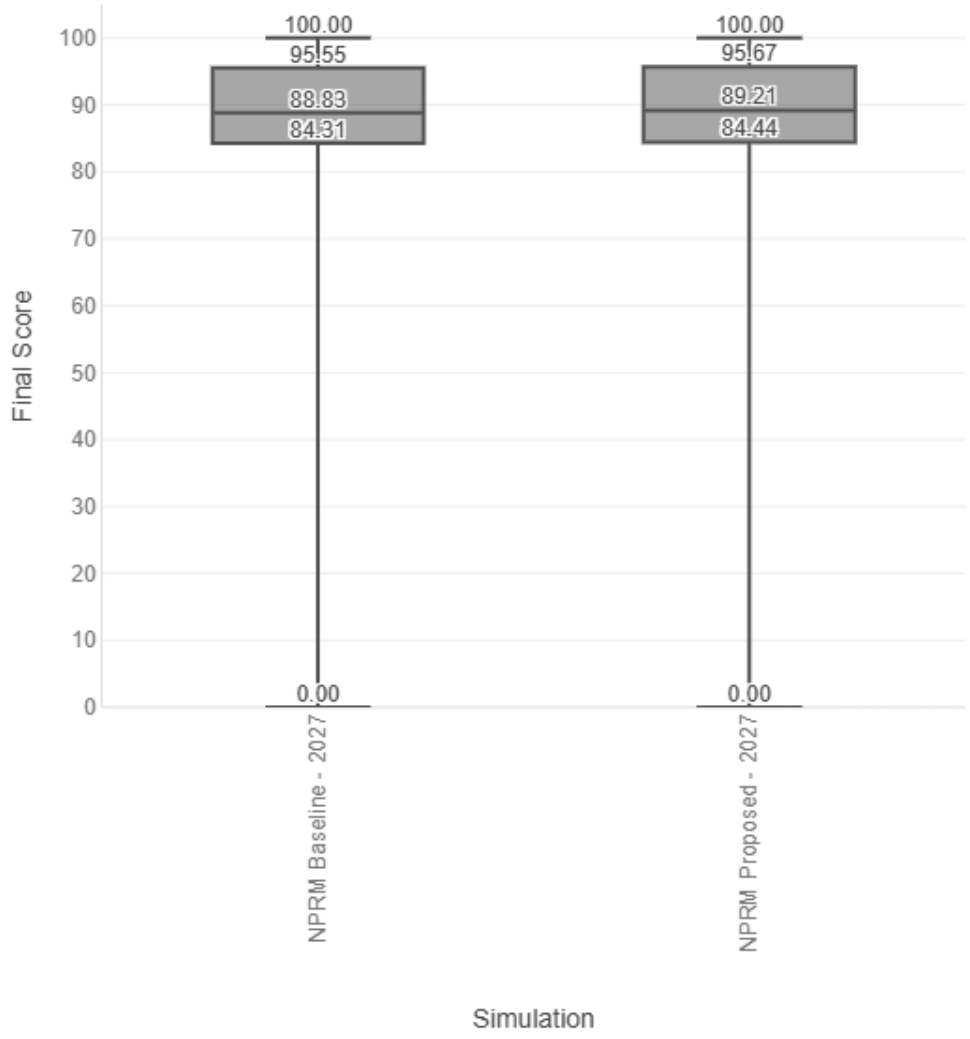


FIGURE D-B3: Distribution of Final Scores for All MIPS Eligible Clinicians

Distribution of Final Scores for All MIPS Eligible Clinicians



Small practices, defined at § 414.1305 as groups with 2 to 15 clinicians, have a median final score of 87.98 in the baseline and 88.61 in the policies model. However, as shown in Table D-B15, the median final score for the reporting small practice providers is 91.35 (baseline) and 91.84 (proposed), substantially higher than the median final score of 75 – in both baseline and proposed policies models - for the non-reporting small practice providers. They are also higher than the median final scores for all MIPS eligible clinicians who submit data, which are 89.85 in the proposed policy model and 89.66 in the baseline model. This indicates that small practice providers who submit MIPS data can perform better than it is for the medium-sized and large

practice providers. Table D-B17 shows the percentage of clinicians, by practice size, either do or do not submit data to MIPS and their corresponding median final scores. Note that, in the proposed policies model, the median final scores for small, medium, and large practice clinicians who do not submit data are 75. This indicates that many small, medium or large practice clinicians who do not submit data to MIPS have been approved for reweighting of all of their MIPS performance categories under our policies at § 414.1380(c)(2). In contrast, the median final scores for solo clinicians, who do not submit data are 24.70. This indicates that many of them are either not being eligible for or not applying for our reweighting policies for extreme uncontrollable circumstances or hardships. Over 90 percent of the medium-sized and large practice clinicians submit data to MIPS. It is possible that the remaining 10 percent or less MIPS eligible clinicians who do not submit data to MIPS are primarily those who have received reweighting under our policies at § 414.1380(c)(2).

TABLE D-B17: PERCENTAGE OF MIPS ELIGIBLE CLINICIANS WHO SUBMIT DATA AND MEDIAN FINAL SCORE

	Percent of MIPS Eligible Clinicians who Submit Data (by practice size)	Median Final Score of MIPS Eligible Clinicians who Submit Data	Median Final Score of MIPS Eligible Clinicians who Do not submit data.
Baseline			
(1) Solo	47.49	89.61	24.70
(2) Small (2 to15)	78.49	91.35	75.00
(3) Medium (16 to 99)	90.67	89.74	75.00
(4) Large (100+)	97.67	89.37	75.00
Overall	**93.00**	**89.66**	**75.00**
Proposed Policies			
(1) Solo	47.48	90.23	24.70
(2) Small (2 to 15)	78.50	91.84	75.00
(3) Medium (16 to 99)	90.71	90.26	75.00
(4) Large (100+)	97.71	89.66	75.00
Overall	**93.03**	**89.85**	**75.00**

(ii) Impact to Rural Providers

In our data we assign rural practitioners a special status. Impact assessment of this group of clinicians indicates that their overall final scores are slightly lower than the overall MIPS eligible clinicians. Table D-B18 shows the median final score and the percentage of eligible clinicians with a positive, neutral, or negative adjustment by practice size for rural practitioners.

TABLE D-B18: CY 2027 FINAL SCORE ESTIMATES BY PRACTICE SIZE FOR RURAL PRACTITIONERS ONLY

Practice Size	Total Number of MIPS Eligible Clinicians	Median Final Score Estimate	Percent Eligible Clinicians with Positive Payment Adjustment	Percent Eligible Clinicians with Neutral Payment Adjustment	Percent Eligible Clinicians with Negative Payment Adjustment
Baseline					
Solo (1)	1,941	75.00	39.41	16.80	43.79
(a) Reporting	1,038	88.34	73.70	5.68	20.62
(b) Non-reporting[1]	903	22.74	0.00	29.57	70.43
Small (2-15)	8,652	88.58	72.03	9.50	18.47
(a) Reporting	7,218	90.92	86.34	2.47	11.19
(b) Non-reporting[2]	1,434	26.77	0.00	44.91	55.09
Medium (16-99)	20,529	89.21	84.70	4.25	11.04
Large (100+)	35,683	87.23	96.07	1.48	2.45
Overall	**66,805**	**87.37**	**87.82**	**3.82**	**8.37**
Proposed Policies					
Solo (1)	1,941	75.00	39.26	16.80	43.95
(a) Reporting	1,038	88.9	73.41	5.68	20.91
(b) Non-reporting[1]	903	22.74	0.00	29.57	70.43
Small (2-15)	8,652	89.08	72.11	9.50	18.39
(a) Reporting	7,218	91.33	86.44	2.47	11.10
(b) Non-reporting[2]	1,434	26.77	0.00	44.91	55.09
Medium (16-99)	20,524	89.8	84.63	4.23	11.14
Large (100+)	35,684	87.22	96.09	1.42	2.49
Overall	**66,801**	**87.46**	**87.81**	**3.77**	**8.41**

[1]46.52% of the rural, solo practitioners did not report by not submitting any data[2]14.22% of the rural, small practice providers did not report by not submitting any data.

The overall median final score for rural practitioners is 87.37 in the baseline model and 87.46 in the policies model. This is slightly lower than the median final score for all MIPS eligible clinicians, which is 88.83 in the baseline model and 89.21in the policies model. According to the results from the proposed policies model, rural clinicians in large practices have a slightly lower median final score (87.22) than it is for reporting, rural, solo practitioners (88.9), reporting, rural, small practice providers (91.33), and rural medium-size practice providers (89.80).

(iii) Impact to Safety Net Providers

(A) Updated Definition of Safety Net Providers

In the CY 2022 PFS final rule (87 FR 70094), we finalized our complex patient bonus methodology. This bonus is composed of two distinct calculations which are added together:

Medical Complexity and Social Risk. Medical Complexity is determined based on a MIPS eligible clinicians Hierarchical Conditions Categories risk score and social risk is determined based on the proportion of a MIPS eligible clinicians Medicare patient population who are dually eligible for both Medicare and Medicaid.

In the 2024 PFS final rule (88 FR 79513), we compared the performance of clinicians who received the complex patient bonus with our overall population. As we further developed our model, we decided to adopt a more precise definition of safety net providers. We believe that by narrowing our definition of safety net providers to clinicians fall in the top 20 percentile for their percentage of patients who are dually eligible for Medicare and Medicaid, we can identify providers who care for a large proportion of socially vulnerable individuals.

Table D-B19 shows the median final score estimates for safety net providers under this definition. In the proposed policies model, safety net providers have a higher median final score (93.22) than the overall MIPS eligible clinicians (89.21). Safety net solo practitioners who actively report data have a substantially higher median final score (93.84 in the proposed model) than that from the non-reporting, safety net, solo practitioners (29.41 in the proposed model). Almost 57 percent of safety net solo practitioners and over 30 percent of safety net small practice providers did not report by not submitting any MIPS data, compared to ~53 percent and ~22 percent of the overall solo practitioners and small practice providers, respectively.

TABLE D-B19: CY 2027 FINAL SCORE ESTIMATES BY PRACTICE SIZE FOR SAFETY NET PRACTITIONERS ONLY

Practice Size	Total Number of MIPS Eligible Clinicians	Median Final Score Estimate	Percent Eligible Clinicians with Positive Payment Adjustment	Percent Eligible Clinicians with Neutral Payment Adjustment	Percent Eligible Clinicians with Negative Payment Adjustment
Baseline					
(1) Solo	4,396	75.00	32.21	30.94	36.85
(a) Reporting	1,918	93.35	73.83	10.74	15.43
(b) Non-Reporting[1]	2,478	29.41	0.00	46.57	53.43
(2) Small (2 to 15)	11,557	85.70	58.48	18.36	23.16
(a) Reporting	8,060	94.35	83.80	5.19	11.02
(b) Non-Reporting[2]	3,497	59.21	0.11	48.73	51.16
(3) Medium (16 to 99)	27,009	91.38	78.14	7.99	13.87

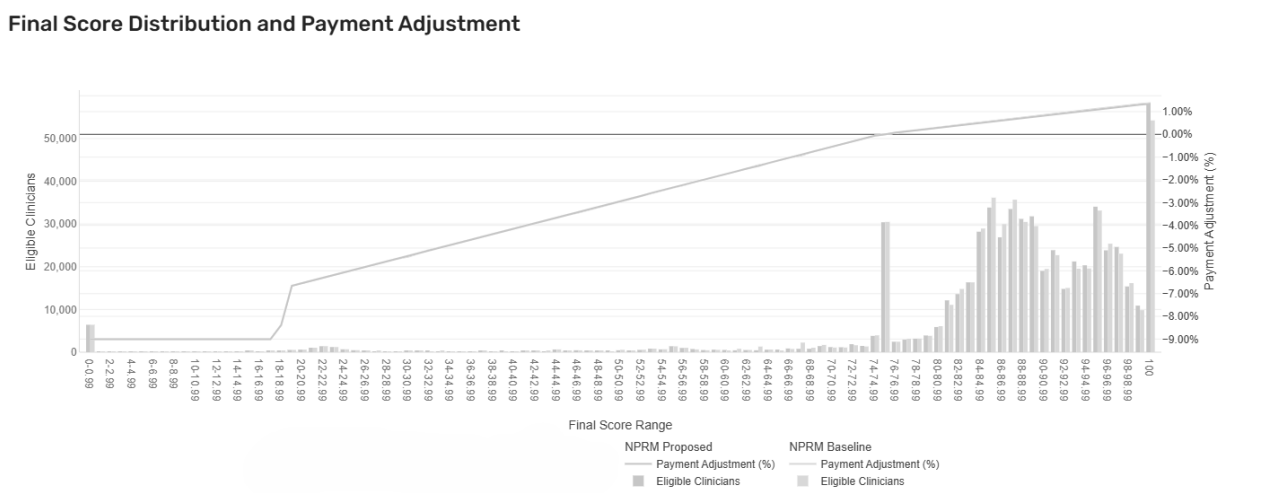
Practice Size	Total Number of MIPS Eligible Clinicians	Median Final Score Estimate	Percent Eligible Clinicians with Positive Payment Adjustment	Percent Eligible Clinicians with Neutral Payment Adjustment	Percent Eligible Clinicians with Negative Payment Adjustment
(4) Large (100+)	75,673	93.42	93.90	1.20	4.90
Overall	**118,635**	**92.54**	**84.58**	**5.52**	**9.90**
Proposed Policies					
(1) Solo	4,396	75.00	32.19	30.94	36.87
(a) Reporting	1,918	93.84	73.77	10.74	15.48
(b) Non-Reporting	2,478	29.41	0.00	46.57	53.43
(2) Small (2 to 15)	11,557	85.75	58.72	18.35	22.93
(a) Reporting	8,060	95.44	84.14	5.17	10.68
(b) Non-Reporting	3,497	59.22	0.11	48.73	51.16
(3) Medium (16 to 99)	27,004	92.59	78.87	7.95	13.18
(4) Large (100+)	75,677	93.93	96.74	1.09	2.18
Overall	**118,634**	**93.22**	**86.57**	**5.44**	**7.99**

[1]56.37% of the safety-net, solo practitioners did not report by not submitting any data
[2]30.26% of the safety-net, small practice providers did not report by not submitting any data

(c) Impact to MIPS Eligible Clinicians' Payment Adjustments

We did not propose to increase the performance threshold in this final rule. Table D-B21 shows that the payment adjustments are very similar between the baseline and proposed policies model. This is because our proposed policies can maintain program stability. The maximum positive payment adjustment is 1.37 percent in the baseline model and 1.34 percent in the proposed policies model. The baseline model estimates redistributing $332 million, and the proposed policies model estimates redistributing $330 million. This slight decrease is due to slightly higher proportions of clinicians receiving positive payment adjustments in the proposed policies model (87.73 percent) than it is in the baseline model (87.30 percent). As the proportion of MIPS eligible clinicians receiving a positive payment adjustment increases slightly, the portion of clinicians receiving a negative payment adjustment also slightly decreases accordingly (7.55 percent in the proposed policies model vs. 7.94 percent in the baseline model). As the proportion of MIPS eligible clinicians receiving negative payment adjustments decreases slightly, the budget neutral funds available for redistribution also decrease somewhat.

FIGURE D-B5: Final Score Distribution and Payment Adjustment



We also report on the median positive and negative payment adjustments by practice size in Table D-B20.

TABLE D-B20: CY 2027 MEDIAN POSITIVE AND NEGATIVE PAYMENT ADJUSTMENT ESTIMATES BY PRACTICE SIZE

Practice Size	Median Positive Payment Adjustment[1]	Median Negative Payment Adjustment
Baseline		
Solo (1)	+1.01	-6.43
(a) Engaged	+1.01	-2.67
(b) Non-Reporting	N/A[2]	-9.00
Small (2-15)	+0.96	-6.08
(a) Reporting	+0.96	-1.50
(b) Non-Reporting	+0.08	-6.74
Medium (16-99)	+0.87	-1.92
Large (100+)	+0.81	-1.35
Overall	+0.83	-2.46
Proposed Policies Model		
Solo (1)	+1.03	-6.42
(a) Engaged	+1.03	-2.53
(b) Non-Reporting	N/A	-9.00
Small (2-15)	+0.97	-6.06
(a) Reporting	+0.97	-1.47
(b) Non-Reporting	+0.08	-6.74
Medium (16-99)	+0.88	-1.92
Large (100+)	+0.80	-2.08
Overall	+0.83	-2.62

[1]Final score above the performance threshold. The median negative adjustment is defined as the medium payment adjustment among clinicians with a final score below the performance threshold. Neither median includes clinicians with a final score equal to the performance threshold.
[2]There are no solo practitioners who did not report data and received a Positive payment adjustment. The maximum they could receive is from the Quality Admins Claims, and even if they received excellent scores, it would still be less than the performance threshold.

The overall median negative payment adjustment in the proposed policies model is slightly lower than it is in the baseline model. That is because the proposed policies model has a higher mean final score than the baseline model (89.21 proposed vs. 88.83 baseline).

e. Additional Impacts from Outside Payment Adjustments

(1) Burden Overall

In addition to policies affecting payment adjustments, we are proposing several policies that, if finalized, will impact burden. In section V.B.7. of this proposed rule, we estimate the burden impacts of proposed policy provisions.

(2) Additional Impacts to Clinicians

We provide additional burden discussions for policy provisions that we are unable to quantify.

(a) Modifications to the MIPS Improvement Activities Inventory

As discussed in section IV.A.4.d.(3) of this proposed rule, we are proposing updates to the MIPS Improvement Activities Inventory beginning with the CY 2027 performance period/2029 MIPS payment year. We do not expect these changes to affect our burden estimates for the number of estimated respondents or response time, as most of the improvement activities in the MIPS Improvement Activities Inventory remain unchanged for the CY 2027 performance period/2029 MIPS payment year. We refer readers to section IV.A.4.d.(3) of this proposed rule for details on the changes to the MIPS Improvement Activities Inventory.

(b) Qualifying Alternative Payment Model (APM) Participant (QP) Determinations

In section IV.F.2. of this proposed rule, we are proposing to modify the application of the QP and partial QP status. We note that year-over-year participation changes have historically had outsized impacts on our projections. For example, ACOs frequently add or remove

participants as part of their operations. These changes in participation make it difficult to project how these proposals will impact clinicians who are determined to be QPs, Partial QPs, or previously reported MIPS (at the individual, group, subgroup, or APM Entity level), if at all. Accordingly, we have not adjusted our estimates related to performance category submissions due to these proposals. For details on these policies, see section IV.F.2. of this proposed rule.

(c) Third Party Intermediaries

In section IV.C. of this proposed rule, we are proposing to (1) add a requirement that CMS-approved third-party intermediaries may be terminated after failure to submit data for 1 year ; and (2) clarify that if a third party intermediary does not submit data for one year, they would be required to provide documentation and would be terminated if documentation cannot be provided and/or the documentation shows that they would not be submitting data for the given MIPS performance period. Due to the technical nature of these changes, there is no data available to quantify the burden for third party intermediaries during the CY 2027 performance period/2029 MIPS payment year. We refer readers to section IV.C. of this proposed rule for additional information on the policy proposals related to third party intermediaries.

G. Alternatives Considered

This proposed rule contains a range of policies, including some provisions related to specific statutory provisions. The preceding preamble provides descriptions of the statutory provisions that are addressed, identifies those policies when we exercise agency discretion, presents rationale for our policies, and, where relevant, alternatives that were considered. For purposes of the payment impact on PFS services of the policies contained in this proposed rule, we presented previously in this section the estimated impact on total allowed charges by specialty.

X. Alternatives Considered Related to the Ambulatory Specialty Model

In section X.E. of this proposed rule, we discuss the mandatory ASM. We will test whether ASM leads to improved chronic condition management, higher quality care, and

reduced costs by incentivizing ASM participants with the opportunity for positive payment adjustments to Medicare Part B covered professional services payments based on their performance on data reported on quality, cost, improvement activities, and CEHRT interoperability.

Throughout this proposed rule, we have identified our proposed policies and alternatives that we have considered and provided information as to the effects of these alternatives and the rationale for each of the proposed policies. This proposed rule provides descriptions of the requirements that we would mandate and presents rationales for our decisions and, where relevant, alternatives that we considered. For example, we considered whether we should waive the requirement for ASM participants in rural areas to attest to complete IA-2: Establishing Communication and Collaboration Expectations with Primary Care using Collaborative Care Arrangements (CCAs) instead of providing the proposed rural scoring adjustment to an ASM participant's final score. Although ASM participants in rural areas may face challenges forming partnerships with primary care providers due to limited primary care availability, we believe that a rural scoring adjustment more broadly accounts for challenges that could affect ASM participant performance across the four ASM performance categories compared to only waiving IA-2.

We solicit comments on our proposals and on the alternatives that we have identified in this proposed rule.

H. Impact on Beneficiaries

As noted previously, we estimate that a combination of proposals for the Shared Savings Program, including introducing a growth adjustment, the increase to the sharing rate in BASIC track Level E, and the increase in the scaling factor for the prior savings adjustment, are expected to increase the number of ACOs in the program and correspondingly the size of the population of beneficiaries assigned to ACOs by up to one million beneficiaries per year, with roughly two-thirds of such increase attributable to the proposed growth adjustment. This growth in

participation is likely to feature beneficiaries who might particularly benefit from care management because the growth adjustment is designed to attract new providers without experience in the program who are serving beneficiaries new to value-based care. Additionally, the proposed increase to the scaling factor for the prior savings adjustment, together with risk-adjusting the 5 percent cap on benchmark adjustments, could moderate the rebasing ratcheting effect and thereby improve the business case for ACOs serving high needs populations to invest additional resources in care management.

We note that in PY 2024, ACOs performed better on certain patient-experience and performance measures than physician groups participating in MIPS (90 FR 50003 and 50004). We refer readers to our discussion in the CY 2026 PFS final rule for additional details on ACOs' measure performance (90 FR 50002).

2. Quality Payment Program

There are several changes in this proposed rule that are expected to have a positive effect on beneficiaries. In general, we believe that many of these changes, including the MVP and subgroup provisions, will lead to meaningful feedback to beneficiaries on the type and scope of care provided by clinicians. Additionally, beneficiaries could use the publicly reported information on clinician performance in subgroups to identify and choose clinicians in multispecialty groups relevant to their care needs. Consequently, we anticipated the policies in this proposed rule will improve the quality and value of care provided to Medicare beneficiaries.

For example, several of the new quality measures include patient-reported outcome-based measures, which could be used to help patients make more informed decisions about treatment options. Patient-reported outcome-based measures provide information on a patient's health status from the patient's point of view and could also provide valuable insights on factors such as quality of life, functional status, and overall disease experience, which will not otherwise be available through routine clinical data collection. Patient-reported outcome-based measured are factors frequently of interest to patients when making decisions about treatment.

3. Ambulatory Specialty Model

We believe that the refinements to ASM proposed in this proposed rule would not change the potential effects of ASM on beneficiaries. We continue to believe that ASM would have no impact on cost to beneficiaries because ASM payment adjustments will not affect Medicare beneficiary coinsurance amounts. The coinsurance will be calculated based on the Medicare allowed amounts before any ASM payment adjustment multipliers are applied to Medicare Part B payments for covered professional services.

I. Estimating Regulatory Familiarization Costs

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this rulemaking, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review the rule, we assume that the total number of unique commenters on this rule will be the number of reviewers on of this last year's proposed rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this rulemaking. It is possible that not all commenters will review this rule in detail, and it is also possible that some reviewers will choose not to comment on this rule. For these reasons, we believe that the number of commenters will be a fair estimate of the number of reviewers of this year's rule.

Using the wage information from the BLS for medical and health service managers (Code 11–9111), we estimated that the cost of reviewing this rulemaking is $113.42, including overhead and fringe benefits *https://www.bls.gov/oes/current/oes_nat.htm*. Assuming an average reading speed, we estimate that it would take approximately 8.0 hours for the staff to review half of this proposed rule. For each facility that reviews the rule, the estimated cost is $907.36 (8.0 hours × $113.42). Therefore, we estimated that the total cost of reviewing this regulation is $12,239,821 ($907.36 × 13,549 reviewers on this year's proposed rule).

J. Accounting Statement

As required by OMB Circular A-4 (available at *https://www.reginfo.gov/public/jsp/Utilities/a-4.pdf*), in Tables D-BXX and D-BXX (Accounting Statements), we have prepared an accounting statement. This estimate includes growth in incurred benefits from CY 2026 to CY 2027 based on the FY 2027 President's Budget baseline.

TABLE D-B21: ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES

CATEGORY	TRANSFERS
CY 2027 Annualized Monetized Transfers	Estimated decrease in expenditures of $2.1 billion for PFS CF update.
Bearers of Transfer Gain	Federal Government to physicians, other practitioners and providers and suppliers who receive payment under Medicare.

TABLE D-B22: ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED COSTS, TRANSFER, AND SAVINGS

CATEGORY	TRANSFER
CY 2027 Annualized Monetized Transfers of beneficiary cost coinsurance.	-$0.4 billion
Bearers of Transfer Gain	Beneficiaries to Federal Government.

TABLE D-B23: ACCOUNTING STATEMENT FOR PROVISIONS FOR MEDICARE SHARED SAVINGS PROGRAM (CYS 2027 to 2036) ($ MILLIONS)

Category	Primary Estimate	Minimum Estimate	Maximum Estimate	Source Citation
BENEFITS				
Annualized monetized: Discount rate: 3%	-$565 million	-$1,058 million	-$115 million	Tables D-B8 through D-B11; summarized in total in Table D-B12
Annualized monetized: Discount rate: 7%	-$579 million	-$1,063 million	$134 million	Tables D-B8 through D-B11; summarized in total in Table D-B12

Notes: Negative values reflect a reduction in Federal net cost resulting from care management by ACOs. Estimates may be a combination of benefits and transfers. To the extent that the incentives created by Medicare payments change the amount of resources society uses in providing medical care, the more accurate categorization of effects would be as costs (positive values) or benefits/cost savings (negative values), rather than as transfers.

K. Conclusion

The analysis in the previous sections, together with the remainder of this proposed rule, provided an initial Regulatory Flexibility Analysis. The previous analysis, together with the preceding portion of this rule, provides an RIA. In accordance with the provisions of Executive Order 12866, this proposed rule was reviewed by the Office of Management and Budget.

Mehmet Oz, Administrator of the Centers for Medicare & Medicaid Services, approved this document on July 10, 2026.

List of Subjects

42 CFR Part 400

Grant programs-health, Health facilities, Health maintenance organizations (HMO), Medicaid, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 405

Administrative practice and procedure, Diseases, Health facilities, Health professions, Medical devices, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 406

Health facilities, Diseases, and Medicare.

42 CFR Part 407

Medicare.

42 CFR Part 410

Diseases, Health facilities, Health professions, Laboratories, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 414

Administrative practice and procedure, Biologics, Diseases, Drugs, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR 415

Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 417

Administrative practice and procedure, Grant programs-health, Health care, Health insurance, Health maintenance organizations (HMO), Loan programs-health, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 422

Administrative practice and procedure, Health facilities, Health maintenance organizations (HMO), Medicare, Penalties, Privacy, Reporting and recordkeeping requirements.

42 CFR Part 423

Administrative practice and procedure, Emergency medical services, Health facilities, Health maintenance organizations (HMO), Health professionals, Medicare, Penalties, Privacy, Reporting and recordkeeping requirements.

42 CFR Part 424

Emergency medical services, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 425

Administrative practice and procedure, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 427

Administrative practice and procedure, Biologics, Inflation rebates, Medicare, Prescription drugs.

42 CFR Part 428

Administrative practice and procedure, Biologics, Inflation rebates, Medicare, Prescription drugs.

42 CFR Part 512

Administrative practice and procedure, Health care, Health facilities, Health insurance, Intergovernmental relations, Medicare, Penalties, Privacy, and Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as set forth below:

PART 400—INTRODUCTION; DEFINITIONS

1. The authority for part 400 continues to read as follows:

Authority: 42 U.S.C. 1302 and 1395hh, and 44 U.S.C. Chapter 35.

2. Section 400.200 is amended by adding a definition for "Eligible noncitizen" in alphabetical order to read as follows:

§ 400.200 General definitions.

* * * * *

Eligible noncitizen means an individual who, effective July 4, 2025, is an—

(1) Alien lawfully admitted for permanent residence under the Immigration and Nationality Act;

(2) Alien who has been granted the status of Cuban and Haitian entrant, as defined in section 501(e) of the Refugee Education Assistance Act of 1980; or

(3) Individual who lawfully resides in the United States in accordance with a Compact of Free Association referred to in 8 U.S.C. 1612(b)(2)(G).

* * * * *

PART 405–FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

3. The authority citation for part 405 continues to read as follows:

Authority: 42 U.S.C. 263a, 405(a), 1302, 1320b-12, 1395x, 1395y(a), 1395ff, 1395hh, 1395kk, 1395rr, and 1395ww(k).

4. Section 405.2463 is amended by—

a. Adding paragraph (a)(1)(iii);

b. In paragraph (b)(2) introductory text, removing the phrase "a FQHC patient" and adding in its place the phrase "an FQHC patient or a RHC patient"; and

c. In paragraph (b)(3), removing the phrase "Not before October 1, 2025" and adding in

its place the phrase “Not before January 1, 2028”;

The addition reads as follows:

§ 405.2463 What constitutes a visit.

(a) * * *

(1) * * *

(iii) Furnished under the direct supervision of the RHC practitioner, a face-to-face encounter between a patient and either of the following:

(A) A qualified provider of medical nutrition therapy services as defined in part 410, subpart G, of this chapter.

(B) A qualified provider of outpatient diabetes self-management training services as defined in part 410, subpart H, of this chapter.

* * * * *

§ 405.2464 [Amended]

5. Section 405.2464 is amended by—

a. In paragraph (b)(1), removing the phrase “paragraphs (d) and (e) of this section” and adding in its place the phrase “paragraphs (c) through (h) of this section”;

b. In paragraph (b)(2)(i), removing the reference “§ 405.2462(c)(1)” and adding in its place the reference “§ 405.2462(e)(1)”;

c. In paragraph (b)(2)(ii), removing the reference “§ 405.2462(c)(2)” and adding in its place the reference “§ 405.2462(e)(2)”; and

d. In paragraph (g), removing the term “an encounter” wherever it appears and adding in its place the term “services”.

6. Section 405.2469 is amended by revising paragraph (d) to read as follows:

§405.2469 FQHC supplemental payments.

* * * * *

(d) *Per visit supplemental payment*. A supplemental payment required under this section

is made to the FQHC when a covered face-to-face encounter, or an encounter furnished using interactive, real-time, audio and video telecommunications technology, or audio-only interactions in cases where the patient is not capable of, or does not consent to, the use of video technology, for the purposes of diagnosis, evaluation, or treatment of a mental health disorder, occurs between a Medicare Advantage enrollee and a practitioner as set forth in § 405.2463. A mental health encounter furnished using interactive, real-time, audio and video telecommunications technology, or audio-only interactions, is not payable unless the FQHC is in compliance with the in-person requirements set forth in § 405.2463(b)(3).

PART 406—HOSPITAL INSURANCE ELIGIBILITY AND ENTITLEMENT

7. The authority for part 406 is revised to read as follows:

Authority: 42 U.S.C. 1302, 1395i-2, 1395i-2a, 1395p, 1395q, and 1395hh.

8. Section 406.5 is amended by revising paragraph (a) to read as follows:

§ 406.5 Basis of eligibility and entitlement.

(a) *Hospital insurance without premiums.* Hospital insurance is available to most individuals without payment of a premium if they meet the following conditions:

(1) The individual--

(i) Is age 65 or over;

(ii) Has received social security or railroad retirement disability benefits for 25 months; or

(iii) Has end-stage renal disease. Subpart B of this part explains the requirements such individuals must meet to obtain hospital insurance without premiums.

(2) Effective July 4, 2025, the individual is a citizen or national of the United States or an eligible noncitizen as defined in 42 CFR 400.200.

* * * * *

9. Section 406.6 is amended by revising paragraph (b) and adding paragraph (f) to read as follows:

§ 406.6 Application or enrollment for hospital insurance.

* * * * *

(b) *Individuals who need not file an application for hospital insurance.* An individual who meets the requirements of § 406.5(a)(2), and any of the following conditions need not file an application for hospital insurance:

* * * * *

(f) *Special rules for eligible noncitizens.* Individuals who only meet the requirements of § 406.5(a)(1), but do not also meet the requirements of § 406.5(a)(2), may subsequently meet both § 406.5(a)(1) and (2) due to a change in U.S. citizenship, U.S. nationality, or immigration status or category. For these individuals, the following requirements apply:

(1) An individual who meets the conditions of paragraph (b) of this section must contact SSA to initiate entitlement to hospital insurance. Entitlement may be retroactive for up to 6 months, but not earlier than the first month in which the individual met all of the requirements of § 406.5(a).

(i) If acceptable evidence establishes the month in which the individual first satisfied § 406.5(a)(2), SSA will use that month, subject to the applicable retroactivity limits noted in the paragraph (f)(1) of this section.

(ii) If the earliest month of eligibility cannot be established based on acceptable documentary evidence, entitlement will begin on the first day of the month in which SSA verifies that the individual satisfies § 406.5(a)(2), based on applicable data made available by the Department of Homeland Security.

(2) An individual who meets the conditions of paragraph (c) of this section must contact SSA to file an application for hospital insurance. Entitlement may be retroactive for up to 6 months, but not earlier than the first month in which the individual met all of the requirements of § 406.5(a).

(i) If acceptable evidence establishes the month in which the individual first satisfied § 406.5(a)(2), SSA will use that month, subject to the applicable retroactivity limits noted in the paragraph (fx)(2) of this section.

(ii) If the earliest month of eligibility cannot be established based on acceptable documentary evidence, entitlement will begin on the first day of the month in which SSA verifies that the individual satisfies § 406.5(a)(2), based on applicable data made available by the Department of Homeland Security.

10. Section 406.10 is amended by revising paragraph (a) and adding paragraph (b)(3) to read as follows:

§ 406.10 Individual age 65 or over who is entitled to social security or railroad retirement benefits, or who is eligible for social security benefits.

(a) *Requirements.* An individual is entitled to hospital insurance benefits under section 226 of the Act under the following conditions:

(1) The individual has attained age 65 and is--

(i) Entitled to monthly social security benefits under section 202 of the Act;

(ii) A qualified railroad retirement beneficiary who has been certified as such to the Social Security Administration by the Railroad Retirement Board in accordance with section 7(d) of the Railroad Retirement Act of 1974; or

(iii) Effective January 1, 1981, eligible for monthly social security benefits under section 202 of the Act and has filed an application for hospital insurance.

(2) Effective July 4, 2025, the individual is a citizen or national of the United States or an eligible noncitizen as defined in 42 CFR 400.200.

(b) * * *

(3) Entitlement continues until the date entitlement is terminated in accordance with § 406.14(b) or (c).

11. Section 406.11 is amended by revising paragraph (b)(2) to read as follows:

§ 406.11 Individual age 65 or over who is not eligible as a social security or railroad retirement benefits beneficiary, or on the basis of government employment.

* * * * *

(b) * * *

(2) *Residence and citizenship.* He or she is a resident of the United States and is

(i) A citizen or national of the United States;

(ii) An alien lawfully admitted for permanent residence under the Immigration and Nationality Act who has continuously resided in the United States for 5 years immediately preceding the first month in which he or she meets all other requirements for entitlement to hospital insurance;

(iii) An alien who has been granted the status of Cuban and Haitian entrant, as defined in section 501(e) of the Refugee Education Assistance Act of 1980; or

(iv) An individual who lawfully resides in the United States in accordance with a Compact of Free Association (COFA), as referred to in 8 U.S.C. 1612(b)(2)(G).

* * * * *

12. Section 406.12 is amended by revising paragraph (a) and adding paragraph (d)(2)(v) to read as follows:

§ 406.12 Individual under age 65 who is entitled to social security or railroad retirement disability benefits.

(a) *Basic requirements.* An individual under age 65 is entitled to hospital insurance benefits under the following conditions:

(1) If, for 25 months, the individual has been—

(i) Entitled or deemed entitled to social security disability benefits as an insured individual, child, widow, or widower who is “under a disability”; or

(ii) A disabled qualified beneficiary certified under section 7(d) of the Railroad Retirement Act.

(2) Effective July 4, 2025, the individual is a citizen or national of the United States or an eligible noncitizen as defined in 42 CFR 400.200.

* * * * *

(d) * * *

(2) * * *

(v) The date entitlement is terminated in accordance with § 406.14(b) or (c).

* * * * *

13. Section 406.13 is amended by revising paragraphs (c) and (f) to read as follows:

§ 406.13 Individual who has end-stage renal disease.

* * * * *

(c) *Requirements.* An individual who has been medically determined to have ESRD is entitled to hospital insurance benefits under the following conditions:

(1) He or she is--

(i) Fully or currently insured under the social security program (title II of the Act) or would be fully or currently insured if his or her employment (after 1936) as defined under the Railroad Retirement Act were considered "employment" under the Act;

(ii) Entitled to monthly social security or railroad retirement benefits; or

(iii) The spouse or dependent child of a person who meets the requirements of paragraph (c)(1)(i) or (c)(1)(ii) of this section.

(2) He or she has filed an application for Medicare Part A.

(3) He or she has satisfied the waiting period explained in paragraph (e) of this section.

(4) Effective July 4, 2025, the individual is a citizen or national of the United States or an eligible noncitizen, as defined in 42 CFR 400.200.

* * * * *

(f) *End of entitlement.* Entitlement ends under any of the following conditions:

(1) With the end of the 12th month after the month in which a regular course of dialysis ends.

(2) With the end of the 36th month after the month in which the individual received a kidney transplant. Beginning January 1, 2023, an individual who is no longer entitled to Part A benefits due to this paragraph may be eligible to enroll in Part B solely for purposes of coverage of immunosuppressive drugs as described in § 407.55 of this subchapter.

(3) With the date entitlement is terminated in accordance with § 406.14(b) or (c).

* * * * *

14. Section 406.14 is added to read as follows:

§ 406.14 End of entitlement due to change in U.S. citizenship, U.S. nationality, or immigration status or category.

(a) *Basis.* Individuals whose U.S. citizenship, U.S. nationality, or immigration status or category changes such that they no longer meet the requirements of § 406.5(a)(2) of this part will lose entitlement to hospital insurance benefits without premiums.

(b) For individuals who were entitled to, or enrolled for, hospital insurance benefits without premiums as of July 4, 2025, the SSA must, not later than 1 year after July 4, 2025, complete a review of individuals for purposes of identifying individuals not described by § 406.5(a)(2). SSA must notify each individual identified under such review that if SSA determines that an individual does not meet the requirements of § 406.5(a)(2), the individual's entitlement to, or enrollment for, hospital insurance benefits will be terminated in accordance with paragraph (d) of this section.

(c) Entitlement will end as provided under paragraph (d) of this section for individuals who were entitled to, or enrolled for, hospital insurance benefits without premiums who were not identified and notified by the SSA per § 406.14(b) and were subsequently determined by the SSA as not meeting the requirements of § 406.5(a)(2).

(d) *Termination notice*. The SSA will send notice to individuals if they no longer satisfy the requirements of § 406.5(a)(2). The notice contains the following information:

(1) Specifies the individual's appeal rights in accordance with 20 CFR part 404, subpart J.

(2) States the effective date of the hospital insurance benefits entitlement termination action, which will be the end of the month following the month in which the termination notice is dated.

(3) States that the individual should contact the SSA if their citizenship, nationality, or immigration status or category changes such that they may be entitled to, or enrolled for, hospital insurance benefits under this part.

(e) *Resumption of benefits.* An individual whose hospital insurance benefits were terminated under paragraph (d) of this section may request resumption of benefits if the individual's U.S. citizenship, U.S. nationality, or immigration status or category changes such that the individual meets the requirements of § 406.5(a)(2) of this part. To request resumption of entitlement, the individual must contact SSA and provide information sufficient to establish that the requirements of § 406.5(a)(2) are met.

15. Section 406.20 is amended by revising paragraph (b)(2) and adding paragraph (c)(5) to read as follows:

§ 406.20 Basic requirements.

* * * * *

(b) * * *

(2) Is a resident of the United States and, effective July 4, 2025, is—

(i) A citizen or national of the United States;

(ii) An alien lawfully admitted for permanent residence under the Immigration and Nationality Act who has continuously resided in the United States for 5 years immediately

preceding the first month in which they meet all other requirements for entitlement to hospital insurance;

(iii) An alien who has been granted the status of Cuban and Haitian entrant, as defined in section 501(e) of the Refugee Education Assistance Act of 1980; or

(iv) An individual who lawfully resides in the United States in accordance with a Compact of Free Association referred to in 8 U.S.C. 1612(b)(2)(G).

* * * * *

(c) * * *

(5) Meets the eligibility requirements in paragraph (b)(2) of this section.

16. Section 406.27 is amended by redesignating paragraph (f) as paragraph (g) and adding a new paragraph (f) to read as follows:

§ 406.27 Special enrollment periods for exceptional conditions.

* * * * *

(f) *Special enrollment period for eligible noncitizens*. An SEP exists for individuals who have not been entitled to, or enrolled for, Medicare due to failure to meet the requirements of § 406.20(b)(2), but subsequently meet the requirements or whose Medicare entitlement or enrollment was terminated due to loss of U.S. citizenship, U.S. nationality, or eligible noncitizen status, who subsequently meet the citizenship, nationality, or immigration status or category requirements specified in § 406.20(b)(2).

(1) *SEP parameters*. (i) An individual is eligible for this SEP if the individual otherwise met the eligibility requirements for Medicare, except for § 406.20(b)(2), and the individual subsequently meets the applicable Medicare eligibility requirements, including § 406.20(b)(2).

(ii)An individual is eligible for this SEP if the individual's prior Medicare entitlement or enrollment was terminated because the individual did not meet the requirements of § 406.20(b)(2) and the individual subsequently meets the applicable Medicare eligibility requirements, including § 406.20(b)(2).

(iii) An individual does not need to miss an enrollment period to be eligible for this SEP.

(2) *SEP duration*. The SEP begins on the first day of the month in which the individual contacts the SSA and provides information sufficient to establish that the requirements of § 406.20(b)(2) are met and ends on the last day of the fifth month after the month in which the SEP began.

(3) *Effective date of coverage*. Coverage under this paragraph begins on the first day of the month following the month of enrollment.

* * * * *

17. Section 406.28 is amended by adding new paragraph (g) to read as follows:

§ 406.28 End of entitlement due to change in citizenship, nationality, or immigration status or category.

* * * * *

(g) *Loss of eligibility due to lack of U.S. citizenship, U.S. nationality, or eligible noncitizen status*. Individuals whose U.S. citizenship, U.S. nationality, or immigration status or category changes such that they no longer meet the requirements of § 406.20(b) of this part will lose entitlement to premium hospital insurance benefits.

(1) For individuals who were entitled to, or enrolled for, premium hospital insurance benefits as of July 4, 2025, the SSA must, not later than 1 year after July 4, 2025, complete a review of individuals for purposes of identifying individuals not described by § 406.20(b)(2). SSA must notify each individual identified under such review that if SSA determines that an individual does not meet the requirements of § 406.20(b)(2), the individual's entitlement to, or enrollment for, premium hospital insurance benefits will be terminated in accordance with paragraph (g)(3) of this section.

(2) Entitlement will end as provided under paragraph (g)(3) of this section for individuals who were entitled to, or enrolled for, premium hospital insurance benefits who were

not identified and notified by the SSA per § 406.28(g)(1) and were subsequently determined by the SSA as not meeting the requirements of § 406.20(b)(2).

(3) *Termination notice*. The SSA will send notice to individuals if they no longer satisfy the requirements of § 406.20(b)(2). The notice contains the following information:

(i) Specifies the individual's appeal rights in accordance with 20 CFR part 404, subpart J.

(ii) States the effective date of the hospital insurance benefits entitlement termination action, which will be the end of the month following the month in which the termination notice is dated.

(iii) States that the individual should contact the SSA if their eligibility status changes such that they may be entitled to, or enrolled for, hospital insurance benefits under this part.

18. Section 406.50 is amended by revising the section heading and paragraph (a) to read as follows:

§ 406.50 Nonpayment of benefits on behalf of eligible noncitizens.

(a) Hospital insurance benefit payments may not be made for services furnished to any eligible noncitizen, as defined in 42 CFR 400.200, for any month in which his or her monthly social security benefits are suspended (or would be suspended if he or she were entitled to those benefits) because the eligible noncitizen remains outside the United States for more than 6 months.

(b) Benefits will be payable beginning with services furnished in the first full calendar month the eligible noncitizen is back in the United States.

* * * * *

PART 407—SUPPLEMENTARY MEDICAL INSURANCE (SMI) ENROLLMENT AND ENTITLEMENT

19. The authority for part 407 is revised to read as follows:

Authority: 42 U.S.C. 1302, 1395p, 1395q, and 1395hh.

20. Section 407.10 is amended by revising paragraph (a) to read as follows:

§ 407.10 Eligibility to enroll.

(a) *Basic rule.* Except as specified in paragraph (b) of this section, an individual is eligible to enroll for SMI if he or she--

(1) Is entitled to hospital insurance under any of the rules set forth in §§ 406.10 through 406.15 of this chapter; or

(2) Meets the following requirements:

(i) Has attained age 65. (An individual is considered to have attained age 65 on the day before the 65th anniversary of his or her birth.)

(ii) Is a resident of the United States and, effective July 4, 2025, is--

(A) A citizen or national of the United States;

(B) An alien lawfully admitted for permanent residence under the Immigration and Nationality Act, who has resided continuously in the United States during the 5 years preceding the month in which he or she applies for enrollment;

(C) An alien who has been granted the status of Cuban and Haitian entrant, as defined in section 501(e) of the Refugee Education Assistance Act of 1980; or

(D) An individual who lawfully resides in the United States in accordance with a Compact of Free Association as referred to in 8 U.S.C. 1612(b)(2)(G).

* * * * *

21. Section 407.23 is amended by redesignating paragraph (f) as paragraph (g) and adding a new paragraph (f) to read as follows:

§ 407.23 Special enrollment periods for exceptional conditions.

* * * * *

(f) *Special enrollment period for eligible noncitizens*. An SEP exists for individuals who have not been entitled to, or enrolled for, Medicare due to failure to meet the requirements of § 407.10(a)(2), but subsequently meet the requirements or whose Medicare entitlement or enrollment was terminated due to loss of U.S. citizenship, loss of U.S. nationality, or eligible

noncitizen status, who subsequently meet the citizenship, nationality, or immigration status or category requirements specified in § 407.10(a)(2).

(1) *SEP parameters*. (i) An individual is eligible for this SEP if the individual otherwise met the eligibility requirements for Medicare, except for § 407.10(a)(2), and the individual subsequently meets the applicable Medicare eligibility requirements, including § 407.10(a)(2).

(ii) An individual is eligible for this SEP if the individual's prior Medicare entitlement or enrollment was terminated because the individual did not meet the requirements of § 407.10(a)(2) and the individual subsequently meets the applicable Medicare eligibility requirements, including § 407.10(a)(2).

(iii) An individual does not need to miss an enrollment period to be eligible for this SEP.

(2) *SEP duration*. The SEP begins on the first day of the month in which the individual contacts the SSA and provides information sufficient to establish that the requirements of § 407.10(a)(2) are met and ends on the last day of the fifth month after the month in which the SEP began.

(3) *Effective date of coverage*. Coverage under this paragraph begins on the first day of the month following the month of enrollment.

* * * * *

22. Section 407.27 is amended by adding paragraph (e) to read as follows:

§ 407.27 Termination of entitlement: Individual enrollment.

* * * * *

(e) *Loss of eligibility due to lack of U.S. citizenship, U.S. nationality, or eligible noncitizen status.* Individuals whose U.S. citizenship, U.S. nationality, or immigration status or category changes such that they do not meet the requirements of § 407.10(a)(2)(ii) of this part will lose entitlement to SMI.

(1) For individuals who were entitled to, or enrolled for, SMI as of July 4, 2025, the SSA must, not later than 1 year after July 4, 2025, complete a review of individuals for purposes of

identifying individuals not described by § 407.10(a)(2). SSA must notify each individual identified under such review that if SSA determines that an individual does not meet the requirements of § 407.10(a)(2), the individual's entitlement to, or enrollment for, SMI will be terminated in accordance with paragraph (e)(3) of this section.

(2) Entitlement will end as provided under paragraph (e)(3) of this section for individuals who were entitled to, or enrolled for, SMI who were not identified and notified by the SSA per § 407.27(e)(1) and were subsequently determined by the SSA as not meeting the requirements of §407.10(a)(2)(ii).

(3) *Termination notice*. The SSA will send notice to individuals if they no longer satisfy the requirements of § 407.10(a)(2). The notice contains the following information:

(i) Specifies the individual's appeal rights in accordance with 20 CFR part 404, subpart J.

(ii) States the effective date of the SMI entitlement termination action, which will be the end of the month following the month in which the termination notice is dated.

(iii) States that the individual should contact the SSA if their citizenship, nationality, or immigration status or category changes such that they may be entitled to, or enrolled for, SMI under this part.

23. Section 407.55 is amended by revising paragraph (a) to read as follows:

§ 407.55 Eligibility to enroll.

(a) Basic rules.

(1) Except as specified in paragraph (b) of this section, an individual is eligible to enroll, be deemed enrolled, or reenroll in the Part B-ID benefit if their Part A entitlement ends as described in § 406.13(f)(2) of this subchapter.

(2) Effective July 4, 2025, the individual must meet the eligibility criteria set forth in § 407.10(a)(2)(ii).

* * * * *

24. Section 407.62 is amended by redesignating paragraph (f) as paragraph (g) and adding a new paragraph (f) to read as follows:

§ 407.62 Termination of coverage.

* * * * *

(f) Enrollment in the Part B-ID benefit ends the date entitlement is terminated in accordance with § 407.27(e) due to the individual's failure to meet the citizenship, nationality, or eligible noncitizen requirements described in § 407.10(a)(2).

* * * * *

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

25. The authority for part 410 continues to read as follows:

Authority: 42 U.S.C. 1302, 1395m, 1395hh, 1395rr, and 1395ddd.

26. Section 410.78 is amended by—

a. Revising paragraph (a)(3);

b. Adding paragraphs (b)(2)(xiii), (b)(3)(xiv)(D), (b)(3)(xv), and (b)(6); and

c. Revising paragraph (f);

The revisions and additions read as follows:

§ 410.78 Telehealth services.

(a) * * *

(3) *Interactive telecommunications system* means, except as otherwise provided in this paragraph (a)(3), multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner.

(i) An interactive telecommunications system may also include two-way, real-time audio-only communication technology for any telehealth service furnished to a patient in their home on or before December 31, 2027.

(ii)(A) For telehealth services furnished after December 31, 2027 date, interactive

telecommunications system may also include two-way, real-time audio-only communication technology for any telehealth service furnished to a patient in their home if the distant site physician or practitioner is technically capable of using an interactive telecommunications system as defined in this paragraph (a)(3), but the patient is not capable of, or does not consent to, the use of video technology.

(B) The following modifiers must be appended to a claim for telehealth services furnished using two-way, real-time audio-only communication technology to verify that the conditions set forth in paragraph (a)(3)(ii)(A) of this section have been met:

* * * * *

(b) * * *

(2) * * *

(xiii) Occupational therapists, physical therapists, speech-language pathologists, or audiologists, through December 31, 2027.

* * * * *

(3) * * *

(xiv) * * *

(D) Consistent with section 6209(d) of the CAA, 2026, in-person visit requirements for the purposes of diagnosis, evaluation, or treatment of a mental health disorder do not apply through December 31, 2027.

* * * * *

(6) Consistent with section 6209(a) of the CAA, 2026, the geographic requirements specified in paragraph (b)(4) of this section do not apply through December 31, 2027.

* * * * *

(f) *Process for adding or deleting services.* Except as otherwise provided in this paragraph (f), changes to the list of Medicare telehealth services are made through the annual physician fee schedule rulemaking process. CMS maintains the list of services that are

Medicare telehealth services under this section, including the current HCPCS codes that describe the services on the CMS website.

§ 410.105 [Amended]

27. Section 410.105 is amended in paragraph (b)(3)(ii) by removing the reference "§ 410.100(m)" and adding in its place the reference "§ 410.100(1)".

28. Section 410.175 is amended by revising paragraphs (a) and (b) to read as follows:

§ 410.175 Alien absent from the United States.

(a) Medicare does not pay Part B benefits for services furnished to an eligible noncitizen, as defined in 42 CFR 400.200, if those services are furnished in any month for which the individual is not paid monthly social security cash benefits (or would not be paid if he or she were entitled to those benefits) because he or she has been outside the United States continuously for 6 full calendar months.

(b) Payment of benefits resumes with services furnished during the first full calendar month the eligible noncitizen, as defined in 42 CFR 400.200, is back in the United States.

* * * * *

PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES

29. The authority citation for part 414 continues to read as follows:

Authority: 42 U.S.C. 1302, 1395hh, and 1395rr(b)(l).

30. Section 414.502 is amended by revising the definitions of ‘‘Data collection period’’ and ‘‘Data reporting period’’ to read as follows:

§ 414.502 Definitions.

* * * * *

Data collection period is the 6 months from January 1 through June 30, during which applicable information is collected and that precedes the data reporting period.

Data reporting period for CDLTs that are not ADLTs is the 3-month period, May 1 through July 31, and for ADLTs is the 3-month period, January 1 through March 31, during

which a reporting entity reports applicable information to CMS and that follows the preceding data collection period.

* * * * *

§ 414.504 [Amended]

31. Section 414.504 is amended in paragraph (a)(1) by removing the date "January 1, 2026" and adding in its place the date "May 1, 2026".

32. Section 414.507 is amended by—

a. Revising paragraph (d) introductory text and paragraph (d)(9); and

b. Adding paragraph (d)(12).

The revisions and addition read as follows:

§ 414.507 Payment for clinical diagnostic laboratory tests.

* * * * *

(d) *Phase-in of payment reductions*. For years 2018 through 2029, the payment rates established under this section for each CDLT that is not a new ADLT or new CDLT, may not be reduced by more than the following amounts for—

* * * * *

(9) 2026 - 0.0 percent of the payment rate established in 2025.

* * * * *

(12) 2029 - 15 percent of the payment rate established in 2028.

* * * * *

33. Section 414.523 is amended by revising paragraph (a)(1)(v) to read as follows:

§ 414.523 Payment for laboratory specimen collection fee and travel allowance.

(a) * * *

(1) * * *

(v) For a specimen collected from a Medicare beneficiary in a skilled nursing facility or on behalf of a home health agency, the specimen collection fee otherwise payable under

paragraph (a)(1) of this section is increased by $2.00.

34. Section 414.610 is amended by—

a. Revising paragraph (c)(1)(ii) introductory text; and

b. In paragraph (c)(5)(ii) removing the date "September 30, 2025" and adding in its place the date "December 31, 2027".

The revision reads as follows:

§ 414.610 Basis of payment.

* * * * *

(c) * * *

(1) * * *

(ii) For services furnished during the period July 1, 2008 through December 31, 2027, ambulance services originating in either of the following:

* * * * *

35. Section 414.1105 is amended by revising paragraph (c) introductory text to read as follows:

§ 414.1105 Payment for Comprehensive Outpatient Rehabilitation Facility (CORF) services.

* * * * *

(c) *Payment for supplies and durable medical equipment, prosthetic and orthotic devices*. Supplies and durable medical equipment that are CORF services under § 410.100(k), prosthetic device services that are CORF services under § 410.100(f), and orthotic devices that are CORF services under § 410.100(g) are paid the lesser of 80 percent of the following:

* * * * *

36. Section 414.1305 is amended by revising the definitions of "APM Incentive Payment", "Certified Electronic Health Record Technology (CEHRT)" paragraph (2), "Collection type", "MVP participant" and "Participant List" to read as follows:

§ 414.1305 Definitions.

* * * * *

APM Incentive Payment means the lump sum incentive payment for a year as described in section 414.1450(b)(1) and that is paid for an eligible clinician who is a QP for the applicable year.

* * * * *

Certified Electronic Health Record Technology (CEHRT) * * *

(2) * * *

(i) For CY 2019 through CY 2026, at 45 CFR 170.315(a)(12) (family health history) and 45 CFR 170.315(e)(3) (patient health information capture); and

(ii) * * *

(A) For CY 2019 through CY 2026, the applicable measure calculation certification criterion at 45 CFR 170.315(g)(1) or (2) for all certification criteria that support a meaningful use objective with a percentage-based measure.

(B) Clinical quality measure certification criteria that support the calculation and reporting of clinical quality measures at 45 CFR 170.315(c)(2) and (c)(3), and for CY 2019 through CY 2026, optionally (c)(4), and can be electronically accepted by CMS.

* * * * *

Collection type means a set of quality measures with comparable specifications and data completeness criteria, as applicable, including, but not limited to: Electronic clinical quality measures (eCQMs); MIPS clinical quality measures (MIPS CQMs); QCDR measures; Medicare Part B claims measures; CMS Web Interface measures (except as provided in paragraph (1) of this definition, for the CY 2017 through CY 2022 performance periods/2019 through 2024 MIPS payment years); the CAHPS for MIPS survey measure; administrative claims measures; Medicare Clinical Quality Measures for Accountable Care Organizations Participating in the Medicare Shared Savings Program (Medicare CQMs); and Medicare Electronic Clinical Quality

Measures for Accountable Care Organizations Participating in the Medicare Shared Savings Program (Medicare eCQMs).

* * * * *

MVP participant means an individual MIPS eligible clinician, multispecialty group, single-specialty group, subgroup, or APM Entity that is assessed on an MVP in accordance with § 414.1365 for all MIPS performance categories. For the CY 2026 performance period/2028 MIPS payment year and future years, MVP participant means an individual MIPS eligible clinician, single-specialty group, multispecialty group that meets the requirements of a small practice, subgroup, or APM Entity that is assessed on an MVP in accordance with § 414.1365 for all MIPS performance categories. Beginning in the CY 2029 performance period/2031 MIPS payment year, MVP participant means an individual MIPS eligible clinician, single specialty group, multispecialty group that meets the requirements of a small practice, virtual group, subgroup, or APM Entity that is assessed on an MVP in accordance with § 414.1365 for all MIPS performance categories.

* * * * *

Participation List means the list of participants in an APM Entity that is compiled from a CMS-maintained list where practicable.

* * * * *

37. Section 414.1330 is amended by revising paragraph (c)(2)(iv) to read as follows.

§ 414.1330 Quality performance category.

(c) * * *

(2) * * *

(iv) Whether the quality measure is designated as high priority or not, through the CY 2026 performance period/2028 MIPS payment year.

* * * * *

38. Section 414.1335 is amended by—

a. Revising paragraphs (a)(1)(i) introductory text, (a)(1)(ii), and (a)(4)(i);

b. Adding paragraph (a)(1)(iii);

c. Revising paragraph (a)(4)(i); and

d. Adding paragraph (a)(5).

The revisions and additions read as follows:

§ 414.1335 Data submission criteria for the quality performance category.

(a) * * *

(1) * * *

(i) For the CY 2017 through 2026 performance periods/2019 through 2028 MIPS payment years, except as provided in paragraph (a)(1)(ii) of this section, submits data on at least six measures, including at least one outcome measure. If an applicable outcome measure is not available, reports one other high priority measure. If fewer than six measures apply to the MIPS eligible clinician, group, virtual group, or APM Entity, reports on each measure that is applicable. Beginning in the CY 2027 performance period/2029 MIPS payment year, MIPS eligible clinicians, except as provided in paragraphs (a)(1)(ii) and (a)(1)(iii) of this section, submits data on at least six measures, including at least one MIPS core measure. If there is not an available and applicable MIPS core measure, a MIPS eligible clinician must attest to not having an available and applicable MIPS core measure and submit data on a separate MIPS quality measure. If fewer than six measures apply then the MIPS eligible clinician, group, virtual group, or APM Entity must report on each measure that is applicable.

* * * * *

(ii) For the CY 2017 through 2026 performance periods/2019 through 2028 MIPS payment years, a MIPS eligible clinician, group, virtual group, and APM Entity that report on a specialty or subspecialty measure set, as designated in the MIPS final list of quality measures established by CMS through rulemaking, must submit data on at least six measures within that set, including at least one outcome measure. If an applicable outcome measure is not available,

report one other high priority measure. If the set contains fewer than six measures or if fewer than six measures within the set apply to the MIPS eligible clinician, group, virtual group, or APM Entity, report on each measure that is applicable. Beginning in the CY 2027 performance period/2029 MIPS payment year, except as provided in paragraph (a)(1)(iii) of this section, a MIPS eligible clinician that reports on a specialty or subspecialty measure set, as designated in the MIPS final list of quality measures established by CMS through rulemaking, must submit data on at least six measures within that set, including at least one MIPS core measure. If there is not an available and applicable MIPS core measure, a MIPS eligible clinician must attest to not having an available and applicable MIPS core measure and submit data on a separate MIPS quality measure within that set. If the set contains fewer than six measures or if fewer than six measures within the set apply to the MIPS eligible clinician, report on each measure that is applicable.

* * * * *

(iii) *Small practices.* Beginning with the CY 2027 performance period/2029 MIPS payment year, MIPS eligible clinicians in small practices are not required to submit at least one MIPS core measure or attest to not having an applicable and available MIPS core measure. MIPS eligible clinicians in small practices must submit data on at least six measures, if applicable.

* * * * *

(4) *For Medicare CQMs*. (i) A MIPS eligible clinician, group, and APM Entity reporting quality data on beneficiaries eligible for Medicare CQMs as defined at § 425.20) within the APP measure set or APP Plus measure set (as applicable) and administering the CAHPS for MIPS Survey as required under the APP.

(ii) [Reserved]

(5) *For Medicare eCQMs*. (i) A MIPS eligible clinician, group, and APM Entity reporting on the Medicare eCQMs (reporting quality data on beneficiaries eligible for Medicare eCQMs as defined at § 425.20) within the APP Plus measure set and administering the CAHPS

for MIPS Survey as required under the APP.

(ii) [Reserved]

* * * * *

39. Section 414.1340 is amended by—

a. Revising paragraphs (d) and (e); and

b. Adding paragraph (f).

The revisions and additions read as follows:

§ 414.1340 Data completeness criteria for the quality performance category.

* * * * *

(d) APM Entities, specifically Medicare Shared Savings Program Accountable Care Organizations meeting reporting requirements under the APP, submitting quality measure data on Medicare CQMs must submit data on the following:

(1) At least 75 percent of the applicable beneficiaries eligible for the Medicare CQM, as defined at § 425.20, who meet the measure's denominator criteria for MIPS payment year 2026 and future MIPS payment years.

(e) APM Entities, specifically Medicare Shared Savings Program Accountable Care Organizations meeting reporting requirements under the APP, submitting quality measure data on Medicare eCQMs must submit data on the following:

(1) At least 75 percent of the applicable beneficiaries eligible for the Medicare eCQM, as defined at § 425.20, who meet the measure's denominator criteria for MIPS payment years 2029 and future MIPS payment years.

(2) [Reserved]

(f) If quality data are submitted selectively such that the submitted data are unrepresentative of a MIPS eligible clinician, group, virtual group, subgroup, or APM Entity's performance, any such data would not be true, accurate, or complete for purposes of § 414.1390(b) or § 414.1400(a)(5).

40. Section 414.1365 is amended by—

a. Adding paragraph (a)(2); and

b. Revising paragraphs (c)(1) introductory text and (c)(1)(ii).

The revisions and additions read as follows:

§ 414.1365 MIPS Value Pathways.

(a) * * *

(2) Beginning in the CY 2029 performance period/ 2031 MIPS payment year, except for MIPS eligible clinicians reporting under the APM Performance Pathway in accordance with § 414.1367, all MIPS eligible clinicians must report an MVP.

* * * * *

(c) * * *

(1) *Quality*. Through the CY 2026 performance period/2028 MIPS payment year, except as provided in paragraph (c)(1)(i) of this section, an MVP participant must select and report, if applicable, four quality measures, including one outcome measure (or, if an outcome measure is not available, one high priority measure), included in the MVP, excluding the population health measure required under paragraph (c)(4)(ii) of this section. Beginning in the CY 2027 performance period/2029 MIPS payment year, except as provided in paragraphs (c)(1)(i) and (c)(1)(ii) of this section, an MVP participant must select and report, if applicable, four quality measures, including one MIPS core measure available in the MVP, excluding the population health measure required under paragraph § 414.1365(c)(4)(ii). If there is not an available and applicable MIPS core measure, an MVP participant must attest to not having an available and applicable MIPS core measure and submit a separate MIPS quality measure within the MVP.

* * * * *

(ii) *Small practices.* Beginning with the CY 2027 performance period/2029 MIPS payment year, an MVP participant that meets the requirements of a small practice is not required to submit at least one MIPS core measure or attest to not having an available and applicable

MIPS core measure. Except as provided in paragraph (c)(1)(i) of this section, an MVP participant that meets the requirements of a small practice must select and report, if applicable, at least four quality measures included in the MVP, excluding the population health measure required under paragraph (c)(4)(ii) of this section.

* * * * *

41. Section 414.1375 is amended is amended by revising paragraphs (b)(2)(ii)(A) and (b)(3)(i) introductory text to read as follows:

§ 414.1375 Promoting Interoperability (PI) performance category.

* * * * *

(b) * * *

(2) * * *

(ii) * * *

(A) Through the 2028 MIPS payment year, report that the MIPS eligible clinician completed the actions included in the Security Risk Analysis measure during the year in which the performance period occurs;

* * * * *

(3) * * *

(i) *Supporting providers with the performance of CEHRT (SPPC).*

From the 2019 MIPS payment year through the 2027 MIPS payment year, to engage in activities related to supporting providers with the performance of CEHRT, the MIPS eligible clinician—

* * * * *

42. Section 414.1380 is amended by—

a. Revising paragraphs (b)(1)(ii)(E) and (b)(1)(ii)(F);

b. Adding paragraphs (b)(1)(ii)(G) and (H), and (b)(1)(iv)(D);

c. Revising paragraphs (b)(3)(i) and (b)(4)(ii)(C)(*3*);

d. Adding paragraph (b)(4)(ii)(C)(*4*); and

e. Revising paragraphs (c)(2)(i)(A)(*10*) and (c)(2)(i)(C)(*12*).

The revisions and additions read as follows:

§ 414.1380 Scoring.

* * * * *

(b) * * *

(1) * * *

(ii) * * *

(E) Beginning with the CY 2025 performance period/2027 MIPS payment year, CMS will publish a list of topped out measures determined to be impacted by limited measure choice on a yearly basis. Measures included on the list are scored from 1 to 10 measure achievement points according to defined topped out measure benchmarks calculated from performance data in the baseline period in which a performance rate of 97 percent corresponds to 10 percent of the performance threshold for the corresponding performance year.

(F) *Medicare CQMs collection type benchmarks*.

(*1*) Beginning in the CY 2025 performance period/2027 MIPS payment year, measures of the Medicare CQMs collection type use flat benchmarks for their first two performance periods in MIPS.

(*2*) Beginning with the CY 2026 performance period/2028 MIPS payment year, measures of the Medicare CQMs collection type use flat benchmarks.

(G) *Medicare eCQMs collection type benchmarks*.

(*1*) Beginning with the CY 2027 performance period/2029 MIPS payment year, measures of the Medicare eCQMs collection type use flat benchmarks.

(*2*) [Reserved]

(H) Beginning in the CY 2027 performance period/2029 MIPS payment year, MIPS core measures, which are required under § 414.1335(a)(1)(i) and (ii), for which the benchmark for the

applicable collection type is identified as topped out for 2 or more consecutive years, are scored from 1 to 10 measure achievement points according to defined topped out measure benchmarks calculated from performance data in the baseline period in which a performance rate of 97 percent corresponds to 10 percent of the performance threshold for the corresponding performance year.

* * * * *

(iv) * * *

(D) Beginning with the CY 2027 performance period/2029 MIPS payment year, MIPS core measures, which are required under § 414.1335(a)(1)(i) and (ii), are not subject to the 7 measure achievement point cap specified in paragraph (b)(1)(iv)(B) of this section.

* * * * *

(3) * * *

(i) For MIPS eligible clinicians participating in APMs, the improvement activities performance category score is at least 50 percent.

* * * * *

(4) * * *

(i) * * *

(C) * * *

(ii) * * *

(C) * * *

(3) Beginning with the CY 2026 performance period/2028 MIPS payment year, the total number of bonus points available to be earned when reporting one optional measure, more than one optional measure, or all optional measures under the Public Health and Clinical Data Exchange objective is a total of 5 bonus points.

(4) For the CY 2027 performance period/2029 MIPS payment year, the total number of bonus points available to be earned when reporting the Electronic Prior Authorization optional measure is a total of 10 bonus points.

* * * * *

(c) * * *

(2) * * *

(i) * * *

(A) * * *

(10) Beginning with the 2026 MIPS payment year, for the quality and improvement activities performance categories, CMS determines based on documentation provided to the agency that data for a MIPS eligible clinician are inaccessible or unable to be submitted due to circumstances outside of the control of the clinician because the MIPS eligible clinician delegated submission of the data to their third party intermediary, evidenced by a written agreement between the MIPS eligible clinician and third party intermediary, and the third party intermediary did not submit the data for the performance category(ies) on behalf of the MIPS eligible clinician in accordance with applicable deadlines. To determine whether to apply reweighting to the affected performance category(ies), CMS will consider: whether the MIPS eligible clinician knew or had reason to know of the issue with its third party intermediary's submission of the clinician's data for the performance category(ies); whether the MIPS eligible clinician took reasonable efforts to correct the issue; and whether the issue between the MIPS eligible clinician and their third party intermediary caused no data to be submitted for the performance category(ies) in accordance with applicable deadlines.

(i) For the 2026 MIPS payment year, requests must be submitted by November 1st of the year preceding the relevant MIPS payment year.

(ii) Beginning with the 2027 MIPS payment year, requests must be submitted by December 31st of the year preceding the relevant MIPS payment year.

* * * * *

(C) * * *

(12) Beginning with the 2026 MIPS payment year, CMS determines based on documentation provided to the agency that data for a MIPS eligible clinician are inaccessible or unable to be submitted due to circumstances outside of the control of the clinician because the MIPS eligible clinician delegated submission of the data to their third party intermediary, evidenced by a written agreement between the MIPS eligible clinician and third party intermediary, and the third party intermediary did not submit the data for the performance category on behalf of the MIPS eligible clinician in accordance with applicable deadlines. To determine whether to apply reweighting to the Promoting Interoperability performance category, CMS will consider: whether the MIPS eligible clinician knew or had reason to know of the issue with its third party intermediary's submission of the clinician's data for the performance category; whether the MIPS eligible clinician took reasonable efforts to correct the issue; and whether the issue between the MIPS eligible clinician and their third party intermediary caused no data to be submitted for the performance category in accordance with applicable deadlines.

(i) For the 2026 MIPS payment year, requests must be submitted by November 1st of the year preceding the relevant MIPS payment year.

(ii) Beginning with the 2027 MIPS payment year, requests must be submitted by December 31st of the year preceding the relevant MIPS payment year.

* * * * *

§414.1395 [Amended]

43. Section 414.1395 is amended by removing and reserving paragraph (c)(2).

44. Section 414.1400 is amended by—

a. Revising paragraphs (b)(3)(iii), (b)(3)(v)(E)(*1*),

b. Redesignating paragraph (b)(3)(vi) and (viii) as (b)(3)(vii)(A) and (B), respectively;

c. Adding paragraph (b)(3)(vii)(C);

d. Reserving paragraphs (b)(3)(vi) and (viii);

e. Revising paragraphs (b)(3)(x), (b)(3)(xiv), and (c)(1) introductory text;

b. Adding paragraphs (c)(2); and

c. Revising paragraph (e)(5);

The revisions and additions read as follows:

§414.1400 Third party intermediaries.

* * * * *

(b) * * *

(3) * * *

(iii) Beginning with the CY 2021 performance period/2023 MIPS payment year, the QCDR or qualified registry must provide performance feedback at least 4 times a year and provide specific feedback on how they compare to other clinicians who have submitted data on a given measure within the QCDR or qualified registry. Feedback must be provided at the level at which data is submitted. Exceptions to this requirement may occur if the QCDR or qualified registry submits notification to CMS within the performance period promptly within the month of realization of the impending deficiency and provides sufficient rationale as to why they do not believe they would be able to meet this requirement (for example, if the QCDR does not receive the data from their clinician until the end of the performance period).

* * * * *

(v) * * *

(E) * * *

(*1*) If the intermediary submits MIPS data to CMS for fewer than 10 Quality Payment Program participants, the data validation audit sample must include all Quality Payment Program participants. If the intermediary submits data for 10 or more Quality Payment Program participants, it must use a sample size of at least 3 percent of a combination of the individual MIPS eligible clinicians, groups, virtual groups, subgroups and APM entities for which the

QCDR or qualified registry will submit data to CMS, except that the sample size may be no fewer than a combination of 10 individual clinicians, groups, virtual groups, subgroups and APM entities, no more than a combination of 50 individual clinicians, groups, virtual groups, subgroups and APM entities.

(*2*) If there are fewer than 5 patient records, the patient record audit sample must include all patient records. If there are 5 or more patient records, the intermediary must use a sample that includes at least 25 percent of the patients of each individual clinician, group, virtual group, subgroup or APM entity in the sample, except that the sample for each individual clinician, group, virtual group, subgroup or APM entity must include a minimum of 5 patients and need not include more than 50 patients.

* * * * *

(vi) [Reserved].

(vii) Participation plan for third party intermediary not submitting data.

(A) For the CY 2024 performance period/2026 MIPS payment year through CY 2026 performance period/2028 MIPS payment year, a QCDR or qualified registry that was approved but did not submit any MIPS data for either of the 2 years preceding the applicable self-nomination period must submit a participation plan for CMS' approval. This participation plan must include the QCDR's and/or qualified registry's detailed plans about how the QCDR or qualified registry intends to encourage clinicians to submit MIPS data to CMS through the QCDR or qualified registry.

(B) Beginning with the CY 2027 performance period/2029 MIPS payment year, a QCDR or qualified registry that was approved but did not submit any MIPS data for the year preceding the applicable self-nomination period must submit a participation plan for CMS' approval. This participation plan must include the QCDR's and/or qualified registry's detailed plans about how the QCDR or qualified registry intends to encourage clinicians to submit MIPS data to CMS through the QCDR or qualified registry.

(viii) [Reserved].

* * * * *

(x) For the CY 2017 performance period/2019 MIPS payment year through CY 2026 performance period/CY 2028 MIPS payment year, a QCDR or a qualified registry must be able to submit to CMS data for at least six quality measures including at least one outcome measure.

(A) For the CY 2017 performance period/2019 MIPS payment year through CY 2026 performance period/CY 2028 MIPS payment year, if no outcome measure is available, a QCDR or qualified registry must be able to submit to CMS results for at least one other high priority measure.

(B) Beginning with CY 2027 performance period/2029 MIPS payment year, a QCDR or a qualified registry must be able to submit to CMS data for at least six quality measures including at least one MIPS core measure.

* * * * *

(xiv) A QCDR or a qualified registry must attest that the information listed on the qualified posting is accurate. Changes to information (for example, cost, services included) on the qualified posting must be included and finalized during the qualified posting review period. Third party intermediaries will not be permitted to make changes after the qualified posting is publicly posted on the Quality Payment Program Resource Library page.

* * * * *

(c) * * *

(1) For the CY 2021 performance period/2023 MIPS payment year through the CY 2024 performance period/2026 MIPS payment year, health IT vendors must be able to submit data for the MIPS performance categories as follows:

* * * * *

(2) Beginning with the CY 2025 performance period/2027 MIPS payment year, health IT vendors cannot submit MIPS data.

* * * * *

(5) *Termination for third party intermediary not submitting data*.

(i) Beginning with the CY 2024 performance period/2026 MIPS payment year, a QCDR or qualified registry that submits a participation plan as required under paragraph (b)(3)(viii) of this section, but does not submit MIPS data for the applicable performance period for which they self-nominated under paragraph (b)(3)(viii) of this section, will be terminated.

(ii) Beginning with the CY 2027 performance period/ 2029 MIPS payment year, a QCDR or qualified registry that submits a participation plan as required under paragraph (b)(3)(viii) of this section, but does not submit MIPS data for the applicable performance period for which they self-nominated under paragraph (b)(3)(viii) of this section, will be queried by CMS before the end of the calendar year for the given MIPS performance period requesting documentation that they have contracted with Quality Payment Program participants who will submit data for the given MIPS performance period. If documentation cannot be provided or the third-party intermediary will not be submitting MIPS data or both for the given MIPS performance period, the third-party intermediary will be terminated.

45. Section § 414.1425 is amended by—

a. Revising paragraph (c)(5); and

b. Adding paragraphs (c)(8) and (d)(5).

The revision and additions read as follows:

§ 414.1425 Qualifying APM participant determination: In general.

* * * * *

(c) * * *

(5) * * *

(ii) The APM Entity voluntarily or involuntarily terminates from an Advanced APM at a date on which the APM Entity would not bear financial risk for that QP performance period under the terms of the Advanced APM, even if such termination date occurs within such QP

Performance Period.

* * * * *

(8) Beginning in the 2027 QP Performance Period, application of QP determination is limited strictly to eligible clinicians as defined at § 414.1305 and that meet the definition of Qualifying APM participant (QP) as defined at § 414.1305 by participating in an Advanced APM during the QP performance period.

* * * * *

(d) * * *

(5) Beginning in the 2027 QP Performance Period, application of Partial QP determination is limited strictly to eligible clinicians as defined at § 414.1305 that meet the definition of Partial Qualifying APM Participant (Partial QP) as defined at § 414.1305 by participating in an Advanced APM during the QP performance period.

* * * * *

46. Section § 414.1430 is amended by revising paragraphs (a), (b(1)(i), (2)(i), (3)(i), and (4)(i) to read as follows:

§ 414.1430 Qualifying APM participant determination: QP and partial QP thresholds.

(a) * * *

(1) *QP payment amount threshold.* The QP payment amount thresholds are the following values for the indicated payment years: (i) 2019 and 2020: 25 percent.

(ii) 2021 through 2026: 50 percent.

(iii) 2027: 75 percent.

(iv) 2028: 50 percent.

(v) 2029 and thereafter: 75 percent.

(2) *Partial QP payment amount threshold.* The Partial QP payment amount thresholds are the following values for the indicated payment years:

(i) 2019 and 2020: 20 percent.

(ii) 2021 through 2026: 40 percent.

(iii) 2027: 50 percent.

(iv) 2028: 40 percent.

(v) 2029 and thereafter: 50 percent.

(3) *QP patient count threshold.* The QP patient count thresholds are the following values for the indicated payment years: (i) 2019 and 2020: 20 percent.

(ii) 2021 through 2026: 35 percent.

(iii) 2027: 50 percent.

(iv) 2028: 35 percent.

(v) 2029 and thereafter: 50 percent.

(4) *Partial QP patient count threshold.* The Partial QP patient count thresholds are the following values for the indicated payment years: (i) 2019 and 2020: 10 percent.

(ii) 2021 through 2026: 25 percent.

(iii) 2027: 35 percent.

(iv) 2028: 25 percent.

(v) 2029 and thereafter: 35 percent.

(b) * * *

(1) * * *

(i) * * *

(A) 2021 through 2026: 50 percent

(B) 2027: 75 percent.

(C) 2028: 50 percent.

(D) 2029 and thereafter: 75 percent.

(2) * * *

(i) * * *

(A) 2021 through 2026: 40 percent

(B) 2027: 50 percent.

(C) 2028: 40 percent.

(D) 2029 and thereafter: 75 percent.

* * * * *

(3) * * *

(i) * * *

(A) 2021 through 2026: 35 percent.

(B) 2027: 50 percent.

(C) 2028: 35 percent.

(D) 2029 and thereafter: 50 percent.

* * * * *

(4) * * *

(i) * * *

(A) 2021 through 2026: 25 percent

(B) 2027: 35 percent.

(C) 2028: 25 percent.

(D) 2029 and thereafter: 35 percent.

* * * * *

47. Section § 414.1450 is amended by revising paragraphs (a)(1)(i) and (b)(1) to read as follows:

§ 414.1450 APM Incentive Payment.

(a) * * *

(1) * * *

(i) For payment years in which an APM incentive payment is authorized under section 1833(z)(1)(A) of the Act , CMS makes a lump sum payment to QPs in the amount described in paragraph (b) of this section for the applicable payment year and in the manner

described in paragraphs (d) and (e) of this section.

(b) * * *

(1) The amount of the APM incentive payment is the applicable percentage established for the payment year of the estimated aggregate payments for covered professional services as defined in section 1848(k)(3)(A) of the Act furnished during the calendar year immediately preceding the payment year. CMS uses the paid amounts on claims for covered professional services to calculate the estimated aggregate payments on which CMS will calculate the APM Incentive Payment. The applicable percentage is the following value for the indicated payment years:

(i) 2019 through 2024: 5 percent.

(ii) 2025: 3.5 percent.

(iii) 2026: 1.88 percent.

(iv) 2028: 3.1 percent.

* * * * *

PART 415--SERVICES FURNISHED BY PHYSICIANS IN PROVIDERS, SUPERVISING PHYSICIANS IN TEACHING SETTINGS, AND RESIDENTS IN CERTAIN SETTINGS

48. The authority citation for part 415 continues to read as follows:

Authority: 42 U.S.C. 1302 and 1395hh.

49. Section 415.172 is amended by revising paragraphs (a) introductory text and (b)(2) to read as follows:

§ 415.172 Physician fee schedule payment for services of teaching physicians.

(a) *General rule*. If a resident participates in a service furnished in a teaching setting, physician fee schedule payment is made only if a teaching physician is present during the key portion of any service or procedure for which payment is sought. For all teaching settings, if a resident participates in a service furnished in a teaching setting, physician fee schedule payment

is made if a teaching physician is present during the key portion of the service including for Medicare telehealth services, through audio/video real-time communications technology for any service or procedure for which payment is sought, when either the teaching physician or resident is in the same physical location as the beneficiary or in instances when the service is a 3-way telehealth visit, with the teaching physician, resident, and patient in different locations.

* * * * *

(b) * * *

(2) For all teaching settings, except for services furnished as set forth in §§ 415.174 (concerning an exception for services furnished in hospital outpatient and certain other ambulatory settings), 415.176 (concerning renal dialysis services), and 415.184 (concerning psychiatric services), the medical records must document whether the teaching physician was physically present or present through audio/video real-time communications technology at the time the service (including a Medicare telehealth service) is furnished. The medical records must contain a notation describing the specific portion(s) of the service for which the teaching physician was present through audio/video real-time communications technology. The presence of the teaching physician during procedures and evaluation and management services may be demonstrated by the notes in the medical records made by the physician or as provided in § 410.20(e) of this chapter.

50. Section 415.174 is amended by revising paragraph (a) introductory text to read as follows:

§ 415.174 Exception: Evaluation and management services furnished in certain centers.

(a) In the case of certain evaluation and management codes (as specified by CMS in program instructions), MACs may make physician fee schedule payment for a service furnished by a resident without the presence of a teaching physician. For the exception to apply, all of the following conditions must be met:

* * * * *

PART 417--HEALTH MAINTENANCE ORGANIZATIONS, COMPETITIVE MEDICAL PLANS, AND HEALTH CARE PREPAYMENT PLANS

51. The authority for part 417 continues to read as follows:

Authority: 42 U.S.C. 1302 and 1395hh, and 300e, 300e-5, and 300e-9, and 31 U.S.C. 9701.

52. Section 417.2 is amended by revising paragraph (b) to read as follows:

§ 417.2 Basis and scope.

* * * * *

(b) Subparts G through R of this part set forth the rules for Medicare contracts with, and payment to, HMOs and competitive medical plans (CMPs) under sections 1876 and 1899C of the Act and 8 U.S.C. 1611.

* * * * *

53. Section 417.422 is amended by revising paragraph (h) to read as follows:

§ 417.422 Eligibility to enroll in an HMO or CMP.

* * * * *

(h) Effective July 4, 2025, is a United States citizen or national, or an eligible noncitizen as defined in 42 CFR 400.200.

54. Section 417.460 is amended by revising paragraphs (b)(2)(iv) and (j) to read as follows:

§ 417.460 Disenrollment of beneficiaries by an HMO or CMP.

* * * * *

(b) * * *

(2) * * *

(iv) No longer meets the requirements of § 417.422(h); or

* * * * *

(j) *Enrollee is not a United States citizen or national, or an eligible noncitizen*. Disenrollment is effective the first day of the month following notice by CMS that the individual is ineligible in accordance with § 417.422(h).

PART 422--MEDICARE ADVANTAGE PROGRAM

55. The authority for part 422 continues to read as follows:

Authority: 42 U.S.C. 1302, 1306, 1395w-21 through 1395w-28, and 1395hh.

56. Section 422.1 is amended by adding paragraph (a)(1)(xii) and removing and reserving paragraph (a)(2) to read as follows:

§ 422.1 Basis and scope.

(a) * * *

(1) * * *

(xii) 1899C–Limiting Medicare coverage of certain individuals.

(2) [Reserved]

* * * * *

57. Section 422.50 is amended by revising paragraph (a)(7) to read as follows:

§ 422.50 Eligibility to elect an MA plan.

* * * * *

(a) * * *

(7) Effective July 4, 2025, is a United States citizen or national, or an eligible noncitizen as defined in 42 CFR 400.200.

* * * * *

58. Section 422.62 is amended by revising paragraph (b)(16) to read as follows:

§ 422.62 Election of coverage under an MA plan.

* * * * *

(b) * * *

(16) The individual becomes an eligible noncitizen.

(i) The SEP begins when the individual provides the Social Security Administration with sufficient information to demonstrate that the requirements of § 406.20(b)(2) and § 407.10(a)(2)(ii) have been met and is entitled to Medicare Part A and enrolled in Medicare Part B. The SEP continues for the first 2 months after the date that the individual is entitled to Medicare Part A and enrolled in Medicare Part B.

* * * * *

59. Section 422.74 is amended by revising paragraphs (b)(2)(v) and (d)(9) to read as follows:

§ 422.74 Disenrollment by the MA organization.

* * * * *

(b) * * *

(2) * * *

(v) The individual no longer meets the requirements of § 422.50(a)(7).

* * * * *

(d) * * *

(9) *Enrollee loses U.S. citizenship, U.S. nationality, or eligible noncitizen status.* Disenrollment is effective the first day of the month following notice by CMS that the individual is ineligible in accordance with § 422.50(a)(7) of this chapter.

* * * * *

PART 423--VOLUNTARY MEDICARE PRESCRIPTION DRUG BENEFIT

60. The authority for part 423 continues to read as follows:

Authority: 42 U.S.C. 1302, 1306, 1395w-101 through 1395w-152, and 1395hh.

61. Section 423.1 is amended by adding a section in numerical order in paragraph (a)(1) and removing and reserving paragraph (a)(3) to read as follows:

§ 423.1 Basis and scope.

(a) * * *

(1) * * *

1899C. Limiting Medicare coverage of certain individuals.

* * * * *

(3) [Reserved]

* * * * *

62. Section 423.30 is amended by revising paragraph (a)(1)(iii) to read as follows:

§ 423.30 Eligibility and enrollment.

(a) * * *

(1) * * *

(iii) Effective July 4, 2025, is a United States citizen or national, or an eligible noncitizen as defined in 42 CFR 400.200.

* * * * *

63. Section 423.38 is amended by revising paragraphs (c)(21)(i) and (ii) to read as follows:

§ 423.38 Enrollment periods.

* * * * *

(c) * * *

(21) * * *

(i) The individual becomes an eligible noncitizen.

(ii) The SEP begins when the individual provides the Social Security Administration with sufficient information to demonstrate that the requirements of § 406.20(b)(2) or § 407.10(a)(2)(ii) have been met and is entitled to, or enrolled for, either Medicare Part A or Part B. The SEP continues for the first 2 months after the Part A or Part B entitlement date, whichever is earlier.

* * * * *

64. Section 423.44 is amended by revising paragraphs (b)(2)(vi) and (d)(8) heading to read as follows:

§ 423.44 Involuntary disenrollment from Part D coverage.

* * * * *

(b) * * *

(2) * * *

(vi) The individual no longer meets the requirements of § 423.30(a)(1)(iii).

* * * * *

(d) * * *

(8) *Individual loses U.S. citizenship, U.S. nationality, or eligible noncitizen status.* * * * * * * * *

PART 424--CONDITIONS FOR MEDICARE PAYMENT

65. The authority for part 424 continues to read as follows:

Authority: 42 U.S.C. 1302 and 1395hh.

66. Section 424.516 is amended by adding paragraph (f)(4) to read as follows:

§ 424.516 Additional provider and supplier requirements for enrolling and maintaining active enrollment status in the Medicare program.

* * * * *

(f) * * *

(4) A provider or supplier that is a covered entity as defined at 42 CFR 10.3 is required to—

(i) Submit to CMS the documentation set forth at § 428.203(c)(1) and (2) relating to covered Part D drugs written or ordered by such provider or supplier.

(ii) Comply with the submission requirements set forth at § 428.203(c)(3) and (4).

* * * * *

PART 425—MEDICARE SHARED SAVINGS PROGRAM

67. The authority citation for part 425 continues to read as follows:

Authority: 42 U.S.C. 1302, 1306, 1395hh, and 1395jjj.

68. Section 425.20 is amended by—

a. Revising and republishing the definition of "Beneficiary eligible for Medicare CQMs";

b. Adding the definition of "Beneficiary eligible for Medicare eCQMs" in alphabetical order;

c. Revising paragraph (2) in the definition of "Experienced with performance-based risk Medicare ACO initiatives";

d. Revising paragraph (2) in the definition of "Inexperienced with performance-based risk Medicare ACO initiatives"; and

e. Adding the definition of "Rural county status" in alphabetical order.

The revisions, republication, and additions read as follows:

§ 425.20 Definitions.

* * * * *

Beneficiary eligible for Medicare CQMs means a beneficiary identified for purposes of reporting Medicare CQMs for ACOs participating in the Medicare Shared Savings Program (Medicare CQMs), who meets the following requirements (as applicable):

(1) For performance years 2024 through 2026, the beneficiary is either of the following:

(i) A Medicare fee-for-service beneficiary (as defined at § 425.20) who —

(A) Meets the criteria for a beneficiary to be assigned to an ACO described at § 425.401(a); and

(B)(*1*) For performance year 2024, 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 who has one of the specialty designations included in § 425.402(c), or who is a physician assistant, nurse practitioner, or clinical nurse specialist.

(*2*) For performance years 2025 and 2026, had at least one primary care service with a date of service during the applicable performance year from an ACO professional who is a primary care physician or who has one of the specialty designations included in § 425.402(c), or who is a physician assistant, nurse practitioner, or clinical nurse specialist.

(ii) A Medicare fee-for-service beneficiary who is assigned to an ACO in accordance with § 425.402(e) because the beneficiary designated an ACO professional participating in an ACO as responsible for coordinating their overall care.

(2) For performance years 2027 and subsequent performance years, a beneficiary that is assigned to the ACO under subpart E of this part.

Beneficiary eligible for Medicare eCQMs means a beneficiary identified for purposes of reporting Medicare eCQMs for ACOs participating in the Medicare Shared Savings Program (Medicare eCQMs), who is a beneficiary that is assigned to the ACO under subpart E of this part.

* * * * *

Experienced with performance-based risk Medicare ACO initiatives * * *

(2) Forty percent or more of the ACO's ACO participants participated in a performance-based risk Medicare ACO initiative, or in an ACO that deferred its entry into a second Shared Savings Program agreement period under a two-sided model under § 425.200(e), in any of the 5 most recent performance years. An ACO participant is considered to have participated in a performance-based risk Medicare ACO initiative if the ACO participant TIN was or will be included in financial reconciliation for one or more performance years under such initiative during any of the 5 most recent performance years, unless the ACO participant TIN did not have a written agreement to participate in the performance-based risk Medicare ACO initiative.

* * * * *

Inexperienced with performance-based risk Medicare ACO initiatives * * *

(2) Less than 40 percent of the ACO's ACO participants participated in a performance-based risk Medicare ACO initiative, or in an ACO that deferred its entry into a second Shared Savings Program agreement period under a two-sided model under § 425.200(e), in each of the 5 most recent performance years. An ACO participant is considered to have participated in a performance-based risk Medicare ACO initiative if the ACO participant TIN was or will be included in financial reconciliation for one or more performance years under such initiative during any of the 5 most recent performance years, unless the ACO participant TIN did not have a written agreement to participate in the performance-based risk Medicare ACO initiative.

* * * * *

Rural county status means a county that has a status of Micropolitan (population of 10,000 to 50,000 individuals) or Noncore (population less than 10,000 individuals) per the Federal Office of Rural Health Policy (FORHP) county designation using the most recently available version of the United States Census Bureau Delineation File.

* * * * *

69. Section 425.304 is amended by—

a. In paragraph (a)(2), removing the phrase "paragraph (b) or (c) of this section" and adding in its place the phrase "paragraph (b), (c), or (e) of this section"; and

b. Adding paragraph (e).

The addition reads as follows:

§ 425.304 Beneficiary incentives.

* * * * *

(e) *Part B Cost Sharing Support.*

(1) *General.* ACOs, subject to certain conditions and safeguards, may enter into Part B cost sharing support arrangements with ACO participants, pursuant to which the ACO participants reduce or eliminate cost sharing for those categories of eligible Part B items and

services and eligible beneficiaries identified by the ACO. This cost sharing support could include both or either of Medicare FFS deductible and coinsurance amounts.

(2) *Application of the CMS-sponsored model safe harbor.* CMS has determined that the Federal anti-kickback statute safe harbor for CMS-sponsored model arrangements and CMS-sponsored model patient incentives (§ 1001.952(ii)(1) and (2) of this title) is available to protect remuneration exchanged under Part B cost sharing support arrangements between ACOs and ACO participants, and patient incentives in the form of Part B cost sharing support furnished to eligible beneficiaries under the Shared Savings Program that meet all of the requirements of this section and the anti-kickback statute safe harbor requirements set forth at § 1001.952(ii) of this title.

(3) *Application procedures.*

(i) *General*. An ACO must submit a Part B cost sharing support implementation plan in the form and manner and by a deadline specified by CMS. The implementation plan must include the following:

(A) The categories of eligible beneficiaries for which the ACO plans to make Part B cost sharing support available.

(B) The categories of eligible Part B items and services for which the ACO plans to make Part B cost sharing support available.

(C) A description of how the ACO's planned Part B cost sharing support strategy meets at least one of the clinical goals in paragraph (e)(4)(iii) of this section.

(D) The procedures that the ACO will implement to ensure that ACO participants that have entered into a Part B cost sharing support arrangement with the ACO have access to the most current list of beneficiaries eligible to receive Part B cost sharing support.

(E) A requirement for the ACO to submit to CMS a complete and accurate list of ACO participants that have entered into a Part B cost sharing support arrangement with the ACO according to paragraph (e)(5)(i) of this section.

(F) An attestation that, in any marketing or communications regarding the availability of Part B cost-sharing support, the ACO and its ACO participants will not represent such support as a substitute for supplemental insurance coverage or encourage beneficiaries to reduce or terminate such coverage.

(G) Such other information as may be specified by CMS.

(ii) *CMS review*. CMS evaluates an ACO's implementation plan and approves or denies the application. An ACO may only offer Part B cost sharing support to beneficiaries if CMS approves its application. CMS may reject the ACO's application on the basis of one or more of the following:

(A) The ACO's and the ACO participant's history of noncompliance in the Shared Savings Program.

(B) The ACO's history of noncompliance in CMMI ACO models.

(C) Whether the implementation plan complies with the requirements of § 425.304.

(D) Such other factors as CMS deems reasonable to protect the integrity of the Shared Savings Program, including concerns that the use of Part B cost sharing support may contribute to fraud, waste or abuse.

(iii) *Changes to the implementation plan.* If an ACO wants to make a change to its implementation plan, the ACO must submit a description of the change to CMS in a form and manner and by a deadline or deadlines specified by CMS. CMS evaluates the proposed change and either approves or rejects it.

(4) *Part B cost sharing support requirements.*

(i) *Beneficiary eligibility*. Beneficiaries are eligible to receive Part B cost sharing support if they meet the following criteria:

(A) The beneficiary is assigned to the applying ACO (as described at § 425.400(a)(1)(i)) if the ACO has selected prospective assignment or the beneficiary is an assignable beneficiary

(as defined at § 425.20), if the applying ACO has selected preliminary prospective assignment with retrospective reconciliation.

(B) The beneficiary does not have secondary insurance that covers the associated Part B cost sharing obligation.

(C) The beneficiary's overall health is expected to be improved or maintained by receiving the associated Part B item or service.

(ii) *Eligible Part B items and services*. ACOs may reduce or eliminate beneficiary cost sharing for all Medicare FFS Part B items and services except durable medical equipment, prosthetics, orthotics, supplies, and prescription drugs.

(iii) *Clinical goals*. Cost sharing support must advance one or more of the following clinical goals:

(A) Adherence to a treatment regime.

(B) Adherence to a drug regime.

(C) Adherence to a follow-up care plan.

(D) Management of a chronic disease or condition.

(5) *Part B cost sharing support arrangements.*

(i) *ACO participant agreements.* The ACO must have a written agreement with each ACO participant that has agreed to reduce or eliminate Part B cost sharing for eligible ACO beneficiaries under a Part B cost sharing support arrangement with the ACO. The terms of the Part B cost sharing support agreement must include all of the following:

(A) The categories of eligible beneficiaries and eligible Part B items and services for which the ACO participant may reduce or eliminate Part B cost sharing.

(B) A requirement that the ACO participant reduce or eliminate cost sharing in accordance with the ACO's approved implementation plan.

(C) The amount and frequency with which the ACO will reimburse the ACO participant for the cost sharing amounts not collected.

(D) A requirement for ACO participants to maintain copies of records that identify each beneficiary who received a reduction or elimination of Part B cost sharing, the type and date of item or service for which cost sharing support was provided, and the dollar amount of the cost sharing support.

(E) The ability for the ACO or ACO participant to terminate the Part B cost sharing support agreement if the ACO or ACO participant fails to comply with the requirements of this section.

(F) A requirement that the ACO or ACO participants will not market to beneficiaries the availability of the Part B cost sharing support as a substitute for their supplemental insurance coverage.

(ii) *Other rules governing participation.*

(A) An ACO participant must not be required by an ACO to participate in a Part B cost sharing support arrangement.

(B) An ACO may participate in Part B cost sharing support in accordance with an approved implementation plan even if not all of its ACO participants agree to participate.

(iii) *Source of funding.* The ACO must finance all payments made to ACO participants in accordance with the Part B cost sharing support agreement from its own funds.

(6) *Record retention.*

(i) The ACO must maintain copies of the written Part B cost sharing support agreement with ACO participants, as well as the following records:

(A) Records that identify each beneficiary who received a reduction or elimination of Part B cost sharing.

(B) Records that document the type and date of the Part B item or service for which Part B cost sharing was reduced or eliminated.

(C) Records that document the dollar amount of Part B cost sharing that was reduced or eliminated.

(D) Records that document the ACO participant that furnished the item or service for which Part B cost sharing was reduced or eliminated.

(ii) The ACO must provide the records specified in paragraph (e)(6)(i) of this section to CMS upon request.

(7) *Addressing compliance problems.* At any time, CMS may suspend or prohibit the ACO or any ACO participant from participating in a Part B cost sharing support arrangement if CMS determines that the ACO or its ACO participants have failed to comply with any of the requirements of this part. This suspension or prohibition will be effective, in CMS' discretion, regardless of whether the ACO has corrected or otherwise resolved the noncompliance.

70. Section 425.308 is amended by—

a. In paragraph (b)(9) introductory text, removing the phrase "For performance year 2025 and subsequent performance years," and adding in its place the phrase "For performance years 2025 and 2026,"; and

b. Adding paragraph (b)(11).

The addition reads as follows:

§ 425.308 Public reporting and transparency.

* * * * *

(b) * * *

(11) For performance year 2027 and subsequent performance years, the CEHRT use activity selected by the ACO for the purpose of meeting the ACO CEHRT use requirement at § 425.507(c).

* * * * *

71. Section 425.312 is amended by—

a. Revising the last sentence in paragraph (a)(2)(iii);

b. Adding a new sentence at the end of paragraph (a)(2)(iv); and

c. Removing paragraph (a)(2)(v).

The revision and addition read as follows:

§ 425.312 Beneficiary notifications.

(a) * * *

(2) * * *

(iii) * * * The standardized written notice must be furnished to all of these beneficiaries by May 30, unless CMS specifies a later date during the performance year.

(iv) * * * The standardized written notice must be furnished to all of these beneficiaries by May 30, unless CMS specifies a later date during the performance year.

* * * * *

72. Section 425.400 is amended by revising paragraph (c)(1)(x) introductory text and adding paragraph (c)(1)(xi) to read as follows:

§ 425.400 General.

* * * * *

(c) * * *

(1) * * *

(x) For the performance year starting on January 1, 2026, as follows:

* * * * *

(xi) For the performance year starting on January 1, 2027, and subsequent performance years as follows:

(A) CPT codes:

(*1*) 96160 and 96161 (codes for administration of health risk assessment).

(*2*) 96202 and 96203 (codes for caregiver behavior management training).

(*3*) 97550, 97551, and 97552 (codes for caregiver training services).

(*4*) 98016 (code for virtual check-in).

(*5*) 99201 through 99215 (codes for office or other outpatient visit for the evaluation and management of a patient).

(*6*) 99304 through 99318 (codes for professional services furnished in a nursing facility; professional services or services reported on an FQHC or RHC claim identified by these codes are excluded when furnished in a skilled nursing facility (SNF)).

(*7*) 99319 through 99340 (codes for patient domiciliary, rest home, or custodial care visit).

(*8*) 99341 through 99350 (codes for evaluation and management services furnished in a patient's home).

(*9*) 99354 and 99355 (add-on codes, for prolonged evaluation and management or psychotherapy services beyond the typical service time of the primary procedure; when the base code is also a primary care service code under this paragraph (c)(1)(xi)).

(*10*) 99406 and 99407 (codes for smoking and tobacco-use cessation counseling services).

(*11*) 99421, 99422, and 99423 (codes for online digital evaluation and management).

(*12*) 99424, 99425, 99426, and 99427 (codes for principal care management services).

(*13*) 99437, 99487, 99489, 99490 and 99491 (codes for chronic care management).

(*14*) 99439 (code for non-complex chronic care management).

(*15*) 99452 (code for interprofessional consultation service).

(*16*) 99483 (code for assessment of and care planning for patients with cognitive impairment).

(*17*) 99484, 99492, 99493 and 99494 (codes for behavioral health integration services).

(*18*) 99495 and 99496 (codes for transitional care management services).

(*19*) 99497 and 99498 (codes for advance care planning; services identified by these codes furnished in an inpatient setting are excluded).

(B) HCPCS codes:

(*1*) G0019 and G0022 (codes for community health integration services).

(*2*) G0023 and G0024 (codes for principal illness navigation services).

(*3*) G0101 (code for cervical or vaginal cancer screening).

(*4*) G0136 (code for physical activity and nutritional assessment services).

(*5*) G0317, G0318, and G2212 (codes for prolonged office or other outpatient visit for the evaluation and management of a patient).

(*6*) G0402 (code for the Welcome to Medicare visit).

(*7*) G0438 and G0439 (codes for the annual wellness visits).

(*8*) G0442 (code for alcohol misuse screening service).

(*9*) G0443 (code for alcohol misuse counseling service).

(*10*) G0444 (code for annual depression screening service).

(*11*) G0463 (code for services furnished in electing teaching amendment (ETA) hospitals).

(*12*) G0506 (code for chronic care management).

(*13*) G0537 and G0538 (codes for cardiovascular risk assessment and risk management services).

(*14*) G0539 and G0540 (codes for individual behavior management/modification caregiver training services).

(*15*) G0541, G0542, and G0543 (codes for direct care caregiver training services).

(*16*) G0544 (code for post-discharge telephonic follow-up contacts intervention).

(*17*) G0556, G0557, and G0558 (codes for advanced primary care management services).

(*18*) G0560 (code for safety planning interventions).

(*19*) G0568 and G0569 (codes for behavioral health integration add-on when furnished with advanced primary care management services).

(*20*) G0570 (code for psychiatric collaborative care model add-on when furnished with advanced primary care management services).

(*21*) G2010 (code for the remote evaluation of patient video/images).

(*22*) G2011, G0396, G0397 (codes for screening, brief intervention, and referral to

treatment).

(*23)* G2012 and G2252 (codes for virtual check-in).

(*24*) G2058 (code for non-complex chronic care management).

(*25*) G2064 and G2065 (codes for principal care management services).

(*26*) G2086, G2087, and G2088 (codes for office-based opioid use disorder services).

(*27*) G2211 (code for visit complexity inherent to evaluation and management services add-on).

(*28*) G2214 (code for psychiatric collaborative care model).

(*29*) G3002 and G3003 (codes for chronic pain management).

(*30*) GACP1 and GACP2 (codes for advance care planning).

(*31*) GADV1 (code for assessment and treatment of vaccine adverse effects).

(C) Primary care service codes include any CPT code identified by CMS that directly replaces a CPT code specified in paragraph (c)(1)(xi)(A) of this section or a HCPCS code specified in paragraph (c)(1)(xi)(B) of this section, when the assignment window or expanded window for assignment (as defined in § 425.20) for a benchmark or performance year includes any day on or after the effective date of the replacement code for payment purposes under FFS Medicare.

* * * * *

73. Section 425.401 is revised and republished to read as follows:

§ 425.401 Criteria for a beneficiary to be assigned to an ACO.

(a) *Assignment eligibility criteria.* A beneficiary may be assigned to an ACO under the assignment methodology in §§ 425.402 and 425.404, for a performance or benchmark year, if the beneficiary meets all of the following criteria during the assignment window:

(1) For performance years starting prior to January 1, 2028 (as applicable):

(i)(A) Has at least 1 month of Part A and Part B enrollment; and

(B) Does not have any months of Part A only or Part B only enrollment.

(ii) Does not have any months of Medicare group (private) health plan enrollment.

(iii) Is not assigned to any other Medicare shared savings initiative.

(iv) Lives in the United States or U.S. territories and possessions, based on the most recent available data in our beneficiary records regarding the beneficiary's residence at the end of the assignment window.

(2) For the performance year starting on January 1, 2028, and subsequent performance years:

(i) Has at least 1 month of Part A and Part B enrollment and does not have Medicare group (private) health plan enrollment during that same month during the assignment window.

(ii) Is not assigned to any other Medicare shared savings initiative.

(iii) Lives in the United States or U.S. territories and possessions, based on the most recent available data in our beneficiary records regarding the beneficiary's residence at the end of the assignment window.

(b) *Prospective assignment exclusion criteria.* A beneficiary is excluded from the prospective assignment list of an ACO that is participating under prospective assignment under § 425.400(a)(3) at the end of a performance or benchmark year and quarterly during each performance year consistent with § 425.400(a)(3)(ii), or at the end of CY 2019 as specified in § 425.609(b)(1)(ii) and (c)(1)(ii) if the beneficiary meets any of the following criteria during the performance or benchmark year:

(1) For performance years starting prior to January 1, 2028 (as applicable):

(i)(A) Does not have at least 1 month of Part A and Part B enrollment; and

(B) Has any months of Part A only or Part B only enrollment.

(ii) Has any months of Medicare group (private) health plan enrollment.

(iii) Did not live in the United States or U.S. territories and possessions, based on the most recent available data in our beneficiary records regarding the beneficiary's residency at the end of the year.

(2) For the performance year starting on January 1, 2028, and subsequent performance years:

(i) Does not have at least 1 month of Part A and Part B enrollment without Medicare group (private) health plan enrollment during that same month during the assignment window.

(ii) Did not live in the United States or U.S. territories and possessions, based on the most recent available data in our beneficiary records regarding the beneficiary's residency at the end of the year.

74. Section 425.402 is amended by revising and republishing paragraphs (b)(3), (b)(4) and (b)(5)(iv) to read as follows:

§ 425.402 Basic assignment methodology.

* * * * *

(b) * * *

(3)(i) Under the first step, a beneficiary identified in paragraph (b)(1) of this section is assigned to an ACO if the allowed charges for primary care services furnished to the beneficiary by primary care physicians who are ACO professionals and non-physician ACO professionals in the ACO are greater than the allowed charges for primary care services furnished by primary care physicians, nurse practitioners, physician assistants, and clinical nurse specialists who are—

(A) ACO professionals in any other ACO; or

(B) Not affiliated with any ACO and identified by a Medicare-enrolled billing TIN.

(ii) For performance year 2028 and subsequent performance years, if an ACO professional for which CMS identifies a primary care service under paragraph (b)(2) of this section also bills primary care services under a Medicare-enrolled billing TIN unaffiliated with any ACO, then CMS excludes from consideration in assignment under paragraph (b)(3)(i) of this section the allowed charges for primary care services billed by the ACO professional under the non-ACO TIN during the applicable assignment window.

(4)(i) The second step considers the remainder of the beneficiaries identified in paragraph

(b)(1) of this section who have not had a primary care service rendered by any primary care physician, nurse practitioner, physician assistant, or clinical nurse specialist, either inside the ACO or outside the ACO. The beneficiary will be assigned to an ACO if the allowed charges for primary care services furnished to the beneficiary by physicians who are ACO professionals with specialty designations as specified in paragraph (c) of this section are greater than the allowed charges for primary care services furnished by physicians with specialty designations as specified in paragraph (c) of this section—

(A) Who are ACO professionals in any other ACO; or

(B) Who are unaffiliated with an ACO and are identified by a Medicare-enrolled billing TIN.

(ii) For performance year 2028 and subsequent performance years, if an ACO professional for which CMS identifies a primary care service under paragraph (b)(2) of this section also bills primary care services under a Medicare-enrolled billing TIN unaffiliated with any ACO, then CMS excludes from consideration in assignment under paragraph (b)(4)(i) of this section the allowed charges for primary care services billed by the ACO professional under the non-ACO TIN during the applicable assignment window.

(5) * * *

(iv)(A) A beneficiary identified in paragraph (b)(5)(ii) of this section is assigned to the ACO if the allowed charges for primary care services furnished to the beneficiary by ACO professionals in the ACO who are primary care physicians, physicians with specialty designations included in paragraph (c) of this section, or non-physician ACO professionals during the applicable expanded window for assignment are greater than the allowed charges for primary care services furnished by primary care physicians, physicians with specialty designations as specified in paragraph (c) of this section, nurse practitioners, physician assistants, and clinical nurse specialists who are—

(*1*) ACO professionals in any other ACO; or

(*2*) Not affiliated with any ACO and identified by a Medicare-enrolled billing TIN.

(B) For performance year 2028 and subsequent performance years, if an ACO professional for which CMS identifies a primary care service under paragraph (b)(5)(iii) of this section also bills primary care services under a Medicare-enrolled billing TIN unaffiliated with any ACO, then CMS excludes from consideration in assignment under paragraph (b)(5)(iv)(A) of this section the allowed charges for primary care services billed by the ACO professional under the non-ACO TIN during the applicable expanded window for assignment.

* * * * *

75. Section 425.507 is amended by—

a. In paragraph (a) introductory text, removing the phrase "For performance years beginning on or after January 1, 2025," and adding in its place the phrase "For performance years 2025 and 2026,";

b. In paragraph (b) introductory text, by adding the words "For performance years 2025 and 2026," to the beginning of the first sentence; and

c. Adding paragraph (c).

The addition reads as follows:

§ 425.507 Incorporating Promoting Interoperability requirements related to the Quality Payment Program for performance years beginning on or after January 1, 2025.

* * * * *

(c) For performance years beginning on or after January 1, 2027, an ACO must demonstrate the use of CEHRT (as defined in paragraph (3) of the CEHRT definition at § 414.1305 of this chapter) in one of the following manners:

(1) The ACO uses CEHRT (as defined in paragraph (3) of the CEHRT definition at § 414.1305 of this chapter) that also supports the calculation and reporting of clinical quality measures by being certified to the ONC health IT certification criteria at 45 CFR 170.315(c)(2) and (c)(3), to completely report at least one of the measures in the APP Plus quality measure set

using the eCQMs or Medicare eCQMs collection types and meets the data completeness requirement at § 414.1340 of this chapter for the applicable performance year.

(2) The ACO completely reports at least one measure in the APP Plus quality measure set and meets the data completeness requirement at § 414.1340 of this chapter for the applicable performance year using EHR technology that meets paragraph (3) of the CEHRT definition at § 414.1305 of this chapter and attests that it used data collected from an HL7® Fast Healthcare Interoperable Resources (FHIR®)-based API to support quality measurement using a Health IT Module (as defined in 45 CFR 170.102) that has been certified to an unexpired criterion or criteria in 45 CFR 170.315 supporting standardized API access.

(3) The ACO attests to at least one of the Shared Savings Program CEHRT use metrics from the list of metrics established for the applicable performance year.

76. Section 425.508 is amended by adding paragraphs (c)(1) through (4) to read as follows:

§ 425.508 Incorporating quality reporting requirements related to the Quality Payment Program.

* * * * *

(c) * * *

(1) For performance years beginning on or after January 1, 2026. ACOs may exclude one or more TINs of ACO participants from an ACO's submission of eCQM/MIPS CQM/Medicare CQM/Medicare eCQM data (as applicable) for each measure as required in this paragraph (c). Applicable exclusions may include:

(i) Unforeseen circumstance(s) that are outside of the control of the ACO, such as the unexpected closure of a group or individual's practice that bills under the ACO participant TIN.

(ii) An ACO participant TIN has a CEHRT that is intended for specialty use and does not support the measure(s) included in the APP Plus quality measure set.

(iii) Other circumstances as determined by CMS.

(2) ACOs may not exclude an ACO participant TIN from the ACO's quality data submission for each measure based on the following:

(i) The demographics of the beneficiaries who had an encounter during the performance year with an ACO participant TIN.

(ii) The health status of the beneficiaries who had an encounter during the performance year with an ACO participant TIN.

(iii) The estimated impact of the ACO participant TIN on the ACO's quality performance.

(3) The ACO's submission of eCQM/MIPS CQM/Medicare CQM/Medicare eCQM data (as applicable) for each measure must include ACO participant TINs that represent at least 95 percent of the beneficiaries assigned to the ACO under subpart E of this part prior to the application of the measure specifications.

(4) CMS retains the right to audit and validate eCQM/MIPS CQM/Medicare CQM/Medicare eCQM data reported by an ACO and may request documentation from the ACO related to the exclusion of ACO participant TINs under paragraph (c)(1) of this section. Failure to report quality measure data accurately, completely, and timely may result in compliance actions as described in §§ 425.216 and 425.218.

* * * * *

77. Section 425.512 is amended by—

a. In paragraph (a)(2)(iv), removing the phrase "eCQMs/Medicare CQMs" and adding in its place the phrase "eCQMs/MIPS CQMs/Medicare CQMs/Medicare eCQMs";

b. In paragraph (a)(5)(i)(B) introductory text, removing the phrase "For performance years 2025 and 2026," and adding in its place the phrase "For performance year 2025 and subsequent performance years,";

c. Removing paragraph (a)(5)(i)(C);

d. In paragraph (a)(5)(iii)(C), removing the phrase "eCQMs/Medicare CQMs" and

adding in its place the phrase “eCQMs/MIPS CQMs/Medicare CQMs/Medicare eCQMs”;

e. In paragraph (a)(7)(ii), removing the phrase “For performance year 2025 and subsequent performance years,” and adding in its place the phrase “For performance years 2025 and 2026”; and

f. Adding paragraph (a)(7)(iii).

The addition reads as follows:

§ 425.512 Determining the ACO quality performance standard for performance years beginning on or after January 1, 2021.

(a) * * *

(7) * * *

(iii) For performance year 2027 and subsequent performance years, if an ACO reports all of the required measures in the APP Plus quality measure set, meeting the data completeness requirement at § 414.1340 of this subchapter for each measure in the APP Plus quality measure set, and receiving a MIPS Quality performance category score as described at § 414.1380(b)(1) of this subchapter, for the relevant performance year, and the ACO meets the following—

(A) The ACO’s MIPS Quality performance category score is calculated on less than five measures; and

(B) Any unscored measure(s) must meet all of the following:

(*1*) The ACO’s total available measure achievement points used to calculate the ACO’s MIPS Quality performance category score are reduced under § 414.1380(b)(1)(vii)(A) of this subchapter.

(*2*) The ACO’s total measure achievement points used to calculate the ACO’s MIPS Quality performance category score are not reduced under § 414.1380(b)(1)(iii) of this subchapter.

* * * * *

§ 425.600 [Amended]

78. Section 425.600 is amended in paragraph (f)(4)(ii) by removing the references "§§ 425.601(f), and 425.656(e)" and adding in their place the references "§ 425.601(f), and § 425.656(e) and (f)".

79. Section 425.605 is amended by—

a. Revising paragraph (d)(1)(v)(A)(*3*)(*ii*), the first sentence of paragraph (d)(1)(v)(A)(*4*) introductory text, and paragraph (d)(1)(v)(A)(*4*)(*ii*);

b. Adding paragraph (d)(1)(v)(A)(*5*);

c. In paragraph (h)(2), removing the references "paragraph (d)(1)(i)(A)(*4*), (d)(1)(ii)(A)(*4*), (d)(1)(iii)(A)(*4*), (d)(1)(iv)(A)(*4*), or (d)(1)(v)(A)(*4*) of this section" and adding in their place the references "paragraph (d)(1)(i)(A)(*4*), (d)(1)(ii)(A)(*4*), (d)(1)(iii)(A)(*4*), (d)(1)(iv)(A)(*4*), (d)(1)(v)(A)(*4*) or (d)(1)(v)(A)(*5*) of this section";

d. In paragraph (i)(2)(i) introductory text, removing the phrase "paragraph (i)(2)(ii) of this section" and adding in its place the phrase "paragraph (i)(2)(ii) or (i)(2)(iii) of this section, as applicable"; and

e. Adding new paragraph (i)(2)(iii).

The revisions and additions read as follows:

§ 425.605 Calculation of shared savings and losses under the BASIC track.

* * * * *

(d) * * *

(1) * * *

(v) * * *

(A) * * *

(*3*) * * *

(*ii*) 50 percent multiplied by the ACO's quality score calculated according to § 425.512 for an ACO that meets the alternative quality performance standard by meeting the criteria specified in § 425.512(a)(4)(ii).

(*4*) *For ACOs in agreement periods beginning on July 1, 2019, through January 1, 2026, for performance years beginning on or after January 1, 2024.* * * *

(*ii*) 50 percent multiplied by the ACO's quality score calculated according to § 425.512 for an ACO that meets the alternative quality performance standard by meeting the criteria specified in § 425.512(a)(5)(ii).

(*5*) *For ACOs in agreement periods beginning on or after January 1, 2027, for performance years beginning on or after January 1, 2027*. An ACO that meets all the requirements for receiving shared savings payments under the BASIC track, Level E, receives a shared savings payment equal to a percentage of all the savings under the updated benchmark (up to the performance payment limit described in paragraph (d)(1)(v)(B) of this section). Except as provided in paragraph (h) of this section, the percentage is as follows:

(*i*) 60 percent for an ACO that that meets the quality performance standard by meeting the criteria specified in § 425.512(a)(2) or (a)(5)(i).

(*ii*) 60 percent multiplied by the ACO's quality score calculated according to § 425.512 for an ACO that meets the alternative quality performance standard by meeting the criteria specified in § 425.512(a)(5)(ii).

* * * * *

(i) * * *

(2) * * *

(iii) For agreement periods beginning on or after January 1, 2024, and before January 1, 2027, for performance year 2025 and subsequent performance years of the ACO's agreement period. CMS calculates the benchmark-based loss recoupment limit as follows:

(A) Calculates the value for total benchmark expenditures as the product of an ACO's per capita updated benchmark expenditures for the performance year prior to the recomputation of the ACPT as specified in § 425.660(c)(1) and an ACO's assigned beneficiary person years for the performance year.

(B) Calculates the value for total benchmark expenditures as the product of an ACO's per capita updated benchmark expenditures for the performance year after the recomputation of the ACPT as specified in § 425.660(c)(1) and an ACO's assigned beneficiary person years for the performance year.

(C) Calculates the product of the percentage specified in paragraph (d)(1)(iii)(D)(*2*), (d)(1)(iv)(D)(*2*), and (d)(1)(v)(D)(*2*) of this section, as applicable, and the lesser of the ACO's total benchmark expenditures calculated according to paragraphs (i)(2)(iii)(A) and (i)(2)(iii)(B) of this section.

80. Section 425.610 is amended by—

a. In paragraph (l)(2) introductory text, removing the phrase "paragraph (l)(3) of this section" and adding in its place the phrase "paragraph (l)(3) or (l)(4) of this section, as applicable"; and

b. Adding paragraph (l)(4).

The addition reads as follows:

§ 425.610 Calculation of shared savings and losses under the ENHANCED track.

* * * * *

(l) * * *

(4) For agreement periods beginning on or after January 1, 2024, and before January 1, 2027, for performance year 2025 and subsequent performance years of the ACO's agreement period. The amount of shared losses for which an eligible ACO is liable may not exceed 15 percent of the lesser of the following:

(i) Total benchmark expenditures calculated as the product of an ACO's per capita updated benchmark expenditures for the performance year prior to the recomputation of the ACPT as specified in § 425.660(c)(1) and an ACO's assigned beneficiary person years for the performance year.

(ii) Total benchmark expenditures calculated as the product of an ACO's per capita

updated benchmark expenditures for the performance year after the recomputation of the ACPT as specified in § 425.660(c)(1) and an ACO's assigned beneficiary person years for the performance year.

§ 425.612 [Amended]

81. Section 425.612(a)(1)(iv)(A)(*2*) is amended by removing the references "§ 425.401(a)(1) and (2)" and adding in its place the references "§ 425.401(a)(1)(i)-(ii) and (a)(2)(i) (as applicable)".

82. Section 425.630 is amended by—

a. In paragraph (e)(1), removing the phrase "social determinants of health" and adding in its place the phrase "upstream drivers of health";

b. Revising paragraph (f)(2)(ii) introductory text to add a new first sentence; and

c. Revising and republishing paragraphs (f)(2)(iii) and (f)(2)(iv).

The revisions and republications read as follows:

§ 425.630 Option to receive advance investment payments.

* * * * *

(f) * * *

(2) * * *

(ii) For performance years 2023 through 2027.

* * * * *

(iii) Determines a beneficiary's payment amount.

(A) For performance years 2023 through 2027. For each beneficiary in the assigned population identified in paragraph (f)(2)(i) of this section, CMS determines the payment amount that corresponds to the beneficiary's risk factors-based score determined in paragraph (f)(2)(ii) of this section. The beneficiary payment amount is as follows:

TABLE 1 TO PARAGRAPH (f)(2)(iii)(A)

Risk factors-based score	**1-24**	**25-34**	**35-44**	**45-54**	**55-64**	**65-74**	**75-84**	**85-100**
Payment amount	$0	$20	$24	$28	$32	$36	$40	$45

(B) For performance year 2028 and subsequent performance years. For each beneficiary in the assigned population identified in paragraph (f)(2)(i) of this section, CMS determines the quarterly payment amount, as follows:

(*1*) An ACO will receive a quarterly payment of $45 for each beneficiary that meets any of the following criteria:

(*i*) Is enrolled in the LIS.

(*ii*) Is dually eligible for Medicare and Medicaid.

(*iii*) Is residing in a county with rural county status (as defined at § 425.20). CMS determines the county of residence for the beneficiary based on the beneficiary's mailing address.

(*2*) An ACO will receive a quarterly payment of $25 for each beneficiary that does not meet any of the criteria listed in paragraph (f)(2)(iii)(B)(*1*) of this section.

(iv) Calculates the ACO's quarterly payment amount.

(A) For performance years 2023 through 2027. The ACO's quarterly payment amount is the sum of the beneficiary payment amounts corresponding to each assigned beneficiary's risk factors-based score, specified in paragraph (f)(2)(iii)(A) of this section, capped at 10,000 beneficiaries. If the ACO has more than 10,000 assigned beneficiaries according to paragraph (f)(2)(i) of this section, CMS will calculate the quarterly payment amount based on the 10,000 assigned beneficiaries with the highest risk factors-based scores determined according to paragraph (f)(2)(ii) of this section.

(B) For performance year 2028 and subsequent performance years. The ACO's quarterly payment amount is the sum of the beneficiary payment amounts corresponding to the quarterly payments specified in paragraph (f)(2)(iii)(B) of this section. If the ACO has more than 10,000 assigned beneficiaries according to paragraph (f)(2)(i) of this section, CMS will calculate the quarterly payment amount based on the 10,000 assigned beneficiaries with the highest quarterly payment amount determined according to paragraph (f)(2)(iii)(B) of this section.

* * * * *

83. Section 425.640 is amended by—

a. In paragraph (b)(1)(i), removing the phrase "January 1, 2026, or in subsequent years" and adding in its place the phrase "January 1, 2026 or January 1, 2027";

b. In paragraph (c)(1), removing the phrase "January 1, 2026, or in subsequent years" and adding in its place the phrase "January 1, 2026 or January 1, 2027"; and

c. Revising paragraphs (f)(1)(i) and (ii).

The revisions read as follows:

§ 425.640 Option to receive prepaid shared savings.

* * * * *

(f) * * *

(1) * * *

(i) An eligible ACO entering an agreement period beginning on January 1, 2026 or January 1, 2027 will receive quarterly prepaid shared savings payments through December 31, 2027, unless the payment is withheld or terminated under paragraph (h) of this section.

(ii) An eligible ACO participating in an agreement period beginning on January 1, 2025, will receive quarterly prepaid shared savings payments starting with the performance year beginning on January 1, 2026 through December 31, 2027, unless the payment is withheld or terminated under paragraph (h) of this section. The ACO will not receive additional or catch-up payments for performance year 2025.

* * * * *

§ 425.650 [Amended]

84. Section 425.650 is amended in paragraph (a) by removing the references "§§ 425.652 through 425.662" and adding in their place the references "§§ 425.652 through 425.664".

85. Section 425.652 is amended by adding paragraph (a)(8)(iii) to read as follows:

§ 425.652 Establishing, adjusting, and updating the benchmark for agreement periods beginning on January 1, 2024, and in subsequent years.

(a) * * *

(8) * * *

(iii) For agreement periods beginning on January 1, 2027, and in subsequent years, in addition to any adjustment applied to the historical benchmark in accordance with paragraph (a)(8)(ii) of this section (either a regional adjustment, prior savings adjustment, or population adjustment, as applicable), the ACO will receive a growth adjustment (as calculated under § 425.664), if eligible. The sum of the adjustment amount (if any) applied in paragraph (a)(8)(ii) of this section and the growth adjustment (determined according to § 425.664(i)(1)) may not exceed an amount equal to the cap specified in § 425.664(i)(2).

* * * * *

86. Section 425.656 is amended by—

a. Revising paragraph (a);

b. In paragraph (c)(2), removing the phrase "paragraph (e) of this section" and adding in its place the phrase "paragraphs (e) or (f) of this section (as applicable)";

c. Revising and republishing paragraph (c)(3);

d. Revising paragraph (e) introductory text;

e. Redesignating paragraph (f) as paragraph (g);

f. Adding new paragraph (f); and

g. In newly redesignated paragraph (g) introductory text, removing the phrase "paragraphs (b) through (e) of this section" and adding in its place the phrase "paragraphs (b) through (f) of this section".

The revisions, republications, and addition read as follows:

§ 425.656 Calculating the regional adjustment to the historical benchmark.

(a) *General*. This section describes the methodology for calculating the regional

adjustment to the historical benchmark based on the ACO's regional service area expenditures, making separate calculations for the following populations of beneficiaries: ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, and aged/non-dual eligible Medicare and Medicaid beneficiaries. This section applies to regional adjustment calculations for agreement periods beginning on January 1, 2024, and in subsequent years, except as specified otherwise.

* * * * *

(c) * * *

(3)(i) For agreement periods beginning on or after January 1, 2024 and before January 1, 2027. Caps the per capita dollar amount for each Medicare enrollment type (ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, aged/non-dual eligible Medicare and Medicaid beneficiaries) calculated under paragraph (c)(2) of this section at a dollar amount equal to a percentage of national per capita expenditures for Parts A and B services under the original Medicare fee-for-service program in BY3 for assignable beneficiaries in that enrollment type identified for the 12-month calendar year corresponding to BY3 using data from the CMS Office of the Actuary. The cap is applied as follows:

(A) For positive adjustments, the per capita dollar amount for a Medicare enrollment type is capped at 5 percent of the national per capita expenditure amount for the enrollment type for BY3.

(B) For negative adjustments, the per capita dollar amount for a Medicare enrollment type is capped at negative 1.5 percent of the national per capita expenditure amount for the enrollment type for BY3.

(ii) For agreement periods beginning on January 1, 2027, and in subsequent years. Caps the per capita dollar amount for each Medicare enrollment type (ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, aged/non-dual eligible Medicare and Medicaid beneficiaries) calculated under paragraph (c)(2) of this section at a dollar amount, as follows:

(A) For positive adjustments, the per capita dollar amount for a Medicare enrollment type is capped at a dollar amount calculated as follows:

(*1*) Calculate the product of the following:

(*i*) The amount of national per capita expenditures for Parts A and B services under the original Medicare fee-for-service program in BY3 for assignable beneficiaries in that enrollment type identified for the 12-month calendar year corresponding to BY3 using data from the CMS Office of the Actuary.

(*ii*) The ACO's weighted average CMS-HCC risk score for the enrollment type for BY3.

(*2*) Calculate 5 percent of the enrollment type-specific product determined in paragraph (c)(3)(ii)(A)(*1*) of this section.

(B) For negative adjustments, the per capita dollar amount for a Medicare enrollment type is capped at a dollar amount equal to negative 1.5 percent of national per capita expenditures for Parts A and B services under the original Medicare fee-for-service program in BY3 for assignable beneficiaries in that enrollment type identified for the 12-month calendar year corresponding to BY3 using data from the CMS Office of the Actuary.

* * * * *

(e) *Phase-in of weights used in the regional adjustment calculation for agreement periods beginning on or after January 1, 2024 and before January 1, 2027.*

* * * * *

(f) *Phase-in weights used in the regional adjustment calculation for agreement periods beginning on January 1, 2027, and in subsequent years*.

(1) The first time that an ACO's benchmark is adjusted based on the ACO's regional service area expenditures, CMS calculates the regional adjustment as follows:

(i) Using 35 percent of the difference between the average per capita amount of expenditures for the ACO's regional service area and the average per capita amount of the ACO's initial or rebased historical benchmark, if the ACO is determined to have lower spending

than the ACO's regional service area.

(ii) Using 15 percent of the difference between the average per capita amount of expenditures for the ACO's regional service area and the average per capita amount of the ACO's initial or rebased historical benchmark, if the ACO is determined to have higher spending than the ACO's regional service area.

(2) The second time that an ACO's benchmark is adjusted based on the ACO's regional service area expenditures, CMS calculates the regional adjustment as follows:

(i) For an ACO participating under the BASIC track—

(A) Using 50 percent of the difference between the average per capita amount of expenditures for the ACO's regional service area and the average per capita amount of the ACO's rebased historical benchmark if the ACO is determined to have lower spending than the ACO's regional service area; or

(B) Using 25 percent of the difference between the average per capita amount of expenditures for the ACO's regional service area and the average per capita amount of the ACO's rebased historical benchmark if the ACO is determined to have higher spending than the ACO's regional service area.

(ii) For an ACO participating under the ENHANCED track—

(A) Using 35 percent of the difference between the average per capita amount of expenditures for the ACO's regional service area and the average per capita amount of the ACO's rebased historical benchmark if the ACO is determined to have lower spending than the ACO's regional service area; or

(B) Using 25 percent of the difference between the average per capita amount of expenditures for the ACO's regional service area and the average per capita amount of the ACO's rebased historical benchmark if the ACO is determined to have higher spending than the ACO's regional service area.

(3) The third time that an ACO's benchmark is adjusted based on the ACO's regional

service area expenditures, CMS calculates the regional adjustment as follows:

(i) For an ACO participating under the BASIC track—

(A) Using 50 percent of the difference between the average per capita amount of expenditures for the ACO's regional service area and the average per capita amount of the ACO's rebased historical benchmark if the ACO is determined to have lower spending than the ACO's regional service area; or

(B) Using 35 percent of the difference between the average per capita amount of expenditures for the ACO's regional service area and the average per capita amount of the ACO's rebased historical benchmark if the ACO is determined to have higher spending than the ACO's regional service area.

(ii) For an ACO participating under the ENHANCED track—

(A) Using 35 percent of the difference between the average per capita amount of expenditures for the ACO's regional service area and the average per capita amount of the ACO's rebased historical benchmark if the ACO is determined to have lower spending than the ACO's regional service area; or

(B) Using 35 percent of the difference between the average per capita amount of expenditures for the ACO's regional service area and the average per capita amount of the ACO's rebased historical benchmark if the ACO is determined to have higher spending than the ACO's regional service area.

(4) The fourth or subsequent time that an ACO's benchmark is adjusted based on the ACO's regional service area expenditures, CMS calculates the regional adjustment as follows:

(i) For an ACO participating under the BASIC track, using 50 percent of the difference between the average per capita amount of expenditures for the ACO's regional service area and the average per capita amount of the ACO's rebased historical benchmark.

(ii) For an ACO participating under the ENHANCED track—

(A) Using 35 percent of the difference between the average per capita amount of

expenditures for the ACO's regional service area and the average per capita amount of the ACO's rebased historical benchmark if the ACO is determined to have lower spending than the ACO's regional service area; or

(B) Using 50 percent of the difference between the average per capita amount of expenditures for the ACO's regional service area and the average per capita amount of the ACO's rebased historical benchmark if the ACO is determined to have higher spending than the ACO's regional service area.

(5) To determine if an ACO has lower or higher spending compared to the ACO's regional service area, CMS does the following:

(i) Multiplies the difference between the average per capita amount of expenditures for the ACO's regional service area and the average per capita amount of the ACO's historical benchmark for each population of beneficiaries (ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, aged/non-dual eligible Medicare and Medicaid beneficiaries) as calculated under paragraph (c)(1) of this section by the applicable proportion of the ACO's assigned beneficiary population (ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, aged/non-dual eligible Medicare and Medicaid beneficiaries) for BY3 of the historical benchmark.

(ii) Sums the amounts determined in paragraph (f)(5)(i) of this section across the populations of beneficiaries (ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, aged/non-dual eligible Medicare and Medicaid beneficiaries).

(iii) If the resulting sum is a net positive value, the ACO is considered to have lower spending compared to the ACO's regional service area. If the resulting sum is a net negative value, the ACO is considered to have higher spending compared to the ACO's regional service area.

(iv) If during the term of the agreement period CMS adjusts the ACO's benchmark, as specified in § 425.652(a)(9), CMS redetermines whether the ACO is considered to have lower

spending or higher spending compared to the ACO's regional service area for purposes of determining the percentage in paragraphs (f)(1) through (4) of this section used in calculating the regional adjustment.

* * * * *

87. Section 425.658 is amended by—

a. Revising paragraph (c)(1) introductory text and paragraph (c)(2); and

b. In paragraph (d), removing the phrase "paragraph (c)(1) of this section" and adding in its place the phrase "paragraph (c) of this section".

The revisions read as follows:

§ 425.658 Calculating the prior savings adjustment to the historical benchmark.

* * * * *

(c) * * *

(1) For agreement periods beginning on or after January 1, 2024 and before January 1, 2027. If an ACO is eligible for the prior savings adjustment as determined in paragraph (b)(3) of this section, the prior savings adjustment will equal the lesser of the following:

* * * * *

(2) For agreement periods beginning on January 1, 2027, and in subsequent years. If an ACO is eligible for the prior savings adjustment as determined in paragraph (b)(3) of this section, the prior savings adjustment will equal the lesser of the following:

(i) 75 percent of the pro-rated average per capita amount computed in paragraph (b)(3)(ii) of this section.

(ii) A single per capita value that is calculated as follows:

(A) Calculate the product of the following for each Medicare enrollment type (ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, aged/non-dual eligible Medicare and Medicaid beneficiaries)—

(*1*) The national per capita expenditures for Parts A and B services under the original Medicare fee-for-service program in BY3 for assignable beneficiaries in that enrollment type identified for the 12-month calendar year corresponding to BY3 using data from the CMS Office of the Actuary; and

(*2*) The ACO's weighted average CMS-HCC risk score for that enrollment type for BY3.

(B) Calculate 5 percent of each enrollment type-specific product determined in paragraph (c)(2)(ii)(A) of this section.

(C) Calculate the single per capita value as a person-year weighted average by multiplying each of the enrollment type-specific values determined in accordance with paragraph (c)(2)(ii)(B) of this section by the proportion of the ACO's assigned beneficiaries within that particular enrollment type, and then summing the results.

* * * * *

88. Section 425.660 is revised to read as follows:

§ 425.660 Accountable Care Prospective Trend (ACPT).

(a) *General*. The methodology by which CMS calculates and adjusts a projected growth rate called the Accountable Care Prospective Trend (ACPT) is described in this section. CMS incorporates the ACPT into the blended update factor described in § 425.652(b) when updating an ACO's benchmark for each performance year of the agreement period, for agreement periods beginning on January 1, 2024, and in subsequent years.

(b) *Determination of ACPT.* An ACPT is a flat dollar amount calculated using one or more annualized growth rates based on national fee-for-service Medicare expenditures projected by the CMS Office of the Actuary. In determining the ACPT for a Medicare enrollment type for each performance year, CMS does all of the following:

(1) *Calculate annualized projected growth rates.* The annualized projected growth rates are calculated as an annual rate of growth in projected expenditures relative to the prior year. CMS projects annualized per capita growth in Parts A and B fee-for-service expenditures for

each performance year of the ACO's agreement period. In calculating the annualized projected growth rates, CMS does all of the following:

(i) Excludes IME and DSH payments, and the supplemental payment for IHS/Tribal hospitals and Puerto Rico hospitals.

(ii) Makes separate expenditure calculations for each of the following populations of beneficiaries:

(A) ESRD.

(B) Aged/Disabled.

(iii) Calculates one or more annualized projected growth rates for the ESRD population of beneficiaries described in paragraph (b)(1)(ii)(A) of this section, and one or more annualized growth rates for the Aged/Disabled population of beneficiaries described in paragraph (b)(1)(ii)(B) of this section, as follows:

(A) Using a uniform annualized projected rate of growth over each of the 5 performance years of the 5-year agreement period (for agreement periods beginning on or after January 1, 2024, and before January 1, 2027), or for each performance year (for agreement periods beginning on January 1, 2027, and in subsequent years), as applicable; or

(B) If annualization as specified in paragraph (b)(1)(iii)(A) of this section is determined not to reasonably fit the anticipated growth curve, CMS applies an alternative annualization technique using two or more annualized growth rates reflecting the projected rates of growth during the 5 performance years comprising the 5-year agreement period (for agreement periods beginning on or after January 1, 2024, and before January 1, 2027), or for each performance year (for agreement periods beginning on January 1, 2027, and in subsequent years), as applicable.

(2) *Calculate cumulative projected growth rate.* For each performance year, CMS calculates cumulative projected growth rates relative to the ACO's benchmark year (BY) 3, using the annualized projected growth rates, determined in accordance with paragraph (b)(1) of

this section, for each population of beneficiaries: the ESRD population and the Aged/Disabled population.

(3) *Express cumulative projected growth rate as a flat dollar amount.* For each performance year, CMS multiplies the applicable cumulative projected growth rate described in paragraph (b)(2) of this section by BY3 truncated national per capita fee-for-service Medicare expenditures for assignable beneficiaries for each Medicare enrollment type (ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, and aged/non-dual eligible Medicare and Medicaid beneficiaries) identified for the 12-month calendar year corresponding to BY3 to express the cumulative projected growth rate as a flat dollar amount as follows:

(i) The ESRD cumulative projected growth rate calculated in accordance with paragraph (b)(2) of this section is used for the ESRD population.

(ii) The Aged/Disabled cumulative projected growth rate calculated in accordance with paragraph (b)(2) of this section is used for the following populations: disabled, aged/dual eligible Medicare and Medicaid beneficiaries, and aged/non-dual eligible Medicare and Medicaid beneficiaries.

(4) *Risk adjust the flat dollar amount*. CMS adjusts the flat dollar amounts described in paragraph (b)(3) of this section for each performance year for differences in severity and case mix between the ACO's BY3 assigned beneficiary population and the national assignable FFS population for each Medicare enrollment type identified for the 12-month calendar year corresponding to BY3.

(5) *Calculate ACO-specific ACPT growth rates.* CMS divides the risk adjusted flat dollar amounts described in paragraph (b)(4) of this section by the ACO's historical benchmark expenditures described in § 425.652(a) for each Medicare enrollment type to calculate the percentage increase to be included in the blended update factor described in § 425.652(b)(4).

(6) *Timing of calculations.*

(i) For agreement periods beginning on or after January 1, 2024, and before January 1, 2027.

(A) At the beginning of the ACO's agreement period, CMS calculates the annualized projected growth rates for all performance years of the ACO's agreement period in accordance with paragraph (b)(1) of this section. These annualized projected growth rates will remain fixed over the ACO's agreement period.

(B) For a given performance year, CMS calculates an ACO-specific ACPT value, in accordance with paragraphs (b)(2) through (b)(5) of this section, using the annualized projected growth rates calculated at the beginning of the ACO's agreement period, as described in paragraph (b)(6)(i)(A) of this section.

(ii) For agreement periods beginning on January 1, 2027, and in subsequent years.

(A) In the calendar year preceding a given performance year, CMS calculates the annualized projected growth rates in accordance with paragraph (b)(1) of this section for that performance year.

(B) For a given performance year, CMS calculates an ACO-specific ACPT value, in accordance with paragraphs (b)(2) through (b)(5) of this section, using the annualized projected growth rates calculated in the preceding calendar year, as described in paragraph (b)(6)(ii)(A) of this section.

(c) *Recomputation of ACPT.* At financial reconciliation for a given performance year, CMS may recompute the ACO-specific ACPT value for a Medicare enrollment type initially determined at paragraph (b)(5) of this section for that performance year, to address under-projection or over-projection of the ACPT (as applicable), as follows:

(1) For agreement periods beginning on or after January 1, 2024, and before January 1, 2027.

(i) For performance year 2025 and subsequent performance years of the ACO's agreement period, CMS separately calculates for the ESRD and Aged/Disabled populations the

difference between the cumulative projected growth rates calculated in paragraph (b)(2) of this section and the cumulative observed growth in per capita expenditures for the national assignable FFS population.

(ii) For the ESRD and Aged/Disabled populations separately, if the difference calculated in paragraph (c)(1)(i) of this section is less (more negative) than -1.0 percentage point, CMS will recompute the ACO-specific ACPT value for the corresponding enrollment type(s) initially determined at paragraph (b)(5) of this section. CMS will calculate an ACO-specific ACPT value for the corresponding enrollment type(s), in accordance with paragraphs (b)(3) through (b)(5) of this section, using the cumulative observed growth in expenditures for the national assignable FFS population minus 1.0 percentage point.

(iii) For the ESRD and Aged/Disabled populations separately, if the difference calculated in paragraph (c)(1)(i) of this section is greater than (less negative) or equal to -1.0 percentage point, CMS will not recompute the ACO-specific ACPT value for the corresponding enrollment type(s) initially determined at paragraph (b)(5) of this section.

(2) For agreement periods beginning on January 1, 2027, and in subsequent years.

(i) CMS separately calculates for the ESRD and Aged/Disabled populations the difference between the cumulative projected growth rates calculated in paragraph (b)(2) of this section and the cumulative observed growth in per capita expenditures for the national assignable FFS population.

(ii) For the ESRD and Aged/Disabled populations separately, if the difference calculated in paragraph (c)(2)(i) of this section is less (more negative) than -1.0 percentage point, CMS will recompute the ACO-specific ACPT value for the corresponding enrollment type(s) initially determined at paragraph (b)(5) of this section. CMS will calculate an ACO-specific ACPT value for the corresponding enrollment type(s), in accordance with paragraphs (b)(3) through (b)(5) of this section, using the cumulative observed growth in expenditures for the national assignable FFS population minus 1.0 percentage point.

(iii) For the ESRD and Aged/Disabled populations separately, if the difference calculated in paragraph (c)(2)(i) of this section is greater than or equal to +1.5 percentage points, CMS will recompute the ACO-specific ACPT value for the corresponding enrollment type(s) initially determined at paragraph (b)(5) of this section. CMS will calculate an ACO-specific ACPT value for the corresponding enrollment type(s), in accordance with paragraphs (b)(3) through (b)(5) of this section, using the cumulative observed growth in expenditures for the national assignable FFS population plus 1.5 percentage point.

(iv) For the ESRD and Aged/Disabled populations separately, if the difference calculated in paragraph (c)(2)(i) of this section is between -1.0 and +1.5 percentage points, inclusive, CMS will not recompute the ACO-specific ACPT value for the corresponding enrollment type(s) initially determined at paragraph (b)(5) of this section.

89. Section 425.662 is amended by revising and republishing paragraph (b)(2) to read as follows:

§ 425.662 Calculating the population adjustment to the historical benchmark.

* * * * *

(b) * * *

(2)(i) For agreement periods beginning on January 1, 2025, or January 1, 2026. Calculates a scaler as the difference between 5 percent of the national per capita expenditure amount, expressed as single value as calculated in paragraph (b)(1) of this section, and the higher of: the regional adjustment, expressed as a single value as described in § 425.656(d); the per capita prior savings adjustment determined in § 425.658(c); or no adjustment, in the case where the regional adjustment is negative and the ACO is not eligible for the prior savings adjustment under § 425.658(b)(3)(i).

(ii) For agreement periods beginning on January 1, 2027, and in subsequent years. Calculates a scaler as the difference between the following:

(A) A single per capita value that is calculated as follows:

(*1*) Calculate the product of the following for each Medicare enrollment type (ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, aged/non-dual eligible Medicare and Medicaid beneficiaries):

(*i*) The national per capita expenditures for Parts A and B services under the original Medicare fee-for-service program in BY3 for assignable beneficiaries in that enrollment type identified for the 12-month calendar year corresponding to BY3 using data from the CMS Office of the Actuary.

(*ii*) The ACO's weighted average CMS-HCC risk score for that enrollment type for BY3.

(*2*) Calculate 5 percent of each enrollment type-specific product determined in paragraph (b)(2)(ii)(A)(*1*) of this section.

(*3*) Calculate a single per capita value as a person-year weighted average by multiplying each of the enrollment type-specific values determined in accordance with paragraph (b)(2)(ii)(A)(*2*) of this section by the proportion of the ACO's assigned beneficiaries within that particular enrollment type, then summing the results.

(B) The highest among—

(*1*) The regional adjustment, expressed as a single value as described in § 425.656(d);

(*2*) The per capita prior savings adjustment determined in § 425.658(c); or

(*3*) No adjustment, in the case where the regional adjustment is negative and the ACO is not eligible for the prior savings adjustment under § 425.658(b)(3)(i).

* * * * *

90. Section 425.664 is added to read as follows:

§ 425.664 Calculating the growth adjustment to the historical benchmark

(a) *General*. This section describes the methodology for calculating the growth adjustment to the historical benchmark for agreement periods beginning on January 1, 2027, and in subsequent years.

(b) *Determine an ACO's new growth share of assigned beneficiary person years*.

(1) *Identify shared savings initiatives for the growth adjustment.* CMS means, for purposes of this part, an initiative implemented by CMS, including the following options and initiatives—

(i) The Shared Savings Program;

(ii) The Innovation Center ACO models; or

(iii) Other initiatives that may be specified by CMS.

(2) *Identify ACO professionals who are inexperienced in shared savings initiatives*. CMS determines that an ACO professional is inexperienced in a shared savings initiative if the ACO professional has not billed primary care services through a participant in the Shared Savings Program, or participated in an Innovation Center ACO model, or other initiative specified by CMS in financial reconciliation for one or more performance years under such initiative during any of the 5 performance years directly preceding the start of the current agreement period.

(3) *Identify beneficiaries who are inexperienced with shared savings initiatives assigned to the ACO*. CMS determines that a beneficiary assigned to an ACO is inexperienced with shared savings initiatives if the beneficiary was not included in assignment in financial reconciliation to an ACO in the Shared Savings Program, Innovation Center ACO model, or other initiative specified by CMS in the performance year that corresponds to the ACO's BY3.

(4) *Calculate an ACO's new growth for the applicable performance year*. CMS calculates an ACO's new growth as follows:

(i) CMS determines the number of beneficiary person years for beneficiaries who are inexperienced with shared savings initiatives (as determined under paragraph (b)(3) of this section) with an ACO professional who is inexperienced with shared savings initiatives (as determined under paragraph (b)(2) of this section) as the ACO professional who provided the highest number of primary care services at the ACO within the assignment window, or to whom the beneficiary was voluntarily aligned, in the performance year as follows:

(A) Count the primary care services (as defined at § 425.20) each assigned beneficiary

who is inexperienced with shared savings initiatives (as determined under paragraph (b)(3) of this section) has with each ACO professional participating in the ACO within the assignment window, or to whom the beneficiary was voluntarily aligned for the applicable performance year.

(B) For the purposes of this calculation, attribute the assigned beneficiary who is inexperienced with shared savings initiatives (as determined under paragraph (b)(3) of this section) to the ACO professional with whom the beneficiary had the highest number of primary care services (as defined at § 425.20) for the applicable performance year.

(C) CMS counts, as new growth for the performance year, the number of beneficiary person years for beneficiaries who are inexperienced with shared savings initiatives (as determined under paragraph (b)(3) of this section) and who received the highest number of primary care services (as defined at § 425.20) for the applicable performance year from an ACO professional who is inexperienced with shared savings initiatives (as determined under paragraph (b)(2) of this section).

(ii) [Reserved]

(c) *Determine an ACO's overall growth assigned beneficiary person years*. CMS calculates an ACO's overall growth as the number of assigned beneficiary person years in the performance year minus the number of assigned beneficiary person years in the performance year that corresponds to the ACO's BY3. If the ACO is a new entrant or re-entering ACO, the overall growth is equal to the number of assigned beneficiary person years in the performance year.

(d) *Determine an ACO's capped new growth for the performance year*. An ACO's new growth is the lesser of an ACO's new growth (as determined in paragraph (b) of this section) and an ACO's overall growth (as determined in paragraph (c) of this section).

(e) *Apply the minimum new growth thresholds for the performance year*. CMS applies the minimum new growth threshold for each performance year, expressed in absolute terms and relative terms. CMS determines the minimum new growth threshold that applies as the lesser of

the relative minimum new growth threshold multiplied by the number of total assigned beneficiary person years and the absolute minimum new growth threshold. The absolute minimum new growth threshold and the relative minimum new growth threshold are as follows:

TABLE 1 TO PARAGRAPH (e)

	PY 1	PY 2	PY 3	PY 4	PY 5
Absolute Minimum New Growth Threshold	100	300	600	900	1200
Relative Minimum New Growth Threshold	0.5%	1.5%	3.5%	5.5%	7.5%

(f) *Calculate the new growth above the minimum and below the cap for the performance year*. CMS calculates the new growth above the minimum and below the cap for each performance year as the difference between an ACO's capped new growth for the applicable performance year (as determined under paragraph (d) of this section) and the minimum new growth threshold applied for the performance year (as determined under paragraph (e) of this section), or zero, if negative. The ACO is eligible for a growth adjustment for the applicable performance year if the new growth above the minimum and below the cap is greater than zero.

(g) *Calculate the new growth share for the performance year.* CMS calculates the new growth share for the performance year as the new growth above the minimum and below the cap in the performance year (as determined under paragraph (f) of this section) divided by the total assigned beneficiary person years in the performance year.

(h) *Determine ACO's incentive factor.* The ACO's incentive factor is an ACO-specific per capita dollar amount calculated as 5 percent of the per capita historical benchmark expressed as a single value before the application of the adjustments to the historical benchmark specified at § 425.652(a)(8)(ii) (as applicable).

(i) *Determine the ACO's growth adjustment to the historical benchmark.*

(1) CMS calculates the growth adjustment to the historical benchmark as the product of the ACO's new growth share (as determined under paragraph (g) of this section) and the ACO's incentive factor (as determined under paragraph (h) of this section).

(2) The per capita dollar amount for a Medicare enrollment type is capped at 5 percent of

the product of the following—

(i) The national per capita expenditure amount for the enrollment type for BY3; and

(ii) The ACO's weighted average CMS-HCC risk score for the enrollment type for BY3.

§ 425.672 [Amended]

91. Section 425.672 is amended in paragraph (c)(2)(iv) by removing the reference "§ 425.658(c)(1)(ii)" and adding in its place the references "§ 425.658(c)(1)(ii) and (c)(2)(ii)".

§ 425.702 [Amended]

92. Section 425.702 is amended in paragraph (c)(1)(iii) introductory text by removing the phrase "For performance year 2024 and subsequent performance years," and adding in its place the phrase "For performance years 2024 through 2026,".

PART 427—MEDICARE PART B DRUG INFLATION REBATE PROGRAM

93. The authority citation for part 427 continues to read as follows:

Authority: 42 U.S.C. 1395w-3a(i), 1302, and 1395hh.

94. Section 427.20 is amended by revising the definition of "First marketed date" to read as follows:

§ 427.20 Definitions.

* * * * *

First marketed date means the earliest date of first sale of any NDC-11 within a billing and payment code among all products and package sizes under the same FDA application. The first marketed date will be identified using ASP data reported by NDC-11 to CMS by a manufacturer as required under sections 1927(b)(3)(A)(iii)(I) and 1847A(f)(2) of the Act, if available. If ASP date are not available, the first marketed date will be identified using an alternative public source, such as the NDC Directory.

95. Section 427.101 is amended by revising paragraph (b)(5) to read as follows.

§ 427.101 Identification of the Part B rebatable drugs.

(b) * * *

(5) *Skin substitutes*. A product included within the suite of cellular- and tissue-based products that aid wound healing, other than skin substitute products that are licensed as a drug or biological product under section 351 of the Public Health Service Act.

96. Section 427.302 is amended by adding paragraph (e)(6) and revising paragraph (f) to read as follows.

§ 427.302 Calculation of the per unit Part B rebate.

* * * * *

(e) * * *

(6) For paragraphs (e)(2) through (e)(5) of this section, in the event CPI-U data are unavailable for the month described in such paragraph, CMS will use the first month for which CPI-U data are available following the month for which CPI-U data are unavailable.

(f) *Identification of the rebate period CPI-U.* For each Part B rebatable drug by billing and payment code, CMS will identify and use the greater of the benchmark period CPI-U index level or the CPI-U index level for the first month of the calendar quarter that is 2 calendar quarters before the applicable calendar quarter in which the Part B rebatable drug is furnished.

(1) In the event CPI-U data are unavailable for the month described in such paragraph, CMS will use the first month for which CPI-U data are available following the month for which CPI-U data are unavailable.

(2) [Reserved].

PART 428--MEDICARE PART D DRUG INFLATION REBATE PROGRAM

97. The authority citation for part 428 continues to read as follows:

Authority: 42 U.S.C. 1395w-114b, 1302, and 1395hh.

98. Section 428.20 is amended by revising the definition of "Applicable period Consumer Price Index for All Urban Consumers (CPI-U)" to read as follows.

§ 428.20 Definitions.

* * * * *

Applicable period Consumer Price Index for All Urban Consumers (CPI-U) means, with respect to an applicable period, the CPI-U for the first month of such applicable period (that is, October). In the case where the first month's CPI-U data are unavailable, CMS will use the first month for which CPI-U data are available following the month for which CPI-U data are unavailable.

99. Section 428.202(e) is amended by adding paragraph (e)(6) to read as follows.

§ 428.202 Calculation of the per unit Part D rebate amount.

* * * * *

(e) * * *

(6) For paragraphs (e)(2) through (e)(5) of this section, in the event CPI-U data are unavailable for the month described in such paragraph, CMS will use the first month for which CPI-U data are available following the month for which CPI-U data are unavailable.

100. Section 428.203 is amended by adding paragraph (c) to read as follows.

§ 428.203 Determination of the total number of units dispensed under Part D.

* * * * *

(c) *Data reporting requirement.*

(1) Beginning with claims with a date of service on or after January 1, 2027, a provider or supplier that is a covered entity as defined at § 10.3 must submit the data elements associated with each claim for a covered Part D drug billed to Medicare Part D for which such covered entity or its contractor(s) (such as contract pharmacies) dispensed units of a drug for which a manufacturer provides a discount under the 340B Program to such covered entity:

(i) Date of service.

(ii) Prescription or service reference number.

(iii) Fill number.

(iv) Dispensing pharmacy NPI.

(v) NDC-11.

(2) In addition to submitting the data elements set forth in paragraph (c)(1) of this section, such provider or supplier must submit its 340B ID and name as designated in the 340B Office of Pharmacy Affairs Information System (OPAIS) database.

(3) The data elements and information set forth in paragraphs (c)(1) and (2) of this section must be submitted on a quarterly basis and in a form and manner specified by CMS in accordance with the following timelines:

(i) Data elements and information associated with claims with dates of service during the first calendar quarter must be submitted by the close of the second calendar quarter.

(ii) Data elements and information associated with claims with dates of service during the second calendar quarter must be submitted by the close of the third calendar quarter.

(iii) Data elements and information associated with claims with dates of service during the third calendar quarter must be submitted by the close of the fourth calendar quarter.

(iv) Data elements and information associated with claims with dates of service during the fourth calendar quarter must be submitted by the close of the first calendar quarter of the immediately following calendar year.

(4) Data elements and information submitted in accordance with paragraph (c)(3) of this section that is either incomplete or contains invalid data must be resubmitted at a later time in a form and manner specified by CMS.

PART 512--STANDARD PROVISIONS FOR MANDATORY INNOVATION CENTER MODELS AND SPECIFIC PROVISIONS FOR CERTAIN MODELS

101. The authority citation for part 512 continues to read as follows:

Authority: 42 U.S.C. 1302, 1315a, and 1395hh.

102. Section 512.705 is amended by—

a. Revising the definition for “ASM beneficiary” and “Dual eligible proportion”; and

b. Adding definitions for “PECOS” and “Rural area” in alphabetical order.

The revisions and additions read as follows:

§ 512.705 Definitions.

* * * * *

ASM beneficiary means a Medicare FFS beneficiary who is being treated by an ASM participant for an ASM targeted chronic condition.

* * * * *

Dual eligible proportion means the share of an ASM participant's beneficiaries who are dually eligible Medicare beneficiaries.

* * * * *

PECOS stands for the Provider Enrollment, Chain, and Ownership System.

* * * * *

Rural area has the same meaning as the term is defined at 42 CFR 414.1305 under MIPS.

* * * * *

103. Section 512.710 is amended by—

a. Revising paragraph (a)(1) introductory text;

b. Revising paragraphs (a)(2) and (c);

c. Revising the introductory text of paragraphs (d)(1) and (d)(2); and

d. Adding paragraph (h).

The revisions and additions read as follows:

§ 512.710 Participant eligibility and selection.

(a) * * *

(1) A clinician selected by CMS as an ASM participant for any ASM performance year and who furnishes covered services during any applicable ASM performance year remains an ASM participant for the duration of the ASM test period unless CMS either terminates ASM in accordance with § 512.165 or the ASM participant receives notice of termination as described in paragraph (h) of this section.

* * * * *

(2) *Effect of not meeting ASM participant eligibility criteria for an ASM performance year.* For any ASM performance year within the ASM test period that an ASM participant does not meet the criteria for mandatory participation set forth in this section, the ASM participant is—

(i) Not subject to §§ 512.715, 512.720, and 512.745 for the applicable ASM performance year;

(ii) Not subject to § 512.750 for the corresponding ASM payment year;

(iii) Not eligible for the waivers described in § 512.775 for the applicable ASM performance year; and

(iv) Not eligible for the CMS-sponsored model arrangements and patient incentives safe harbor described in § 512.765 with respect to remuneration attributable to the applicable ASM performance year; and

* * * * *

(c) *Exceptions to specific ASM performance requirements.*

(1) *Exceptions.* CMS may in its sole discretion determine that an ASM participant who meets the requirements described in paragraph (c)(1)(i) or (c)(1)(ii) is excepted from model requirements as described in paragraph (c)(2) of this section for the duration specified in paragraph (c)(3) of this section.

(i) *Exception based on change in TIN.* An ASM participant stops reassigning billing rights to the TIN that CMS used to select the ASM participant for the applicable ASM performance year and satisfies the written notice requirements in paragraph (c)(1)(i)(A) or (c)(1)(i)(B) of this section.

(A) *Notification of change in TIN before an ASM performance year.* An ASM participant who stops reassigning billing rights to the TIN that CMS used to select the ASM participant before the applicable ASM performance year must provide written notice of the change to CMS in a form and manner determined by CMS no later than 60 days after the start of the applicable

ASM performance year.

(B) *Notification of change in TIN during an ASM performance year*. An ASM participant who stops reassigning billing rights to the TIN that CMS used to select the ASM participant during an applicable ASM performance year must provide written notice of the change to CMS in a form and manner determined by CMS within 30 days of the effective date of the termination of reassignment to the ASM participant's TIN.

(ii) *Exception based on ASM heart failure participant specialty type redesignation*. An ASM heart failure participant redesignates their primary specialty type through the applicable paper CMS-855 form or Internet-based PECOS before or during the applicable ASM performance year to a specialty type described in paragraph (c)(1)(ii)(A) and satisfies the written notice requirements in paragraph (c)(1)(ii)(B) of this section.

(A) S*pecialty type redesignations for ASM heart failure participants.*

(*1*) Cardiac Electrophysiology.

(*2*) Cardiac Surgery.

(*3*) Interventional Cardiology.

(*4*) Advanced Heart Failure and Transplant Cardiology.

(*5*) Adult Congenital Heart Disease

(B) *Notification of specialty type redesignation.* An ASM heart failure participant who redesignates their primary specialty type through the applicable paper CMS-855 form or Internet-based PECOS before or during the applicable ASM performance year as described in paragraph (c)(1)(ii) of this section must provide written notice of the CMS-approved redesignation together with verification of board certification in the newly designated primary specialty type to CMS in a form and manner determined by CMS within 30 days of the effective date of the CMS-approved redesignation.

(2) *Effect of exception.* If CMS determines an ASM participant meets an exception under paragraph (c)(1) of this section, the ASM participant is—

(i) Not subject to §§ 512.715, 512.720, and 512.745 for the applicable ASM performance year;

(ii) Not subject to § 512.750 for the corresponding ASM payment year;

(iii) Not eligible for the waivers described in § 512.775 for the applicable ASM performance year;

(iv) Not eligible for the CMS-sponsored model arrangements and patient incentives safe harbor described at § 512.765 with respect to remuneration attributable to the period beginning on the CMS-determined date of the exception described in paragraph (c)(3) of this section.

(3) *Duration of exception.*

(i) An exception under paragraph (c)(1)(i) of this section is effective on the CMS-determined date and applies for the ASM performance year specified by CMS.

(ii) An exception under paragraph (c)(1)(ii) of this section is effective on the CMS-determined date and applies for the ASM performance year specified by CMS and for the remainder of the ASM test period.

(d) * * *

(1) Heart failure specialty type—

* * * * *

(2) Low back pain specialty type—

* * * * *

(h) *Termination*.

(1) CMS may in its sole discretion terminate an ASM participant's participation in the model immediately or upon advance notice if CMS determines:

(i) One or more grounds for remedial action described in § 512.160(a) have occurred with respect to the ASM participant; or

(ii) The ASM participant's continued participation would be inconsistent with the purposes of ASM, the requirements of this part, or applicable law.

104. Section 512.720 is amended by—

a. Revising paragraphs (a)(1)(i), (a)(ii)(B), and (e); and

b. Removing paragraph (f).

The revisions read as follows:

§ 512.720 Data submission requirements.

(a) * * *

(1) * * *

(i) * * *

(A) Include numerator and denominator data for at least one applicable quality measure described in § 512.725(b) or (c) that is not an administrative claims-based collection type and that meets the data completeness requirement as specified at § 512.725(f); and

(B) Except as provided in paragraph (a)(1)(i)(C) of this section, be submitted at the TIN/NPI level.

(C) An ASM participant who is in a small practice may submit quality ASM performance category data at either the TIN/NPI or the TIN level.

(ii) * * *

(B) Be submitted at either the TIN/NPI or TIN level;

* * * * *

(e) * * *

(1) *Quality ASM performance category.*

(i) If CMS receives multiple data submissions in the quality ASM performance category in accordance with paragraph (a)(1)(i) of this section from submitters in multiple organizations (for example, qualified registry, practice administrator, or EHR vendor) for an individual ASM participant, CMS scores each submission and assigns the highest score.

(ii) If CMS receives multiple data submissions for the quality ASM performance category in accordance with paragraph (a)(1)(i) of this section from one or more submitters in the same

organization for an individual ASM participant, CMS scores the most recent submission and assigns that score.

(iii) If CMS receives a TIN-level data submission in the quality ASM performance category in accordance with paragraph (a)(1)(i) of this section for an ASM participant in a small practice, CMS scores the TIN-level submission and assigns that score to all individual ASM participants in the small practice, regardless of any TIN/NPI-level submission(s) received for one or more of those ASM participants.

(2) *Improvement activities ASM performance category.*

(i) If CMS receives multiple data submissions in the improvement activities ASM performance category in accordance with paragraph (a)(1)(ii) of this section from submitters in multiple organizations (for example, qualified registry, practice administrator, or EHR vendor) for an individual ASM participant, CMS scores each submission and assigns the highest score.

(ii) If CMS receives multiple data submissions in the improvement activities ASM performance category in accordance with paragraph (a)(1)(ii) of this section from one or more submitters in the same organization for an individual ASM participant, CMS scores the most recent submission and assigns that score.

(3) *Promoting Interoperability ASM performance category.*

(i) For multiple data submissions received for the Promoting Interoperability ASM performance category in accordance with paragraph (a)(1)(iii) of this section, CMS calculates a score for each submission and assigns the highest of the scores.

* * * * *

105. Section 512.725 is amended by—

a. Revising paragraph (c)(4);

b. Adding paragraphs (c)(5), (e)(3)(i), and adding and reserving paragraph (e)(3)(ii);

c. Revising paragraphs (f)(3), (h)(1)(i), (h)(2) introductory text, and (h)(2)(i) introductory text;

d. Removing paragraph (h)(2)(iii);

e. Redesignating paragraph (h)(2)(iv) as paragraph (h)(2)(iii); and

f. Adding new paragraphs (h)(2)(iv) and (i).

The revisions and additions read as follows:

§ 512.725 Quality ASM performance category.

* * * * *

(c) * * *

(4) Functional Outcome Assessment (MIPS Q182).

(5) Magnetic Resonance Imaging (MRI) Lumbar Spine for Low Back Pain (modified for ASM).

* * * * *

(e) * * *

(3) * * *

(i) For ASM participants in small practices, CMS scores all administrative claims-based quality measures at the TIN/NPI level according to the measure specifications for the applicable ASM performance year.

(ii) [Reserved].

* * * * *

(f) * * *

(3) CMS excludes from an ASM participant’s total measure achievement points and total available measure achievement points any measure required under paragraph (b) or (c) of this section that meets the respective measure's data completeness requirement but does not have a benchmark.

* * * * *

(h) * * *

(1) * * *

(i) For each ASM performance year, an ASM participant receives between 1 and 10 measure achievement points (including partial points) for each measure specified in paragraph (b) or (c) of this section that satisfies the requirements described in paragraph (h)(1)(i)(A) or (h)(1)(i)(B) of this section, as applicable.

(A) For each measure other than an administrative claims-based quality measure under the quality ASM performance category on which data is submitted in accordance with paragraph (e) of this section, the measure must do all of the following:

(*1*) Have a benchmark specified in paragraph (h)(2) of this section.

(*2*) Meet the case minimum requirements specified in paragraph (g) of this section.

(*3*) Meet the data completeness criteria specified in paragraph (f) of this section.

(B) For each administrative claims-based quality measure calculated by CMS under the quality ASM performance category, the measure must have a benchmark as specified in paragraph (h)(2) of this section and meet the case minimum requirements specified in paragraph (g) of this section.

* * * * *

(2) *Benchmarks for quality ASM performance category.*

(i) CMS bases benchmarks on an ASM participant's performance by collection type, from one of the following data sources:

* * * * *

(iv) CMS excludes from an ASM participant’s total measure achievement points and total available measure achievement points any measure required under paragraphs (b) or (c) of this section that does not have a benchmark.

* * * * *

(i) *Voluntary submission of patient-reported outcome data.* For any ASM cohort and ASM performance year for which CMS specifies that a voluntary patient-reported outcome data submission is available, CMS may add 5 additional points to the ASM participant's quality ASM

performance category score for the ASM participant's voluntary submission of patient-reported outcome data that meets the applicable requirements set forth in paragraph (i)(1) of this section for any CMS-specified data collection period. Additional points awarded under this paragraph are added to the ASM participant's total measure achievement points calculated under paragraph (h)(4)(i) of this section, subject to the limitation set forth under paragraph (h)(4)(i)(B) of this section.

(1) *Requirements for successful voluntary submission of patient-reported outcome data.* To be eligible to receive the additional points for the quality ASM performance category for the applicable ASM performance year described in paragraph (i) of this section, an ASM participant must submit all of the following:

(i) Baseline assessment data for at least 20 ASM beneficiaries for a first CMS-specified data collection period or follow-up assessment data for at least 20 ASM beneficiaries who received a baseline assessment during the preceding data collection period.

(ii) All data elements for the applicable voluntary patient-reported outcome instrument for each required assessment, as specified and in a form and manner determined by CMS, for the applicable data collection period.

(iii) Data on all risk variables, as specified and in a form and manner determined by CMS, for each ASM beneficiary from whom an ASM participant voluntarily collects patient-reported outcome data during the applicable data collection period.

(iv) The voluntary patient-reported outcome data in a form and manner determined by CMS by the data submission deadline for the applicable ASM performance year as described at § 512.720(d).

(2) *Correction and resubmission of voluntary patient-reported outcome data.*

(i) An ASM participant may correct or resubmit any data needed to meet the voluntary data submission requirements described in paragraph (i)(1) of this section.

(ii) CMS does not accept new submissions, corrected submissions, or resubmissions of

voluntary patient-reported outcome data after the applicable data submission deadline described in paragraph (i)(1)(iv) of this section.

(3) *Timely error notice for determination of quality ASM performance category scoring incentive.* An ASM participant may submit a written timely error notice as described at § 512.755 if the ASM participant believes an error occurred in CMS' determination of whether the ASM participant met the requirements described in paragraph (i)(1) of this section to receive the additional quality ASM performance category points described in paragraph (i) of this section for the applicable ASM performance year as provided to an ASM participant by CMS in an ASM performance report.

106. Section 512.740 is amended by—

a. Revising paragraphs (b)(2)(ii), (b)(2)(iv), and (b)(3)(i)(C);

b. Removing paragraph (b)(3)(ii);

c. Redesignating paragraph (b)(3)(iii) as paragraph (b)(3)(ii);

d. Removing paragraph (b)(4)(i);

e. Redesignating paragraph (b)(4)(ii) as paragraph (b)(4)(i) and reserving paragraph (b)(4)(ii);

f. Revising newly redesignated paragraph (b)(4)(i);

g. Redesignating paragraph (c)(2) as paragraph (c)(3); and

h. Adding new paragraph (c)(2).

The revisions and addition read as follows:

§ 512.740 Promoting Interoperability ASM performance category.

* * * * *

(b) * * *

(2) * * *

(ii) An ASM participant must fulfill the Health Information Exchange objective through the following:

(A) For each ASM performance year, report one of the following options:

(1) Support Electronic Referral Loops by Sending Health Information (Measure ID # PI_HIE_1) and Support Electronic Referral Loops by Receiving and Reconciling Health Information (Measure ID # PI_HIE_4).

(2) Health Information Exchange (HIE) Bi-Directional Exchange (Measure ID # PI_HIE_5).

(3) Enabling Exchange Under the Trusted Exchange Framework and Common Agreement (TEFCA) (Measure ID # PI_HIE_6).

(B) For the 2027 ASM performance year, an ASM participant may, but is not required to, report the Electronic Prior Authorization measure (Measure ID # PI_HIE_7).

(C) Beginning with the 2028 ASM performance year, an ASM participant must report both measures described in paragraphs (b)(2)(ii)(C)*(1)* and (b)(2)(ii)(C)*(2)* of this section, report one measure and claim one exclusion, or claim exclusions to both measures:

(1) Electronic Prior Authorization (Measure ID # PI_HIE_7).

(2) Electronic Prior Authorization for Prescription Drugs (Measure ID # PI_HIE_8).

* * * * *

(iv) An ASM participant must fulfill the Public Health and Clinical Data Exchange objective by reporting both measures described in paragraphs (b)(2)(iv)(A) and (b)(2)(iv)(B) of this section, reporting one measure and claiming one exclusion, or claiming exclusions to both measures:

(A) Immunization Registry Reporting (Measure ID # PI_PHCDRR_1).

(B) Electronic Case Reporting (Measure ID # PI_PHCDRR_3).

* * * * *

(3) * * *

(i) * * *

(C) An exclusion for each measure that includes an option for an exclusion.

(ii) Submit an affirmative attestation regarding the ASM participant's completion of the annual self-assessment checklist under the MIPS Promoting Interoperability High Priority Practices Guide of the SAFER Guides measure (Measure ID# PI_PPHI_2) within the calendar year of the ASM performance year.

(4) * * *

(i) *Actions to limit or restrict the compatibility or interoperability of CEHRT*. To fulfill ASM requirements for activities related to limiting or restricting the compatibility or interoperability of CEHRT, an ASM participant must not knowingly and willfully take action, such as disabling functionality, to limit or restrict the compatibility or interoperability of CEHRT.

(ii) [Reserved].

* * * * *

(c) * * *

(2) *Promoting Interoperability measure suppression.* If certain circumstances occur that impact CMS' assessment of the performance of ASM participants on a measure specified for the Promoting Interoperability ASM performance category, CMS may in its sole discretion suppress the affected measure by excluding it from CMS' assessment of ASM participant performance while allocating the maximum points available or providing full credit for the affected measure as long as the affected measure is reported, resulting in a suppressed measure contributing to the Promoting Interoperability ASM performance category objective score under paragraph (c)(3) of this section; or excluding it from the determination of a meaningful EHR user if the affected measure is not scored. CMS determines whether certain circumstances exist that warrant suppression of a measure based on CMS' consideration of one or more of the following factors:

(i) The nature, breadth, and duration of the circumstances' effect on ASM participants' ability to fulfill the measure requirement.

(ii) The availability of certified health IT modules to fulfill the measure.

(iii) The circumstance affects the measure such that calculating the measure score would lead to misleading or inaccurate results, which may include performance or compliance.

(iv) Out-of-date or conflicting technical standards.

(v) Technical and operational capacity of required partners.

(vi) Other factors as determined by CMS.

* * * * *

107. Section 512.745 is amended by—

a. Revising paragraph (a) introductory text and paragraph (a)(2)(iii)(B);

b. Redesignating paragraph (a)(5) as paragraph (a)(6);

c. Adding new paragraph (a)(5);

d. Revising newly redesignated paragraph (a)(6);

e. Revising paragraphs (b)(2) through (b)(6); and

f. Adding paragraphs (b)(7) and (b)(8).

The revisions and additions read as follows:

§ 512.745 Final scoring.

(a) *Final score calculation.* CMS calculates a final score of zero to 100 points using the formula specified at paragraph (a)(6) of this section for each ASM participant that meets the requirements to receive a final score as specified in paragraph (a)(2) of this section.

* * * * *

(2) * * *

(iii) * * *

(B) Do not receive either a—

(*1*) Quality ASM performance category score under § 512.725(h)(4)(iii); or

(*2*) Cost ASM performance category score under § 512.730(e)(3)(i).

* * * * *

(5) *Rural scoring adjustment*.

(i) *Scoring adjustment for an ASM participant in a rural area.* CMS adds 5 points to the final score of an ASM participant who is in a rural area as defined at § 512.705 and meets the requirements to receive a final score greater than zero as described in paragraph (a)(2)(i) of this section for an applicable ASM performance year.

(6) *Final score formula.* Final score = [(quality ASM performance category score × quality ASM performance category weight) + (cost ASM performance category score × cost ASM performance category weight)] × 100 + improvement activities ASM performance category scoring adjustment + Promoting Interoperability ASM performance category scoring adjustment + complex patient scoring adjustment + small practice scoring adjustment + rural scoring adjustment. The final score cannot be below zero points or exceed 100 points.

(b) * * *

(2) The ASM participant's quality ASM performance category scoring incentive for voluntary reporting of patient-reported outcome data under § 512.725(i), as applicable.

(3) The ASM participant's complex patient scoring adjustment under paragraph (a)(3) of this section, as applicable.

(4) The ASM participant's small practice or solo practitioner scoring adjustment under paragraph (a)(4) of this section, as applicable.

(5) The ASM participant's rural scoring adjustment under paragraph (a)(5) of this section, as applicable.

(6) The ASM participant's final score, as applicable.

(7) The ASM payment adjustment factor under § 512.750(c)(1).

(8) The ASM payment multiplier under § 512.750(c).

* * * * *

108. Section 512.750 is amended by revising paragraphs (f)(1) and (f)(2) to read as follows:

§ 512.750 Payment adjustment.

* * * * *

(f) * * *

(1) If an NPI submits Part B covered professional service claims during an ASM payment year under a different TIN than the TIN CMS selected them as an ASM participant for that same ASM performance year and to which the NPI began assigning billing rights after the applicable ASM performance year but before the end of the corresponding ASM payment year, CMS multiplies the amount otherwise paid under Part B for covered professional services to the different TIN by the ASM payment multiplier calculated for the ASM participant based on their performance in the corresponding ASM performance year.

(2) CMS multiplies the amount otherwise paid under Part B for covered professional services by the highest ASM payment multiplier calculated for an NPI who meets all the following:

(i) Is an ASM participant under multiple TINs for a given ASM performance year.

(ii) Submits Part B covered professional service claims during an ASM payment year under a TIN by which CMS did not select the NPI as an ASM participant and to which the ASM participant began reassigning billing rights after the applicable ASM performance year but before the end of the corresponding ASM payment year.

* * * * *

109. Section 512.765 is amended by adding paragraph (c) to read as follows:

§ 512.765 Application of the CMS-sponsored model arrangements and patient incentives safe harbor.

* * * * *

(c) *Scope.* The CMS-sponsored model arrangements and patients incentives safe harbor described in paragraphs (a) and (b) of this section is available only with respect to remuneration exchanged or furnished in connection with an ASM participant's performance under the model and does not apply with respect to remuneration attributable to any period for which CMS

determines the ASM participant does not meet ASM participant eligibility criteria under § 512.710(a)(2) or is excepted from specified ASM requirements under § 512.710(c).

110. Section 512.771 is amended by—

a. Revising paragraphs (a)(1), (a)(2), (a)(5), and (a)(6);

b. Redesignating paragraphs (a)(7) and (a)(8) as paragraphs (d)(2) and (d)(3), respectively.

c. Redesignating paragraphs (a)(9) through (13) as (a)(7) through (11), respectively.

d. Revising newly redesignated paragraphs (a)(7) and (a)(9); and

e. Adding paragraph (d).

The revisions and additions read as follows:

§ 512.771 Collaborative care arrangements.

(a) * * *

(1) The collaborative care arrangement must be in writing, signed by all parties, specify the effective date, and be exclusively between one or more ASM participants who reassign billing rights through the same TIN and a primary care practice.

(2) The primary care practice party and an ASM participant party to the collaborative care arrangement must share one or more patients who are ASM beneficiaries.

* * * * *

(5) All parties to the collaborative care arrangement must comply with the provisions of this section and all other applicable statutes, regulations, and guidance.

(6) Neither the opportunity to enter into a collaborative care arrangement nor remuneration given or received under a collaborative care arrangement may be conditioned directly or indirectly on the volume or value of past or anticipated referrals or business generated by, between, or among the parties to the collaborative care arrangement or any other person. A selection criterion that considers whether an ASM participant and primary care practice share one or more ASM beneficiaries for the purpose of satisfying the requirement set forth in

paragraph (a)(2) of this section will be deemed not to violate the volume or value standard of this section if the purpose of the criterion is to further the purpose of the collaborative care arrangement.

(7) All parties to the collaborative care arrangement must retain the ability to make decisions in the best interests of ASM beneficiaries, including the selection of clinicians, devices, supplies, and treatments.

* * * * *

(9) An ASM participant must maintain contemporaneous documentation, in accordance with § 512.135, regarding all collaborative care arrangements entered into, including the following:

(i) The relevant written agreements.

(ii) Records of all remuneration exchanged, if any, for each ASM participant party to a collaborative care arrangement, including, at a minimum, all of the following:

(A) A description of the remuneration.

(B) The value of remuneration.

(C) The methodology for determining the value of any in-kind remuneration in accordance with paragraph (d)(2)(ii) of this section, if applicable.

(D) The date on which the remuneration was exchanged.

(iii) The identity of each ASM participant who is a party to the collaborative care arrangement.

* * * * *

(d) *Remuneration under a collaborative care arrangement.* If the parties to a collaborative care arrangement elect to include terms allowing for the exchange of remuneration under the collaborative care arrangement, the parties must also comply with all of the following:

(1) The purpose of the exchange of remuneration under the collaborative care arrangement must be reasonably related to the purpose of the collaborative care arrangement, consistent with the requirements of paragraph (a)(3) of this section.

(2) The total amount of any remuneration exchanged under a collaborative care arrangement in a given ASM performance year must not exceed an amount equal to the ASM participant's ASM payment adjustment factor for the applicable ASM performance year multiplied by the amount otherwise paid to the ASM participant by CMS under Part B for covered professional services during the applicable ASM performance year.

(i) The collaborative care arrangement must specify a methodology for the parties to identify and calculate the total amount of remuneration exchanged under such arrangement in the ASM performance year for each ASM participant and determine within a reasonable amount of time after the information necessary to make the calculation in paragraph (d)(2) of this section becomes available whether the total amount of remuneration exceeds the limitation in paragraph (d)(2) of this section.

(ii) For in-kind remuneration, the value of remuneration exchanged for the purpose of this section is determined based on the offeror's cost for the remuneration, using any reasonable accounting methodology, or the fair market value of the in-kind remuneration.

(iii) The collaborative care arrangement must require the parties to reconcile any remuneration exchanged by each ASM participant under the arrangement in the ASM performance year after the limitation in paragraph (d)(2) of this section is determined.

(iv) If the total amount of remuneration received by a party in the ASM performance year exceeds the limitation in paragraph (d)(2) of this section, the collaborative care arrangement must require the party that received the excess amount to repay the excess amount to the other party within a reasonable amount of time after the reconciliation.

(3) Any remuneration exchanged under a collaborative care arrangement must be solely between the parties to the arrangement. To the extent that remuneration exchanged is monetary,

any payment between the parties must be made by check, electronic funds transfer, or another traceable cash transaction.

* * * * *

111. Section 512.775 is amended in paragraph (a) by removing the reference "§ 512.710(a)(2)" and adding in its place the phrase "§512.710(a)(2) or § 512.710(c)".

Robert F. Kennedy, Jr.,

Secretary,

Department of Health and Human Services.

Note: The following Appendices will not appear in the **Code of Federal Regulations**.

APPENDIX 1: MIPS QUALITY MEASURES

NOTE: Except as otherwise noted in this proposed rule, previously finalized measures and specialty sets would continue to apply for the CY 2027 performance period/2029 MIPS payment year and future years. Previously finalized measures and specialty sets are in the CY 2017 through CY 2026 PFS final rules: 81 FR 77558 through 77816, 82 FR 53966 through 54174, 83 FR 60097 through 60285, 84 FR 63205 through 63513, 85 FR 85045 through 85369, 86 FR 65687 through 65968, 87 FR 70250 through 70633, 88 FR 79556 through 79964, 89 FR 98599 through 98957, and 90 FR 50036 through 50353. In addition, electronic clinical quality measures (eCQMs) that are endorsed by a Consensus-Based Entity (CBE) are shown in Table A of this Appendix as follows: CBE # / eCQM CBE #.

NOTE: In section IV.A.4.d.(1)(c)(i) of this proposed rule, we are proposing to implement MIPS core measures for traditional MIPS and MVP reporting which are identified in the tables in this Appendix. In addition, in section IV.A.4.d.(1)(c)(ii) of this proposed rule, we are proposing to remove the high priority designation from MIPS quality measures and therefore, we have removed the high priority indicator across all tables in this Appendix.

Table Group A: New MIPS Quality Measures Proposed for the CY 2027 Performance Period/2029 MIPS Payment Year and Future Years

Note: Proposed specialty sets for new measures are indicated under Table Group A of this Appendix within the last row of each A table.

We request comments on these new measures and the applicable specialty sets.

A.1. Low Density Lipoprotein Cholesterol (LDL-C) Monitoring and Management

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality #:	TBD
Description:	Percentage of patients aged 18 years and older with clinical atherosclerotic cardiovascular disease (ASCVD) who received a low-density lipoprotein cholesterol (LDL-C) test via lipid panel and achieved an LDL-C of <70mg/dL on the most recent test during the performance period.
Measure Steward:	American Heart Association
Numerator:	Numerator 1: Patients aged 18 years and older with clinical atherosclerotic cardiovascular disease (ASCVD) who had a low density lipoprotein cholesterol (LDL-C) test via a lipid panel. Numerator 2: Patients aged 18 years and older with clinical ASCVD and had a lipid panel completed during the 12-month measurement period who achieved an LDL-C of <70 mg/dL on the most recent test during the 12-month measurement period.
Denominator:	Denominator 1: All patients aged 18 years and older diagnosed with clinical atherosclerotic cardiovascular disease (ASCVD). Denominator 2: All patients aged 18 years and older with clinical ASCVD who had a low density lipoprotein cholesterol (LDL-C) test via a lipid panel during the measurement period.
Exclusions:	Pregnancy, ESRD, hospice, over age 66+ with advanced illness, frailty, or dementia medications
Measure Type:	Intermediate Outcome
MIPS Core Measure:	Yes
Collection Type:	MIPS CQM
Measure-Specific Case Minimum/Performance Period:	N/A

Category	Description
Rationale:	We are proposing this intermediate outcome measure because it addresses appropriate care for adult patients with clinical atherosclerotic cardiovascular disease (ASCVD), ensuring patients diagnosed with this condition are annually tested for LDL-C and achieve a desired level. Studies support that elevated LDL-C levels contribute to ASCVD and once identified can be addressed via lipid management. Lowering LDL-C produces a marked reduction in clinical ASCVD and evidence shows that lower LDL-C levels are associated with better outcomes.[403] This measure ensures that patients receiving cholesterol lowering treatment, such as statin therapy, achieve a reduction in LDL-C, which in turn reduces risk of ASCVD and other patient outcomes, such as hospitalizations and cardiovascular death.[404] This measure is based on peer-reviewed evidence demonstrating that, for adults 20 years of age or older and not on lipid-lowering therapy, measurement of either a fasting or non-fasting plasma lipid profile is effective in estimating ASCVD risk and documenting baseline LDL-C.[405] This measure would expand on current MIPS measure Q438: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease, which focuses on appropriate statin treatment of patients at high risk for cardiovascular events. While measure Q438 assesses for the prescribing of statin therapy, this new measure would build on measure Q438 by assessing the outcome of LDL-C treatment, through achievement of reaching a desired LDL-C level. The Pre-Rulemaking Measure Review (PRMR) Clinician Recommendation Committee reached consensus agreement to recommend the measure. Testing indicated good reliability based on signal to noise ratio and adequate face validity. Testing of measure performance indicated a gap in care with a mean performance rate of 46.8 percent for the first criteria and 64.9 percent for the second criteria. This demonstrates that there is room for improvement among clinicians treating this patient population. This measure is not currently CBE endorsed. Although CBE endorsement is preferred, it is still recommended this measure be added to MIPS because it is an evidence-based measure, satisfying the requirement set forth at section 1848(q)(2)(D)(v) of the Act, stating that any measure selected for inclusion in MIPS that is not endorsed by a CBE shall have a focus that is evidence-based. This measure could be added to multiple MVPs in the future, including the proposed Hypertension MVP, Advancing Care for Heart Disease MVP, and Value in Primary Care MVP. We are proposing to add this measure to applicable specialty sets based on available coding and because the clinical quality action is within the scope of care for clinicians in these specialties. Note: Refer to the PRMR Clinician Recommendation Committee Spreadsheet of Final Recommendations to CMS and HHS at *https://p4qm.org/sites/default/files/2026-02/Final-2025-2026-MUC-Recommendations-Report-508.pdf.*
Measure Proposed for Addition to the Following Specialty Sets:	Cardiology, Endocrinology, Family Medicine, Geriatrics, Internal Medicine, Nephrology, Neurology, Obstetrics/Gynecology, Preventive Medicine, Vascular Surgery

[403] Grundy, S. M., Stone, N. J., Bailey, A. L., Beam, C., Birtcher, K. K., Blumenthal, R. S., Braun, L. T., de Ferranti, S., Faiella-Tommasino, J., Forman, D. E., Goldberg, R., Heidenreich, P. A., Hlatky, M. A., Jones, D. W., Lloyd-Jones, D., Lopez-Pajares, N., Ndumele, C. E., Orringer, C. E., Peralta, C. A., Saseen, J. J., … Yeboah, J. (2019). 2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. Circulation, 139(25), e1082–e1143. https://doi.org/10.1161/CIR.0000000000000625.

[404] See footnote Grundy et al., 2019.

[405] See footnote Grundy et al., 2019.

A.2. Functional Improvement for Patients with Neck Impairments

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality #:	TBD
Description:	Percentage of patients aged 18 years and older with a neck impairment that met the risk-adjusted Predicted Moderate Clinical Improvement (P-MCI) on the PROMIS Pain Interference (PPI) or the alternative (legacy) patient-reported outcome measure (PROM), the Neck Disability Index (NDI).
Measure Steward:	Limber Health, Inc. and Patient360, LLC
Numerator:	Patients whose most recent PPI score beyond the baseline score meets or exceeds the P-MCI at the time of the completed episode of care.
Denominator:	All patients aged 18 years or older at the start of the episode of care with a neck impairment who completed a baseline PPI.
Exclusions:	Pre-operative Care: Patients who are being seen for pre-operative care and/or have surgery for the neck impairment within 30 days after the initial assessment, documented in the medical record. Cognitive Deficit: A significant mental or cognitive impairment that compromises the patient's ability to complete the PROM, such as dementia or intellectual disabilities, documented in the medical record. Hospice: Patient is in hospice care or receiving palliative care for terminal illness, as documented in the medical record. Active Cancer Treatment: The patient is in active treatment for cancer (e.g., undergoing chemotherapy, radiation therapy, immunotherapy, or cancer-related surgery) AND the goal of musculoskeletal care is primarily to avoid or minimize decline in function, documented in the medical record. Maintenance Therapy: The patient meets Medicare requirements for maintenance therapy, such as the maintenance of functional status or prevention of a slow deterioration in function, as defined by the Medicare Benefits Policy Manual, Chapter 15,[406] as documented in the medical record.
Measure Type:	Patient-Reported Outcome-Based Performance Measure (PRO-PM)
MIPS Core Measure:	No
Collection Type:	MIPS CQM
Measure-Specific Case Minimum/Performance Period:	N/A

[406] Medicare Benefit Policy Manual. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c15.pdf.

Category	Description
Rationale:	We are proposing this current QCDR patient-reported outcome-based performance measure to replace current MIPS quality measure Q478: Functional Status Change for Patients with Neck Impairments. This new measure would address the same clinical topic as measure Q478; however, it allows for broader implementation by including widely available, non-proprietary tools to assess physical function improvement. Additionally, this measure's analytic allows independent calculation of performance by the clinician, or easy and free collaboration with the steward, which supports clinicians reporting this important aspect of rehabilitative care. This measure utilizes the PROMIS® Pain Interference tool, which was developed using item response theory (IRT) methods. Evidence indicates that the PROMIS-PI items constitute a psychometrically sound item bank for assessing the negative effects of pain on functioning across the range commonly experienced by people who have pain.[407] It allows clinician flexibility in administration as it uses computer adaptive testing (CAT) or a fixed-length short form. This measure also allows utilization of the Neck Disability Index (NDI), which is a commonly used tool for neck pain with established reliability and validity.[408] [409] Under section 1848(q) of the Act, a QCDR measure may only become reportable as a MIPS quality measure if the Secretary formerly adopts it through rulemaking and includes it in the MIPS quality measure inventory. We have the authority to establish quality measures under MIPS. This authority is not dependent upon the pre-rulemaking process used to develop measures. Beginning with the CY 2024 performance period/2026 MIPS payment year, all QCDR measures are required to be fully developed and tested at the clinician level by their second year in MIPS, as finalized in the CY 2023 PFS final rule (87 FR 70104 through 70106) and codified at § 414.1400(b)(4)(iii)(A)(3). As a current QCDR measure, this measure has demonstrated feasibility, reliability, and validity in accordance with § 414.1400(b)(4)(iii)(A)(3). The measure is evidence-based and is fully developed and tested. This measure may be added to the Rehabilitative Support for Musculoskeletal Care MVP (currently proposed to be renamed as the Rehabilitative Support MVP under Appendix 3: MVP Inventory, Table B.24). We are proposing to add this measure to the Chiropractic Medicine and Physical Therapy/Occupational Therapy specialty sets based on available coding and because the clinical quality action is within the scope of care for clinicians in these specialties.
Measure Proposed for Addition to the Following Specialty Sets:	Chiropractic Medicine, Physical Therapy/Occupational Therapy

[407] Amtmann, D., Cook, K. F., Jensen, M. P., Chen, W. H., Choi, S., Revicki, D., Cella, D., Rothrock, N., Keefe, F., Callahan, L., & Lai, J. S. (2010). Development of a PROMIS Item Bank to Measure Pain Interference. *Pain*, *150*(1), 173–182. https://doi.org/10.1016/j.pain.2010.04.025.

[408] Young, I. A., Dunning, J., Butts, R., Mourad, F., & Cleland, J. A. (2019). Reliability, Construct Validity, and Responsiveness of the Neck Disability Index and Numeric Pain Rating Scale in Patients with Mechanical Neck Pain Without Upper Extremity Symptoms. *Physiotherapy Theory and Practice*, *35*(12), 1328–1335. https://doi.org/10.1080/09593985.2018.1471763.

[409] MacDermid, J. C., Walton, D. M., Avery, S., Blanchard, A., Etruw, E., McAlpine, C., & Goldsmith, C. H. (2009). Measurement Properties of the Neck Disability Index: A Systematic Review. *The Journal of Orthopaedic and Sports Physical Therapy*, *39*(5), 400–417. https://doi.org/10.2519/jospt.2009.2930.

A.3. Functional Improvement for Patients with Upper Extremity Impairments

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality #:	TBD
Description:	Percentage of patients aged 18 years and older with an upper extremity impairment that met the risk-adjusted Predicted Moderate Clinical Improvement (P-MCI) on the PROMIS Upper Extremity (PUE) or the alternative (legacy) patient-reported outcome measure (PROM), the Quick Disabilities of the Arm, Shoulder, & Hand (QDASH).
Measure Steward:	Limber Health, Inc. and Patient360, LLC
Numerator:	Patients whose most recent PUE score beyond the baseline score meets or exceeds the P-MCI at the time of the completed episode of care.
Denominator:	All patients aged 18 years or older at the start of the episode of care with an upper extremity impairment who completed a baseline PUE.
Exclusions:	Pre-operative Care: Patients who are being seen for pre-operative care and/or have surgery for upper extremity impairment within 30 days after the initial assessment, documented in the medical record. Cognitive Deficit: A significant mental or cognitive impairment that compromises the patient's ability to complete the PROM, such as dementia or intellectual disabilities, documented in the medical record. Hospice: Patient is in hospice care or receiving palliative care for terminal illness, as documented in the medical record. Active Cancer Treatment: The patient is in active treatment for cancer (e.g., undergoing chemotherapy, radiation therapy, immunotherapy, or cancer-related surgery) AND the goal of musculoskeletal care is primarily to avoid or minimize decline in function, documented in the medical record. Maintenance Therapy: The patient meets Medicare requirements for maintenance therapy, such as the maintenance of functional status or prevention of a slow deterioration in function, as defined by the Medicare Benefits Policy Manual, Chapter 15,[410] as documented in the medical record.
Measure Type:	Patient-Reported Outcome-Based Performance Measure (PRO-PM)
MIPS Core Measure:	No
Collection Type:	MIPS CQM
Measure-Specific Case Minimum/Performance Period:	N/A

[410] Medicare Benefit Policy Manual. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c15.pdf.

Category	Description
Rationale:	We are proposing this current QCDR patient-reported outcome-based performance measure to replace current MIPS quality measure Q221: Functional Status Change for Patients with Shoulder Impairments and Q222: Functional Status Change for Patients with Elbow, Wrist or Hand Impairments. This new measure would address the same clinical topics as measures Q221 and Q222; however, it allows for broader implementation by including widely available, non-proprietary tools to assess physical function improvement. Additionally, this measure's analytic allows independent calculation of performance by the clinician, or easy and free collaboration with the steward, which supports clinicians reporting this important aspect of rehabilitative care. This measure utilizes the PROMIS® Upper Extremity tool, which was developed using item response theory (IRT) methods and evidence supports high reliability and validity[411]. It allows clinician flexibility in administration as it uses computer adaptive testing (CAT) or a fixed-length short form. This measure also allows use of the Quick Disabilities of the Arm, Shoulder, and Hand (QuickDASH) tool, which has also shown to be highly reliable and valid for use in patients with upper extremity musculoskeletal disorders.[412] Under section 1848(q) of the Act, a QCDR measure may only become reportable as a MIPS quality measure if the Secretary formerly adopts it through rulemaking and includes it in the MIPS quality measure inventory. We have the authority to establish quality measures under MIPS. This authority is not dependent upon the pre-rulemaking process used to develop measures. Beginning with the CY 2024 performance period/2026 MIPS payment year, all QCDR measures are required to be fully developed and tested at the clinician level by their second year in MIPS, as finalized in the CY 2023 PFS final rule (87 FR 70104 through 70106) and codified at § 414.1400(b)(4)(iii)(A)(3). As a current QCDR measure, this measure has demonstrated feasibility, reliability, and validity in accordance with § 414.1400(b)(4)(iii)(A)(3). The measure is evidence-based and is fully developed and tested. This measure may be added to the Rehabilitative Support for Musculoskeletal Care MVP (currently proposed to be renamed as the Rehabilitative Support MVP under Appendix 3: MVP Inventory, Table B.24). We are proposing to add this measure to the Chiropractic Medicine and Physical Therapy/Occupational Therapy specialty sets based on available coding and because the clinical quality action is within the scope of care for clinicians in these specialties.
Measure Proposed for Addition to the Following Specialty Sets:	Chiropractic Medicine, Physical Therapy/Occupational Therapy

[411] Hung, M., Voss, M. W., Bounsanga, J., Crum, A. B., & Tyser, A. R. (2017). Examination of the PROMIS Upper Extremity Item Bank. *Journal of Hand Therapy: Official Journal of the American Society of Hand Therapists*, *30*(4), 485–490. https://doi.org/10.1016/j.jht.2016.10.008.

[412] Chao, Z., & Guo, H. (2023). Reliability and Validity of Quick Disabilities of the Arm, Shoulder, and Hand Questionnaire in Taiwan. *Archives of Physical Medicine and Rehabilitation*, *104*(3), e49. https://doi.org/10.1016/j.apmr.2022.12.142.

A.4. Functional Improvement for Patients with Back Impairments

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality #:	TBD
Description:	Percentage of patients aged 18 years and older with a back impairment that met the risk-adjusted Predicted Moderate Clinical Improvement (P-MCI) on the PROMIS Pain Interference (PPI) or the alternative (legacy) patient-reported outcome measure (PROM), the Modified Low Back Disability Questionnaire (MDQ).
Measure Steward:	Limber Health, Inc. and Patient360, LLC
Numerator:	Patients whose most recent PPI score beyond the baseline score meets or exceeds the P-MCI at the time of the completed episode of care.
Denominator:	All patients aged 18 years or older at the start of the episode of care with a back impairment who completed a baseline PPI.
Exclusions:	Pre-operative Care: Patients who are being seen for pre-operative care and/or have surgery for the back impairment within 30 days after the initial assessment, documented in the medical record. Cognitive Deficit: A significant mental or cognitive impairment that compromises the patient's ability to complete the PROM, such as dementia or intellectual disabilities, documented in the medical record. Hospice: Patient is in hospice care or receiving palliative care for terminal illness, as documented in the medical record. Active Cancer Treatment: The patient is in active treatment for cancer (e.g., undergoing chemotherapy, radiation therapy, immunotherapy, or cancer-related surgery) AND the goal of musculoskeletal care is primarily to avoid or minimize decline in function, documented in the medical record. Maintenance Therapy: The patient meets Medicare requirements for maintenance therapy, such as the maintenance of functional status or prevention of a slow deterioration in function, as defined by the Medicare Benefits Policy Manual, Chapter 15,[413] as documented in the medical record.
Measure Type:	Patient-Reported Outcome-Based Performance Measure (PRO-PM)
MIPS Core Measure:	Yes
Collection Type:	MIPS CQM
Measure-Specific Case Minimum/Performance Period:	N/A

[413] Medicare Benefit Policy Manual. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c15.pdf.

Category	Description
Rationale:	We are proposing this current QCDR patient-reported outcome-based performance measure to replace current MIPS quality measure Q220: Functional Status Change for Patients with Low Back Impairments. This new measure would address the same clinical topic as measure Q220; however, it allows for broader implementation by including widely available, non-proprietary tools to assess physical function improvement. Additionally, this measure's analytic allows independent calculation of performance by the clinician, or easy and free collaboration with the steward, which supports clinicians reporting this important aspect of rehabilitative care. This measure utilizes the PROMIS® Pain Interference tool, which was developed using item response theory (IRT) methods. Evidence indicates that the PROMIS-PI items constitute a psychometrically sound item bank for assessing the negative effects of pain on functioning across the range commonly experienced by people who have pain.[414] It allows clinician flexibility in administration as it uses computer adaptive testing (CAT) or a fixed-length short form. This measure also allows utilization of the Modified Low Back Disability Questionnaire (MDQ), which has shown to be a valid, reliable, and responsive condition-specific assessment tool that is suited for use in clinical practice.[415] Under section 1848(q) of the Act, a QCDR measure may only become reportable as a MIPS quality measure if the Secretary formerly adopts it through rulemaking and includes it in the MIPS quality measure inventory. We have the authority to establish quality measures under MIPS. This authority is not dependent upon the pre-rulemaking process used to develop measures. Beginning with the CY 2024 performance period/2026 MIPS payment year, all QCDR measures are required to be fully developed and tested at the clinician level by their second year in MIPS, as finalized in the CY 2023 PFS final rule (87 FR 70104 through 70106) and codified at § 414.1400(b)(4)(iii)(A)(3). As a current QCDR measure, this measure has demonstrated feasibility, reliability, and validity in accordance with § 414.1400(b)(4)(iii)(A)(3). The measure is evidence-based and is fully developed and tested. This measure may be added to the Rehabilitative Support for Musculoskeletal Care MVP (currently proposed to be renamed as the Rehabilitative Support MVP under Appendix 3: MVP Inventory, Table B.24). We are proposing to add this measure to the Chiropractic Medicine and Physical Therapy/Occupational Therapy specialty sets based on available coding and because the clinical quality action is within the scope of care for clinicians in these specialties.
Measure Proposed for Addition to the Following Specialty Sets:	Chiropractic Medicine, Physical Therapy/Occupational Therapy

[414] See footnote Amtmann et al., 2010.

[415] Vianin M. (2008). Psychometric Properties and Clinical Usefulness of the Oswestry Disability Index. *Journal of Chiropractic Medicine*, *7*(4), 161–163. https://doi.org/10.1016/j.jcm.2008.07.001.

A.5. Functional Improvement for Patients with Lower Extremity Impairments

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality #:	TBD
Description:	Percentage of patients aged 18 years and older with a lower extremity impairment—not including knee impairments—that met the risk-adjusted Predicted Moderate Clinical Improvement (P-MCI) on the PROMIS Physical Function (PPF) or alternative (legacy) patient-reported outcome measure (PROM), the Lower Extremity Functional Scale (LEFS).
Measure Steward:	Limber Health, Inc. and Patient360, LLC
Numerator:	Patients whose most recent PPF score beyond the baseline score meets or exceeds the P-MCI at the time of the completed episode of care.
Denominator:	All patients aged 18 years or older at the start of the episode of care with a non-knee impairment who completed a baseline PPF.
Exclusions:	Pre-operative Care: Patients who are being seen for pre-operative care and/or have surgery for the non-knee lower extremity impairment within 30 days after the initial assessment, documented in the medical record. Cognitive Deficit: A significant mental or cognitive impairment that compromises the patient's ability to complete the PROM, such as dementia or intellectual disabilities, documented in the medical record. Hospice: Patient is in hospice care or receiving palliative care for terminal illness, as documented in the medical record. Active Cancer Treatment: The patient is in active treatment for cancer (e.g., undergoing chemotherapy, radiation therapy, immunotherapy, or cancer-related surgery) AND the goal of musculoskeletal care is primarily to avoid or minimize decline in function, documented in the medical record. Maintenance Therapy: The patient meets Medicare requirements for maintenance therapy, such as the maintenance of functional status or prevention of a slow deterioration in function, as defined by the Medicare Benefits Policy Manual, Chapter 15,[416] as documented in the medical record.
Measure Type:	Patient-Reported Outcome-Based Performance Measure (PRO-PM)
MIPS Core Measure:	No
Collection Type:	MIPS CQM
Measure-Specific Case Minimum/Performance Period:	N/A

[416] Medicare Benefit Policy Manual. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c15.pdf.

Category	Description
Rationale:	We are proposing this current QCDR patient-reported outcome-based performance measure to replace current MIPS quality measures Q218: Functional Status Change for Patients with Hip Impairments and Q219: Functional Status Change for Patients with Lower Leg, Foot or Ankle Impairments. This new measure would address the same clinical topics as measures Q218 and Q219; however, it allows for broader implementation by including widely available, non-proprietary tools to assess physical function improvement. Additionally, this measure's analytic allows independent calculation of performance by the clinician, or easy and free collaboration with the steward, which supports clinicians reporting this important aspect of rehabilitative care. This measure utilizes the PROMIS® Physical Function (PPF) tool, which was developed using item response theory (IRT) methods and has demonstrated reliability, convergent and known-groups discriminant validity, and responsiveness in a sample of patients with a lower extremity orthopedic trauma injury.[417] This measure also allows utilization of the Lower Extremity Functional Scale (LEFS). Evidence supports the reliability, validity, and responsiveness of LEFS scores for assessing functional impairment in a wide array of patient groups with lower extremity musculoskeletal conditions.[418] Under section 1848(q) of the Act, a QCDR measure may only become reportable as a MIPS quality measure if the Secretary formerly adopts it through rulemaking and includes it in the MIPS quality measure inventory. We have the authority to establish quality measures under MIPS. This authority is not dependent upon the pre-rulemaking process used to develop measures. Beginning with the CY 2024 performance period/2026 MIPS payment year, all QCDR measures are required to be fully developed and tested at the clinician level by their second year in MIPS, as finalized in the CY 2023 PFS final rule (87 FR 70104 through 70106) and codified at § 414.1400(b)(4)(iii)(A)(3). As a current QCDR measure, this measure has demonstrated feasibility, reliability, and validity in accordance with § 414.1400(b)(4)(iii)(A)(3). The measure is evidence-based and is fully developed and tested. This measure may be added to the Rehabilitative Support for Musculoskeletal Care MVP (currently proposed to be renamed as the Rehabilitative Support MVP under Appendix 3: MVP Inventory, Table B.24). We are proposing to add this measure to the Chiropractic Medicine and Physical Therapy/Occupational Therapy specialty sets based on available coding and because the clinical quality action is within the scope of care for clinicians in these specialties.
Measure Proposed for Addition to the Following Specialty Sets:	Chiropractic Medicine, Physical Therapy/Occupational Therapy

[417] Rothrock, N. E., Kaat, A. J., Vrahas, M. S., O'Toole, R. V., Buono, S. K., Morrison, S., & Gershon, R. C. (2019). Validation of PROMIS Physical Function Instruments in Patients With an Orthopaedic Trauma to a Lower Extremity. *Journal of Orthopaedic Trauma*, *33*(8), 377–383. https://doi.org/10.1097/BOT.0000000000001493.

[418] Mehta, S. P., Fulton, A., Quach, C., Thistle, M., Toledo, C., & Evans, N. A. (2016). Measurement Properties of the Lower Extremity Functional Scale: A Systematic Review. *The Journal of Orthopaedic and Sports Physical Therapy*, *46*(3), 200–216. https://doi.org/10.2519/jospt.2016.6165.

A.6. Functional Improvement for Patients with Knee Impairments

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality #:	TBD
Description:	Percentage of patients aged 18 years and older with a knee impairment that met the risk-adjusted Predicted Moderate Clinical Improvement (P-MCI) on the PROMIS Physical Function (PPF) or the alternative (legacy) patient-reported outcome measure (PROM), the Knee Outcome Survey (KOS).
Measure Steward:	Limber Health, Inc. and Patient360, LLC
Numerator:	Patients whose most recent PPF score beyond the baseline score meets or exceeds the P-MCI at the time of the completed episode of care.
Denominator:	All patients aged 18 years or older at the start of the episode of care with a knee impairment who completed a baseline PPF.
Exclusions:	Pre-operative Care: Patients who are being seen for pre-operative care and/or have surgery for the knee impairment within 30 days after the initial assessment, documented in the medical record. Cognitive Deficit: A significant mental or cognitive impairment that compromises the patient's ability to complete the PROM, such as dementia or intellectual disabilities, documented in the medical record. Hospice: Patient is in hospice care or receiving palliative care for terminal illness, as documented in the medical record. Active Cancer Treatment: The patient is in active treatment for cancer (e.g., undergoing chemotherapy, radiation therapy, immunotherapy, or cancer-related surgery) AND the goal of musculoskeletal care is primarily to avoid or minimize decline in function, documented in the medical record. Maintenance Therapy: The patient meets Medicare requirements for maintenance therapy, such as the maintenance of functional status or prevention of a slow deterioration in function, as defined by the Medicare Benefits Policy Manual, Chapter 15,[419] as documented in the medical record.
Measure Type:	Patient-Reported Outcome-Based Performance Measure (PRO-PM)
MIPS Core Measure:	No
Collection Type:	MIPS CQM
Measure-Specific Case Minimum/Performance Period:	N/A

[419] Medicare Benefit Policy Manual. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c15.pdf.

Category	Description
Rationale:	We are proposing this current QCDR patient-reported outcome-based performance measure to replace current MIPS quality measure Q217: Functional Status Change for Patients with Knee Impairments. This new measure would address the same clinical topic as measure Q217; however, it allows for broader implementation by including widely available, non-proprietary tools to assess physical function improvement. Additionally, this measure's analytic allows independent calculation of performance by the clinician, or easy and free collaboration with the steward, which supports clinicians reporting this important aspect of rehabilitative care. This measure utilizes the PROMIS® Physical Function (PPF) tool, which was developed using item response theory (IRT) methods and has demonstrated reliability, convergent and known-groups discriminant validity, and responsiveness in a sample of patients with a lower extremity orthopedic trauma injury.[420] This measure also allows utilization of the Knee Outcome Survey (KOS). Evidence shows it is a reliable, valid, and responsive instrument for the assessment of functional limitations that result from a wide variety of pathological disorders and impairments of the knee.[421] Under section 1848(q) of the Act, a QCDR measure may only become reportable as a MIPS quality measure if the Secretary formerly adopts it through rulemaking and includes it in the MIPS quality measure inventory. We have the authority to establish quality measures under MIPS. This authority is not dependent upon the pre-rulemaking process used to develop measures. Beginning with the CY 2024 performance period/2026 MIPS payment year, all QCDR measures are required to be fully developed and tested at the clinician level by their second year in MIPS, as finalized in the CY 2023 PFS final rule (87 FR 70104 through 70106) and codified at § 414.1400(b)(4)(iii)(A)(3). As a current QCDR measure, this measure has demonstrated feasibility, reliability, and validity in accordance with § 414.1400(b)(4)(iii)(A)(3). The measure is evidence-based and is fully developed and tested. This measure may be added to the Rehabilitative Support for Musculoskeletal Care MVP (currently proposed to be renamed as the Rehabilitative Support MVP under Appendix 3: MVP Inventory, Table B.24). We are proposing to add this measure to the Chiropractic Medicine and Physical Therapy/Occupational Therapy specialty sets based on available coding and because the clinical quality action is within the scope of care for clinicians in these specialties.
Measure Proposed for Addition to the Following Specialty Sets:	Chiropractic Medicine, Physical Therapy/Occupational Therapy

[420] See footnote Rothrock et al., 2019.

[421] Irrgang, J. J., Snyder-Mackler, L., Wainner, R. S., Fu, F. H., & Harner, C. D. (1998). Development of a Patient-Reported Measure of Function of the Knee. *The Journal of Bone and Joint Surgery. American volume*, *80*(8), 1132–1145. https://doi.org/10.2106/00004623-199808000-00006.

A.7. Age-Related Hearing Loss: Comprehensive Audiometric Evaluation

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality #:	TBD
Description:	Percentage of patients aged 50 years and older who failed a hearing screening and/or who report suspected hearing loss or tinnitus who were ordered or referred for a comprehensive audiometric evaluation on the day of diagnosis/office visit OR received a comprehensive audiometric evaluation within 4 weeks of the office visit.
Measure Steward:	American Academy of Otolaryngology - Head and Neck Surgery Foundation
Numerator:	Patients were ordered or referred for a comprehensive audiometric evaluation on the day of diagnosis/office visit OR received a comprehensive audiometric evaluation within 4 weeks of the office visit.
Denominator:	All patients aged 50 years and older who failed a hearing screening and/or who report suspected hearing loss or tinnitus.
Exclusions:	None
Measure Type:	Process
MIPS Core Measure:	Yes
Collection Type:	MIPS CQM
Measure-Specific Case Minimum/Performance Period:	N/A
Rationale:	We are proposing this current QCDR measure as it fills a gap in the Quality Care for the Treatment of Ear, Nose, and Throat Disorders MVP. It is specific to audiology and ensures that patients suspected of having age-related hearing loss, either identified through a failed hearing screen or diagnosis, are referred for or receive a comprehensive audiometric evaluation. Implementation of this measure as a MIPS CQM would allow wider availability for reporting by MIPS eligible clinicians. The objective of auditory assessment is to diagnose the type and magnitude of hearing loss and the need for treatment, including candidacy for amplification. Age-related hearing loss (ARHL), despite being the most common sensory deficit seen in the older population, remains an underdiagnosed and undertreated condition among individuals aged 50 years and above.[422] Identifying ARHL in early stages could prevent its known adverse outcomes, such as lower quality of life and ability to function.[423] [424] Undertreatment may lead to associated health risks, including dementia, depression, cardiovascular disease, and falls.[425] This measure is based on clinical guidelines intended to inform the practice of hearing care professionals involved in the audiological management of adults with severe to profound hearing loss.[426] Additionally, the guidelines identify quality improvement opportunities and evidence-based recommendations regarding the identification and management of ARHL.[427] Under section 1848(q) of the Act, a QCDR measure may only become reportable as a MIPS quality measure if the Secretary formerly adopts it through rulemaking and includes it in the MIPS quality measure inventory. We have the authority to establish quality measures under MIPS. This authority is not dependent upon the pre-rulemaking process used to develop measures. Beginning with the CY 2024 performance period/2026 MIPS payment year, all QCDR measures are required to be fully developed and tested at the clinician level by their second year in MIPS, as finalized in the CY 2023 PFS final rule (87 FR 70104 through 70106) and codified at § 414.1400(b)(4)(iii)(A)(3). As a current QCDR measure, this measure has demonstrated feasibility, reliability, and validity in accordance with § 414.1400(b)(4)(iii)(A)(3). The measure is evidence-based and is fully developed and tested. We are proposing to add this measure to the Audiology and Otolaryngology specialty sets based on available coding and because the clinical quality action is within the scope of care for clinicians in these specialties.

[422] Tsai Do, B. S., Bush, M. L., Weinreich, H. M., Schwartz, S. R., Anne, S., Adunka, O. F., Bender, K., Bold, K. M., Brenner, M. J., Hashmi, A. Z., Keenan, T. A., Kim, A. H., Moore, D. J., Nieman, C. L., Palmer, C. V., Ross, E. J., Steenerson, K. K., Zhan, K. Y., Reyes, J., & Dhepyasuwan, N. (2024). Clinical Practice Guideline: Age-Related Hearing Loss. *Otolaryngology--Head and Neck Surgery: Official Journal of American Academy of Otolaryngology-Head and Neck Surgery*, *170 Suppl 2*, S1–S54. https://doi.org/10.1002/ohn.750.

[423] Zazove, P., Plegue, M. A., McKee, M. M., DeJonckheere, M., Kileny, P. R., Schleicher, L. S., Green, L. A., Sen, A., Rapai, M. E., & Mulhem, E. (2020). Effective Hearing Loss Screening in Primary Care: The Early Auditory Referral-Primary Care Study. *Annals of Family Medicine*, *18*(6), 520–527. https://doi.org/10.1370/afm.2590.

[424] Chou, R., Dana, T., Bougatsos, C., Fleming, C., & Beil, T. (2011). Screening Adults Aged 50 Years or Older for Hearing Loss: A Review of the Evidence for the U.S. Preventive Services Task Force. *Annals of Internal Medicine*, *154*(5), 347–355. https://doi.org/10.7326/0003-4819-154-5-201103010-00009.

[425] See footnote Zazove et al., 2020.

[426] Turton, L., Souza, P., Thibodeau, L., Hickson, L., Gifford, R., Bird, J., Stropahl, M., Gailey, L., Fulton, B., Scarinci, N., Ekberg, K., & Timmer, B. (2020). Guidelines for Best Practice in the Audiological Management of Adults with Severe and Profound Hearing Loss. *Seminars in Hearing*, *41*(3), 141–246. https://doi.org/10.1055/s-0040-1714744.

[427] See footnote Tsai et al., 2024.

Category	Description
Measure Proposed for Addition to the Following Specialty Sets:	Audiology, Otolaryngology

A.8. Patient-Reported Experience with Anesthesia

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality #:	TBD
Description:	Percentage of patients, aged 18 and older, who were surveyed on their patient experience and satisfaction with anesthesia care and who reported a positive experience.
Measure Steward:	American Society of Anesthesiologists Anesthesia Quality Institute
Numerator:	Numerator 1. Patients who received a valid survey within 30 days of the procedure to assess their experience and satisfaction with anesthesia. Numerator 2. Patients who reported a positive experience with anesthesia care within 60 days of receipt of the survey.
Denominator:	Denominator 1. Patients aged 18 and older, who undergo a procedure under anesthesia during the denominator identification period. Denominator 2. All patients from Submission Criteria 1 who complete a survey on their patient experience and satisfaction with anesthesia care within 60 days of receipt of the survey.
Exclusions:	Organ Donors as designated by American Society of Anesthesiologists (ASA) Physical Status 6[428] Patient died within 30 days of the procedure Patients who did not complete the mandatory anesthesia satisfaction question within 60 days of receipt of the survey
Measure Type:	Patient-Reported Outcome-Based Performance Measure (PRO-PM)
MIPS Core Measure:	No
Collection Type:	MIPS CQM
Measure-Specific Case Minimum/Performance Period:	A minimum of 20 completed surveys required to be eligible to report Denominator 2
Rationale:	We are proposing this current QCDR patient-reported outcome-based performance measure as it fills a gap in the Anesthesiology specialty set. It would be the only patient experience of care measure for that specialty and is reported for each procedure. The measure assesses for patients that receive a valid survey and report a positive experience with their anesthesia care. The assessment of patient satisfaction with anesthesia care provides important feedback allowing clinicians to improve the quality-of-care delivery.[429] There are a variety of surveys available for practices and clinicians to implement based upon local patient populations, such as the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS): Patients' Perspectives of Care Survey[430] and Outpatient and Ambulatory Surgery CAHPS.[431] However, the measure would not require the use of a specific survey to collect patient feedback. Under section 1848(q) of the Act, a QCDR measure may only become reportable as a MIPS quality measure if the Secretary formerly adopts it through rulemaking and includes it in the MIPS quality measure inventory. We have the authority to establish quality measures under MIPS. This authority is not dependent upon the pre-rulemaking process used to develop measures. Beginning with the CY 2024 performance period/2026 MIPS payment year, all QCDR measures are required to be fully developed and tested at the clinician level by their second year in MIPS, as finalized in the CY 2023 PFS final rule (87 FR 70104 through 70106) and codified at § 414.1400(b)(4)(iii)(A)(3). As a current QCDR measure, this measure has demonstrated feasibility, reliability, and validity in accordance with § 414.1400(b)(4)(iii)(A)(3). The measure is evidence-based and is fully developed and tested. This measure may be added to the Patient Safety and Support of Positive Experiences with Anesthesia MVP. We are proposing to add this measure to the Anesthesiology specialty set based on available coding and because the clinical quality action is within the scope of care for anesthesiologists.
Measure Proposed for Addition to the Following Specialty Sets:	Anesthesiology

[428] American Society of Anesthesiologists (ASA) Physical Status 6 is defined as a declared brain-dead patient whose organs are being removed for donor purposes.
ASA. (2026). American Society of Anesthesiologists Statement on ASA Physical Status Classification System. *Anesthesiology Open, 1*(1), e0002. https://doi.org/10.1097/ao9.0000000000000002.
[429] Agency for Healthcare Research and Quality. (2013). Guide to Patient and Family Engagement in Hospital Quality and Safety. https://psnet.ahrq.gov/issue/guide-patient-and-family-engagement-hospital-quality-and-safety.
[430] CMS. (2025). HCAHPS: Patients' Perspectives of Care Survey. https://www.cms.gov/data-research/research/consumer-assessment-healthcare-providers-systems/hospital-cahps-hcahps.
[431] CMS. (2026). Outpatient and Ambulatory Surgery CAHPS (OAS CAHPS). https://www.cms.gov/data-research/research/consumer-assessment-healthcare-providers-systems/outpatient-and-ambulatory-surgery-cahps.

A.9. Intraoperative Hypotension (IOH) Among Non-Emergent Noncardiac Surgical Cases

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality #:	TBD
Description:	Percentage of general, neuraxial, or regional anesthesia care cases performed during the performance period in which the mean arterial pressure (MAP) fell below 65 mmHg for a cumulative total of 15 minutes or more.
Measure Steward:	Anesthesia Quality Registry (AQR QCDR) in Collaboration with Anesthesia Quality Institute (AQI) and American Society of Anesthesiologists (ASA)
Numerator:	Patients who have a MAP below 65 mmHg that exceeds the cumulative length of 15 minutes during the performance period.
Denominator:	All cases in which adults (ages 18 and older) with non-cardiac, non-emergency surgery require general, neuraxial, or regional anesthesia care during the performance period.
Exclusions:	Patients with a baseline MAP below 65 mmHg Patients with surgeries where anesthesia is complicated by utilization of controlled hypotension during the primary anesthesia procedure American Society of Anesthesiologists (ASA) Physical Status Classification of 1, 5 or 6[432] Emergency cases Cardiac procedures Obstetric non-operative procedures Liver or lung transplant procedures Cataract procedures
Measure Type:	Intermediate Outcome
MIPS Core Measure:	Yes
Collection Type:	MIPS CQM
Measure-Specific Case Minimum/Performance Period:	N/A
Rationale:	We are proposing this current QCDR measure as it fills a gap in the Anesthesiology specialty set. This inverse, intermediate outcome measure ensures mean arterial pressure (MAP) does not fall below 65mmHg for greater than 15 minutes during a procedure as it could be associated with adverse outcomes, such as acute kidney injury (AKI) or myocardial injury.[433] Evidence indicates a MAP below absolute thresholds of 65 mmHg or relative thresholds of 20 percent was progressively related to both myocardial and kidney injury. Prolonged exposure below the threshold was also associated with increased risk. Noncardiac surgery patients are at increased risk of AKI when their cumulative time below a MAP of 65 mmHg reaches or exceeds 13 minutes. When patients fall further below 65 mmHg, even shorter durations are associated with increased risk of AKI.[434] Under section 1848(q) of the Act, a QCDR measure may only become reportable as a MIPS quality measure if the Secretary formerly adopts it through rulemaking and includes it in the MIPS quality measure inventory. We have the authority to establish quality measures under MIPS. This authority is not dependent upon the pre-rulemaking process used to develop measures. Beginning with the CY 2024 performance period/2026 MIPS payment year, all QCDR measures are required to be fully developed and tested at the clinician level by their second year in MIPS, as finalized in the CY 2023 PFS final rule (87 FR 70104 through 70106) and codified at § 414.1400(b)(4)(iii)(A)(3). As a current QCDR measure, this measure has demonstrated feasibility, reliability, and validity in accordance with § 414.1400(b)(4)(iii)(A)(3). The measure is evidence-based and is fully developed and tested. This measure may be added to the Patient Safety and Support of Positive Experiences with Anesthesia MVP. We are proposing to add this measure to the Anesthesiology specialty set based on available coding and because the clinical quality action is within the scope of care for anesthesiologists.

[432] ASA Physical Status 1 is defined as a normal healthy patient. Physical Status 5 is defined as a moribund patient who is not expected to survive without the operation. Physical Status 6 is defined as a declared brain-dead patient whose organs are being removed for donor purposes.
See footnote ASA, 2026.

[433] Walsh, M., Devereaux, P. J., Garg, A. X., Kurz, A., Turan, A., Rodseth, R. N., Cywinski, J., Thabane, L., & Sessler, D. I. (2013). *Relationship Between Intraoperative Mean Arterial Pressure and Clinical Outcomes After Noncardiac Surgery*. Anesthesiology, 119(3), 507–515. https://doi.org/10.1097/ALN.0b013e3182a10e26.

[434] Salmasi, V., Maheshwari, K., Yang, D., Mascha, E. J., Singh, A., Sessler, D. I., & Kurz, A. (2017). Relationship between Intraoperative Hypotension, Defined by Either Reduction from Baseline or Absolute Thresholds, and Acute Kidney and Myocardial Injury after Noncardiac Surgery: A Retrospective Cohort Analysis. *Anesthesiology*, *126*(1), 47–65. https://doi.org/10.1097/ALN.0000000000001432.

Category	Description
Measure Proposed for Addition to the Following Specialty Sets:	Anesthesiology

A.10. SGLT2 Inhibitors for Patients with Chronic Kidney Disease (CKD) With or Without Type 2 Diabetes Mellitus

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality #:	TBD
Description:	The percentage of patients aged 18 years and older with chronic kidney disease (CKD) stages 2 and 3 who are prescribed an SGLT2 inhibitor during the measurement period.
Measure Steward:	A Value-Based Care Registry
Numerator:	Patients who were prescribed or were currently taking an SGLT2 inhibitor during the performance period.
Denominator:	All patients aged 18 years and older diagnosed with chronic kidney disease (CKD) stages 2-3 during the measurement period.
Exclusions:	Patients with Type 1 Diabetes Mellitus Diabetic Ketoacidosis
Measure Type:	Process
MIPS Core Measure:	No
Collection Type:	MIPS CQM
Measure-Specific Case Minimum/Performance Period:	N/A

Category	Description
Rationale:	We are proposing this current QCDR measure as it fills a gap in the MIPS quality measure inventory, ensuring the appropriate, evidence-based treatment of patients diagnosed with CKD with SGLT2 inhibitors. Evidence demonstrates that SGLT2 inhibitors slow the progression of CKD and reduce cardiovascular events in this patient population.[435] [436] [437] As a result, SGLT2 inhibitors have become a key disease-modifying therapy to prevent CKD progression. These medications prevent decline in kidney function through reduction in glomerular hypertension, independent of their effect on glycemic control. This has expanded the approved clinical indications for these medications beyond patients with diabetes.[438] Current clinical and practice guidelines also recommend use of SGLT2 inhibitors to slow CKD progression in patients with or without type 2 diabetes.[439] [440] Under section 1848(q) of the Act, a QCDR measure may only become reportable as a MIPS quality measure if the Secretary formerly adopts it through rulemaking and includes it in the MIPS quality measure inventory. We have the authority to establish quality measures under MIPS. This authority is not dependent upon the pre-rulemaking process used to develop measures. Beginning with the CY 2024 performance period/2026 MIPS payment year, all QCDR measures are required to be fully developed and tested at the clinician level by their second year in MIPS, as finalized in the CY 2023 PFS final rule (87 FR 70104 through 70106) and codified at § 414.1400(b)(4)(iii)(A)(3). As a current QCDR measure, this measure has demonstrated feasibility, reliability, and validity in accordance with § 414.1400(b)(4)(iii)(A)(3). The measure is evidence-based and is fully developed and tested. We are proposing to add this measure to multiple applicable specialty sets based on available coding and because the clinical quality action is within the scope of care for clinicians in these specialties.
Measure Proposed for Addition to the Following Specialty Sets:	Cardiology, Endocrinology, Family Medicine, Geriatrics, Internal Medicine, Nephrology

[435] Heerspink, H. J. L., Stefánsson, B. V., Correa-Rotter, R., Chertow, G. M., Greene, T., Hou, F. F., Mann, J. F. E., McMurray, J. J. V., Lindberg, M., Rossing, P., Sjöström, C. D., Toto, R. D., Langkilde, A. M., Wheeler, D. C., & DAPA-CKD Trial Committees and Investigators (2020). Dapagliflozin in Patients with Chronic Kidney Disease. *The New England Journal of Medicine*, *383*(15), 1436–1446. https://doi.org/10.1056/NEJMoa2024816.

[436] Perkovic, V., Jardine, M. J., Neal, B., Bompoint, S., Heerspink, H. J. L., Charytan, D. M., Edwards, R., Agarwal, R., Bakris, G., Bull, S., Cannon, C. P., Capuano, G., Chu, P. L., de Zeeuw, D., Greene, T., Levin, A., Pollock, C., Wheeler, D. C., Yavin, Y., Zhang, H., … CREDENCE Trial Investigators (2019). Canagliflozin and Renal Outcomes in Type 2 Diabetes and Nephropathy. *The New England Journal of Medicine*, *380*(24), 2295–2306. https://doi.org/10.1056/NEJMoa1811744.

[437] The EMPA-KIDNEY Collaborative Group, Herrington, W. G., Staplin, N., Wanner, C., Green, J. B., Hauske, S. J., Emberson, J. R., Preiss, D., Judge, P., Mayne, K. J., Ng, S. Y. A., Sammons, E., Zhu, D., Hill, M., Stevens, W., Wallendszus, K., Brenner, S., Cheung, A. K., Liu, Z. H., Li, J., … Haynes, R. (2023). Empagliflozin in Patients with Chronic Kidney Disease. *The New England Journal of Medicine*, *388*(2), 117–127. https://doi.org/10.1056/NEJMoa2204233.

[438] Yau, K., Dharia, A., Alrowiyti, I., & Cherney, D. Z. I. (2022). Prescribing SGLT2 Inhibitors in Patients With CKD: Expanding Indications and Practical Considerations. *Kidney International Reports*, *7*(7), 1463–1476. https://doi.org/10.1016/j.ekir.2022.04.094.

[439] Kidney Disease: Improving Global Outcomes (KDIGO) Diabetes Work Group. (2022). *KDIGO 2022 Clinical Practice Guideline for Diabetes Management in Chronic Kidney Disease*. *Kidney International, 102*(5S), S1–S127. https://doi.org/10.1016/j.kint.2022.06.008.

[440] American Diabetes Association Professional Practice Committee. (2024). *11. Chronic Kidney Disease and Risk Management: Standards of Care in Diabetes—2024*. *Diabetes Care, 47*(Suppl. 1), S219–S230. https://doi.org/10.2337/dc24-S011.

Table Group AA: New MIPS Quality Measures Proposed for the CY 2028 Performance Period/2030 MIPS Payment Year and Future Years

In addition to the new quality measures proposed in Table Group A of this Appendix, we are proposing to add one eCQM measure for the 2028 performance period/2030 MIPS payment year and future years to allow clinicians sufficient time to adapt their workflows prior to implementation within MIPS. We request comments on this new measure.

AA.1. Rate of Timely Follow-up on Abnormal Screening Mammograms for Breast Cancer Detection

Category	Description
CBE # / eCQM CBE #:	N/A / 4700e
Quality #:	TBD
Description:	This electronic clinical quality measure (eCQM) reports the percentage of female patients aged 40 to 75 years with at least one abnormal screening (BI-RADS 0) or screening-to-diagnostic (BI-RADS 4, 5) mammogram during the measurement period (i.e., calendar year) who received timely diagnostic resolution defined as either follow-up imaging with negative/benign/probably benign results or a breast biopsy within 60 days after their index (i.e., first) abnormal screening mammogram.
Measure Steward:	Brigham and Women's Hospital
Numerator:	Patients in the denominator population who received timely diagnostic resolution defined as negative/benign/probably benign follow-up imaging (BI-RADS 1, 2, 3) or breast biopsy within 60 days after the date of their index (i.e., first) abnormal screening (BI-RADS 0) or screening-to-diagnostic (BI-RADS 4, 5) mammogram.
Denominator:	Female patients aged 40 to 75 years with an abnormal screening (BI-RADS 0) or screening-to-diagnostic (BI-RADS 4, 5) mammogram during the measurement period (i.e., calendar year). Only the first abnormal screening or screening-to-diagnostic mammogram (i.e., index screening test) is included in the measure calculation.
Exclusions:	N/A
Measure Type:	Process
MIPS Core Measure	No
Collection Type:	eCQM
Measure-Specific Case Minimum/Performance Period:	N/A
Rationale:	We are proposing this eCQM because it addresses timely follow up of diagnostic testing for patients with an abnormal mammogram. Additionally, it fills a gap in the Diagnostic Radiology specialty set with potential for inclusion in an MVP. Breast cancer is the second most common cause of cancer deaths among women in the United States[441] and survival is dependent upon cancer stage at diagnosis. Breast cancer mainly occurs in middle-aged and older women, with the median age at the time of diagnosis being 62 years.[442] Noninvasive mammographic screening is the primary screening modality used to detect breast cancer. Studies show that between 27 to 72 percent of women did not receive appropriate follow-up within 6 months of an abnormal mammogram.[443] Delays in diagnostic follow-up after abnormal mammographic screening results increase the risk of diagnosing cancer at a more advanced stage.[444] Timely follow-up is essential to facilitate early-stage detection and improve overall survival outcomes. The Pre-Rulemaking Measure Review (PRMR) Clinician Recommendation Committee did not reach consensus on this measure; however, the majority (71 percent) of the committee expressed support for use of the measure. The measure is CBE endorsed with conditions of continued monitoring of performance and additional data element validity testing of other electronic health records (EHRs). We are proposing this measure with a one-year delay in implementation to allow time for clinicians to adapt their workflows and therefore ensure greater feasibility of reporting within MIPS. If finalized as proposed, this measure would be available for reporting for the CY 2028 performance period/2030 MIPS payment year. We are proposing to add this measure to the Diagnostic Radiology specialty set for the CY 2028 performance period/2030 MIPS payment year based on available coding and because the clinical quality action is within the scope of care for clinicians in these specialties.

[441] American Cancer Society (ACS). (2024). Key Statistics for Breast Cancer. https://www.cancer.org/cancer/types/breast-cancer/about/how-common-is-breast-cancer.html.
[442] See footnote ACS, 2024.
[443] Reece, J. C., Neal, E. F. G., Nguyen, P., et al. (2021). Delayed or Failure To Follow-up Abnormal Breast Cancer Screening Mammograms in Primary Care: A Systematic Review. *BMC Cancer, 21*, 373. https://doi.org/10.1186/s12885-021-08100-3.
[444] McCarthy, A. M., Kim, J. J., Beaber, E. F., Zheng, Y., Burnett-Hartman, A., Chubak, J., Ghai, N. R., McLerran, D., Breen, N., Conant, E. F., Geller, B. M., Green, B. B., Klabunde, C. N., Inrig, S., Skinner, C. S., Quinn, V. P.,

Category	Description
Measure Proposed for Addition to the Following Specialty Sets:	Diagnostic Radiology

Haas, J. S., Schnall, M., Rutter, C. M., Barlow, W. E., … PROSPR consortium (2016). Follow-Up of Abnormal Breast and Colorectal Cancer Screening by Race/Ethnicity. *American Journal of Preventive Medicine*, *51*(4), 507–512. https://doi.org/10.1016/j.amepre.2016.03.017.

Table Group B: Modifications to Previously Finalized Specialty Sets Proposed for the CY 2027 Performance Period/2029 MIPS Payment Year and Future Years

We are proposing to modify the previously finalized specialty sets based upon review of updates made to existing quality measure specifications, the proposed addition of new measures for inclusion in MIPS, and feedback provided by specialty societies and other interested parties. There may be instances where the quality measures within a specialty set remain static, but the individual measures have proposed substantive changes in Table Group D of this Appendix.

We use the following symbols in the Indicator column in the Table Group B tables below:

- Existing quality measures with substantive changes described in Table Group D of this Appendix are identified with an asterisk (*).
- Quality measures designated as MIPS core measures are identified with an exclamation point (!). As discussed in section IV.A.4.d.(1)(c)(i) of this proposed rule, we are proposing to implement the MIPS core measure designation for traditional MIPS and MVP reporting.
- Quality measures proposed for addition to a proposed specialty set are identified with a plus sign (+).

Additionally, measures that are endorsed by a CBE are shown in Table Group B of this Appendix as follows: CBE # / eCQM CBE #.

Note: We updated the format of the specialty set tables to reflect what the specialty set would be for the CY 2027 performance period, if finalized as proposed. Measures proposed for addition to the specialty sets have been added to applicable tables and are noted with a plus sign (+) in the Indicator column. See Table Group A of this Appendix for rationales for proposed new measures. Existing measures proposed for addition to a specific specialty set are also indicated with a plus sign (+) and are included in the introductory paragraphs of the specialty set, as applicable.

Measures proposed for removal have been removed from each specialty set, as applicable. See Table Group C of this Appendix for rationales for proposed measure removals from MIPS. Specialty-specific measure additions and/or removals would be noted under applicable specialty sets. If a measure is not finalized for addition, it would be removed from the specialty set(s) in the final rule. If a measure is not finalized for removal, it would be added back to the specialty set(s) in the final rule.

We request comments on proposed measure additions and/or proposed measure removals under applicable specialty sets in Table Group B of this Appendix. New measures proposed for addition to applicable specialty sets are open for comment under Table Group A of this Appendix. Measures proposed for removal from MIPS are open for comment under Table Group C of this Appendix. Previously finalized measures that have proposed substantive changes are open for comment under Table Group D of this Appendix. Previously finalized measures that have no substantive changes are not open for comment under this proposed rule.

The following specialty set is not open for comment as it has no proposed modifications for the CY 2027 performance period/2029 MIPS payment year: Diagnostic Radiology.

B.1. Allergy/Immunology

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Allergy/Immunology specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.1. Allergy/Immunology

PROPOSED MEASURES IN THE ALLERGY/IMMUNOLOGY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
*	N/A / N/A	130	CMS68 v16	eCQM, MIPS CQM	Process	Documentation of Current Medications in the Medical Record	Centers for Medicare & Medicaid Services
!	N/A / N/A	226	CMS13 8v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	National Committee for Quality Assurance
!	0022 / N/A	238	CMS15 6v15	eCQM, MIPS CQM	Process	Use of High-Risk Medications in Older Adults	National Committee for Quality Assurance
* !	N/A / N/A	317	CMS22 v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Centers for Medicare & Medicaid Services
!	N/A / N/A	331	N/A	MIPS CQM	Process	Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse)	American Academy of Otolaryngology – Head and Neck Surgery Foundation
!	N/A / N/A	338	CMS31 4v4	eCQM, MIPS CQM	Outcome	HIV Viral Suppression	Health Resources and Services Administration
	N/A / N/A	340	CMS11 57v3	eCQM, MIPS CQM	Process	HIV Annual Retention in Care	Health Resources and Services Administration
*	N/A / N/A	374	CMS50 v15	eCQM, MIPS CQM	Process	Closing the Referral Loop: Receipt of Specialist Report	Centers for Medicare & Medicaid Services
* !	N/A / N/A	398	N/A	MIPS CQM	Outcome	Optimal Asthma Control	Minnesota Community Measurement
	3620 / N/A	493	N/A	MIPS CQM	Process	Adult Immunization Status	National Committee for Quality Assurance

B.1. Allergy/Immunology

PROPOSED MEASURES IN THE ALLERGY/IMMUNOLOGY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
	2483 / N/A	503	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Gains in Patient Activation Measure (PAM®) Scores at 12 Months	Insignia Health, LLC, a wholly owned subsidiary of Phreesia

B.2. Anesthesiology

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Anesthesiology specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.2. Anesthesiology

PROPOSED MEASURES IN THE ANESTHESIOLOGY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
!	N/A / N/A	404	N/A	MIPS CQM	Intermediate Outcome	Anesthesiology Smoking Abstinence	American Society of Anesthesiologists
!	N/A / N/A	477	N/A	MIPS CQM	Process	Multimodal Pain Management	American Society of Anesthesiologists
+	N/A / N/A	TBD	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Patient-Reported Experience with Anesthesia	American Society of Anesthesiologists Anesthesia Quality Institute
+ !	N/A / N/A	TBD	N/A	MIPS CQM	Intermediate Outcome	Intraoperative Hypotension (IOH) among Non-Emergent Noncardiac Surgical Cases	Anesthesia Quality Registry (AQR QCDR) in Collaboration with Anesthesia Quality Institute (AQI) and American Society of Anesthesiologists (ASA)

B.3. Audiology

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Audiology specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.3. Audiology

PROPOSED MEASURES IN THE AUDIOLOGY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
*	N/A / N/A	130	CMS68v16	eCQM, MIPS CQM	Process	Documentation of Current Medications in the Medical Record	Centers for Medicare & Medicaid Services
* !	N/A / N/A	134	CMS2v16	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Centers for Medicare & Medicaid Services
!	0101 / N/A	155	N/A	MIPS CQM	Process	Falls: Plan of Care	National Committee for Quality Assurance
!	N/A / N/A	181	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Elder Maltreatment Screen and Follow-Up Plan	Centers for Medicare & Medicaid Services
	N/A / N/A	182	N/A	MIPS CQM	Process	Functional Outcome Assessment	Centers for Medicare & Medicaid Services
!	N/A / N/A	226	CMS138v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	National Committee for Quality Assurance
	NA / NA	261	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Referral for Otologic Evaluation for Patients with Acute or Chronic Dizziness	Audiology Quality Consortium
* !	N/A / N/A	317	CMS22v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Centers for Medicare & Medicaid Services
	0101 / N/A	318	CMS139v15	eCQM	Process	Falls: Screening for Future Fall Risk	National Committee for Quality Assurance
	2152/ N/A	431	N/A	MIPS CQM	Process	Preventive Care and Screening: Unhealthy Alcohol Use	National Committee for Quality Assurance

B.3. Audiology

PROPOSED MEASURES IN THE AUDIOLOGY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
+ !	N/A / N/A	TBD	N/A	MIPS CQM	Process	Age-Related Hearing Loss: Comprehensive Audiometric Evaluation	American Academy of Otolaryngology – Head and Neck Surgery Foundation

B.4a. Cardiology

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Cardiology specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.4a. Cardiology

PROPOSED MEASURES IN THE CARDIOLOGY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
!	0081 / 0081e	005	CMS135v15	eCQM, MIPS CQM	Process	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) or Angiotensin Receptor-Neprilysin Inhibitor (ARNI) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	American Heart Association
!	0083 / 0083e	008	CMS144v15	eCQM, MIPS CQM	Process	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	American Heart Association
!	0326 / N/A	047	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Advance Care Plan	National Committee for Quality Assurance
	0066 / N/A	118	N/A	MIPS CQM	Process	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy – Diabetes or Left Ventricular Systolic Dysfunction (LVEF ≤ 40%)	American Heart Association
*	N/A / N/A	130	CMS68v16	eCQM, MIPS CQM	Process	Documentation of Current Medications in the Medical Record	Centers for Medicare & Medicaid Services
	N/A / N/A	187	N/A	MIPS CQM	Process	Stroke and Stroke Rehabilitation: Thrombolytic Therapy	American Heart Association
!	N/A / N/A	226	CMS138v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	National Committee for Quality Assurance
* !	N/A / N/A	236	CMS165v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Inter-mediate Outcome	Controlling High Blood Pressure	National Committee for Quality Assurance
!	0022 / N/A	238	CMS156v15	eCQM, MIPS CQM	Process	Use of High-Risk Medications in Older Adults	National Committee for Quality Assurance
	0643 / N/A	243	N/A	MIPS CQM	Process	Cardiac Rehabilitation Patient Referral from an Outpatient Setting	American Heart Association

B.4a. Cardiology

PROPOSED MEASURES IN THE CARDIOLOGY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
* !	N/A / N/A	317	CMS22 v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Centers for Medicare & Medicaid Services
!	N/A / N/A	344	N/A	MIPS CQM	Outcome	Rate of Carotid Endarterectomy (CEA) or Carotid Artery Stenting (CAS) for Asymptomatic Patients, Without Major Complications (Discharged to Home by Post-Operative Day #2)	Society for Vascular Surgery
*	N/A / N/A	374	CMS50 v15	eCQM, MIPS CQM	Process	Closing the Referral Loop: Receipt of Specialist Report	Centers for Medicare & Medicaid Services
	2152 / N/A	431	N/A	MIPS CQM	Process	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	National Committee for Quality Assurance
*	N/A / N/A	438	CMS34 7v10	eCQM, MIPS CQM	Process	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	Centers for Medicare & Medicaid Services
* !	N/A / N/A	441	N/A	MIPS CQM	Intermediate Outcome	Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control)	Wisconsin Collaborative for Healthcare Quality
	3620 / N/A	493	N/A	MIPS CQM	Process	Adult Immunization Status	National Committee for Quality Assurance
!	3665/ N/A	495	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood	American Academy of Hospice and Palliative Medicine (AAHPM)
	2483 / N/A	503	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Gains in Patient Activation Measure (PAM®) Scores at 12 Months	Insignia Health, LLC, a wholly owned subsidiary of Phreesia
+ !	N/A / N/A	TBD	N/A	MIPS CQM	Intermediate Outcome	Low Density Lipoprotein Cholesterol (LDL-C) Monitoring and Management	American Heart Association
+	N/A / N/A	TBD	N/A	MIPS CQM	Process	SGLT2 Inhibitors for Patients with Chronic Kidney Disease (CKD) With or Without Type 2 Diabetes Mellitus	A Value-Based Care Registry

B.4b. Electrophysiology Cardiac Specialist

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Electrophysiology Cardiac Specialist specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.4b. Electrophysiology Cardiac Specialist

PROPOSED MEASURES IN THE ELECTROPHYSIOLOGY CARDIAC SPECIALIST SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
*	2474 / N/A	392	N/A	MIPS CQM	Outcome	Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation	American College of Cardiology Foundation
*	N/A / N/A	393	N/A	MIPS CQM	Outcome	Infection within 180 Days of Cardiac Implantable Electronic Device (CIED) Implantation, Replacement, or Revision	American College of Cardiology Foundation

B.5. Certified Nurse Midwife

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Certified Nurse Midwife specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable.

We are also proposing to add one existing MIPS quality measure to this specialty set:

- **Q493:** Adult Immunization Status: This MIPS quality measure assesses whether adult patients are up-to-date with recommended routine immunizations. We agree with interested parties' feedback that this measure is clinically relevant to this clinician type. Certified Nurse Midwives are advanced practice clinicians uniquely qualified to deliver comprehensive primary care, pregnancy care, and gynecological care. Their scope of practice often includes primary care services such as immunizations, especially in alignment with their focus on preventive care and wellness for women.[445] [446] Adding this measure would align the Certified Nurse Midwife specialty set with the Obstetrics and Gynecology specialty set, recognizing the similarities in care delivery between these specialties and ensuring consistency across specialty sets. Including this measure in the Certified Nursing Midwife specialty set acknowledges the important role they play in preventive care and primary health maintenance, as well as promoting consistent, high quality care delivery across patient populations. The measure being added to this specialty set would be contingent on the inclusion of applicable coding by the time of the CY 2027 PFS final rule publication. In the event appropriate coding is not included in the final specification, this measure would not be finalized for inclusion within this specialty measure set.

Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.5. Certified Nurse Midwife

PROPOSED MEASURES IN THE CERTIFIED NURSE MIDWIFE SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
!	0326 / N/A	047	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Advance Care Plan	National Committee for Quality Assurance
*	N/A / N/A	130	CMS68 v16	eCQM, MIPS CQM	Process	Documentation of Current Medications in the Medical Record	Centers for Medicare & Medicaid Services
!	N/A / N/A	226	CMS13 8v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	National Committee for Quality Assurance
	N/A / N/A	335	N/A	MIPS CQM	Outcome	Maternity Care: Elective Delivery (Without Medical Indication) at < 39 Weeks (Overuse)	Centers for Medicare & Medicaid Services
*	N/A / N/A	336	N/A	MIPS CQM	Process	Maternity Care: Postpartum Follow-up and Care Coordination	Centers for Medicare & Medicaid Services
	2152 / N/A	431	N/A	MIPS CQM	Process	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	National Committee for Quality Assurance

[445] American College of Nurse-Midwives. (2024). Discover Midwives: Certified Nurse-Midwives and Certified Midwives. https://midwife.org/wp-content/uploads/2024/11/2022_Discover-Midwives.pdf.

[446] American College of Nurse-Midwives. (2025). American College of Nurse-Midwives Statement on Maternal Immunization: Updated July 2025. https://midwife.org/american-college-of-nurse-midwives-statement-on-maternal-immunization-updated-july-2025/.

B.5. Certified Nurse Midwife

PROPOSED MEASURES IN THE CERTIFIED NURSE MIDWIFE SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
*	N/A / N/A	475	CMS349v9	eCQM	Process	HIV Screening	Centers for Disease Control and Prevention
+	3620 / N/A	493	N/A	MIPS CQM	Process	Adult Immunization Status	National Committee for Quality Assurance
	N/A / N/A	496	N/A	MIPS CQM	Process	Cardiovascular Disease (CVD) Risk Assessment Measure – Proportion of Pregnant/Postpartum Patients that Receive CVD Risk Assessment with a Standardized Instrument	University of California, Irvine
	2483 / N/A	503	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Gains in Patient Activation Measure (PAM®) Scores at 12 Months	Insignia Health, LLC, a wholly owned subsidiary of Phreesia
	N/A / N/A	504	N/A	MIPS CQM	Process	Initiation, Review, and/or Update to Suicide Safety Plan for Individuals with Suicidal Thoughts, Behavior, or Suicide Risk	American Psychiatric Association
*	N/A / N/A	505	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Reduction in Suicidal Ideation or Behavior Symptoms	American Psychiatric Association

B.6. Chiropractic Medicine

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Chiropractic Medicine specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.6. Chiropractic Medicine

PROPOSED MEASURES IN THE CHIROPRACTIC MEDICINE SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
	N/A / N/A	182	N/A	MIPS CQM	Process	Functional Outcome Assessment	Centers for Medicare & Medicaid Services
+	N/A / N/A	TBD	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Functional Improvement for Patients with Neck Impairments	Limber Health, Inc. and Patient360, LLC
+	N/A / N/A	TBD	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Functional Improvement for Patients with Upper Extremity Impairments	Limber Health, Inc. and Patient360, LLC
+ !	N/A / N/A	TBD	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Functional Improvement for Patients with Back Impairments	Limber Health, Inc. and Patient360, LLC
+	N/A / N/A	TBD	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Functional Improvement for Patients with Lower Extremity Impairments	Limber Health, Inc. and Patient360, LLC
+	N/A / N/A	TBD	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Functional Improvement for Patients with Knee Impairments	Limber Health, Inc. and Patient360, LLC

B.7. Clinical Social Work

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Clinical Social Work specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.7. Clinical Social Work

PROPOSED MEASURES IN THE CLINICAL SOCIAL WORK SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
!	0326 / N/A	047	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Advance Care Plan	National Committee for Quality Assurance
*	N/A / N/A	130	CMS68 v16	eCQM, MIPS CQM	Process	Documentation of Current Medications in the Medical Record	Centers for Medicare & Medicaid Services
* !	N/A / N/A	134	CMS2v 16	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Centers for Medicare & Medicaid Services
!	N/A / N/A	181	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Elder Maltreatment Screen and Follow-Up Plan	Centers for Medicare & Medicaid Services
!	N/A / N/A	226	CMS13 8v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	National Committee for Quality Assurance
	N/A / 2872e	281	CMS14 9v15	eCQM	Process	Dementia: Cognitive Assessment	American Academy of Neurology
!	N/A / N/A	282	N/A	MIPS CQM	Process	Dementia: Functional Status Assessment	American Academy of Neurology
	N/A / N/A	286	N/A	MIPS CQM	Process	Dementia: Safety Concern Screening and Follow-Up for Patients with Dementia	American Academy of Neurology/ American Psychiatric Association
*	N/A / N/A	288	N/A	MIPS CQM	Process	Dementia: Education and Support of Caregivers for Patients with Dementia	American Academy of Neurology
!	N/A / N/A	305	CMS13 7v15	eCQM	Process	Initiation and Engagement of Substance Use Disorder Treatment	National Committee for Quality Assurance
!	0710 / 0710e	370	CMS15 9v15	eCQM, MIPS CQM	Outcome	Depression Remission at Twelve Months	Minnesota Community Measurement
	N/A / N/A	382	CMS17 7v15	eCQM	Process	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	Centers for Medicare & Medicaid Services

B.7. Clinical Social Work

PROPOSED MEASURES IN THE CLINICAL SOCIAL WORK SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
* !	1879 / N/A	383	N/A	MIPS CQM	Intermediate Outcome	Adherence to Antipsychotic Medications For Individuals with Schizophrenia	Centers for Medicare & Medicaid Services
	2152 / N/A	431	N/A	MIPS CQM	Process	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	National Committee for Quality Assurance
!	3665 / N/A	495	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood	American Academy of Hospice and Palliative Medicine (AAHPM)
	N/A / N/A	502	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Improvement or Maintenance of Functioning for Individuals with a Mental and/or Substance Use Disorder	American Psychiatric Association
	2483 / N/A	503	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Gains in Patient Activation Measure (PAM®) Scores at 12 Months	Insignia Health, LLC, a wholly owned subsidiary of Phreesia
	N/A / N/A	504	N/A	MIPS CQM	Process	Initiation, Review, and/or Update to Suicide Safety Plan for Individuals with Suicidal Thoughts, Behavior, or Suicide Risk	American Psychiatric Association
*	N/A / N/A	505	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Reduction in Suicidal Ideation or Behavior Symptoms	American Psychiatric Association

B.8. Dentistry

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Dentistry specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.8. Dentistry

PROPOSED MEASURES IN THE DENTISTRY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
	N/A / N/A	379	CMS 74v16	eCQM	Process	Primary Caries Prevention Intervention as Offered by Dentists	Centers for Medicare & Medicaid Services

B.9. Dermatology

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Dermatology specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.9. Dermatology

PROPOSED MEASURES IN THE DERMATOLOGY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
*	N/A / N/A	130	CMS68 v16	eCQM, MIPS CQM	Process	Documentation of Current Medications in the Medical Record	Centers for Medicare & Medicaid Services
* !	N/A/ N/A	176	N/A	MIPS CQM	Process	Tuberculosis Screening Prior to First Course of Biologic and/or Immune Response Modifier Therapy	American College of Rheumatology
!	N/A / N/A	226	CMS13 8v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	National Committee for Quality Assurance
* !	N/A / N/A	317	CMS22 v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Centers for Medicare & Medicaid Services
*	N/A / N/A	374	CMS50 v15	eCQM, MIPS CQM	Process	Closing the Referral Loop: Receipt of Specialist Report	Centers for Medicare & Medicaid Services
!	N/A / N/A	410	N/A	MIPS CQM	Intermediate Outcome	Psoriasis: Clinical Response to Systemic Medications	American Academy of Dermatology
* !	N/A / N/A	440	N/A	MIPS CQM	Process	Skin Cancer: Biopsy Reporting Time – Pathologist to Clinician	American Academy of Dermatology
	N/A / N/A	485	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Psoriasis – Improvement in Patient-Reported Itch Severity	American Academy of Dermatology
!	N/A / N/A	486	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Dermatitis – Improvement in Patient-Reported Itch Severity	American Academy of Dermatology
	2483 / N/A	503	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Gains in Patient Activation Measure (PAM®) Scores at 12 Months	Insignia Health, LLC, a wholly owned subsidiary of Phreesia

B.9. Dermatology

PROPOSED MEASURES IN THE DERMATOLOGY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
*	N/A / N/A	509	N/A	MIPS CQM	Process	Melanoma: Tracking and Evaluation of Recurrence	American Academy of Dermatology

B.10. Diagnostic Radiology

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Diagnostic Radiology specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set. This specialty set has no proposed changes and is not open for comment.

B.10. Diagnostic Radiology

PREVIOUSLY FINALIZED MEASURES IN THE DIAGNOSTIC RADIOLOGY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
!	N/A / N/A	145	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Radiology: Exposure Dose Indices Reported for Procedures Using Fluoroscopy	American College of Radiology
!	N/A / N/A	360	N/A	MIPS CQM	Process	Optimizing Patient Exposure to Ionizing Radiation: Count of Potential High Dose Radiation Imaging Studies: Computed Tomography (CT) and Cardiac Nuclear Medicine Studies	American College of Radiology
	N/A / N/A	364	N/A	MIPS CQM	Process	Optimizing Patient Exposure to Ionizing Radiation: Appropriateness: Follow-up CT Imaging for Incidentally Detected Pulmonary Nodules According to Recommended Guidelines	American College of Radiology
!	N/A / N/A	405	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Appropriate Follow-up Imaging for Incidental Abdominal Lesions	American College of Radiology
	N/A / N/A	406	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Appropriate Follow-up Imaging for Incidental Thyroid Nodules	American College of Radiology
	3633e, 3662e / 3633e, 3662e	494	CMS1056v4	eCQM	Intermediate Outcome	Excessive Radiation Dose or Inadequate Image Quality for Diagnostic CT in Adults (Clinician Level)	Alara Imaging, Inc. in collaboration with the University of California, San Francisco (UCSF)

B.11. Emergency Medicine

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Emergency Medicine specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.11. Emergency Medicine

PROPOSED MEASURES IN THE EMERGENCY MEDICINE SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
	0069/ N/A	065	CMS154v15	eCQM, MIPS CQM	Process	Appropriate Treatment for Upper Respiratory Infection (URI)	National Committee for Quality Assurance
	N/A / N/A	066	CMS146v15	eCQM, MIPS CQM	Process	Appropriate Testing for Pharyngitis	National Committee for Quality Assurance
!	0058 / N/A	116	N/A	MIPS CQM	Process	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	National Committee for Quality Assurance
!	N/A / N/A	181	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Elder Maltreatment Screen and Follow-Up Plan	Centers for Medicare & Medicaid Services
	N/A / N/A	187	N/A	MIPS CQM	Process	Stroke and Stroke Rehabilitation: Thrombolytic Therapy	American Heart Association
* !	N/A / N/A	317	CMS22 v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Centers for Medicare & Medicaid Services
!	N/A / N/A	331	N/A	MIPS CQM	Process	Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse)	American Academy of Otolaryngology – Head and Neck Surgery Foundation
!	N/A / N/A	416	N/A	MIPS CQM	Efficiency	Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 Through 17 Years	American College of Emergency Physicians

B.12. Endocrinology

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Endocrinology specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.12. Endocrinology

PROPOSED MEASURES IN THE ENDOCRINOLOGY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
* !	0059 / N/A	001	CMS122v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Intermediate Outcome	Diabetes: Glycemic Status Assessment Greater Than 9%	National Committee for Quality Assurance
!	0046 / N/A	039	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Screening for Osteoporosis for Women Aged 65-85 Years of Age	National Committee for Quality Assurance
	0055 / N/A	117	CMS131v15	eCQM, MIPS CQM	Process	Diabetes: Eye Exam	National Committee for Quality Assurance
	0066 / N/A	118	N/A	MIPS CQM	Process	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy – Diabetes or Left Ventricular Systolic Dysfunction (LVEF ≤ 40%)	American Heart Association
!	N/A / N/A	126	N/A	MIPS CQM	Process	Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation	American Podiatric Medical Association
*	N/A / N/A	130	CMS68v16	eCQM, MIPS CQM	Process	Documentation of Current Medications in the Medical Record	Centers for Medicare & Medicaid Services
* !	N/A / N/A	134	CMS2v16	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Centers for Medicare & Medicaid Services
!	N/A / N/A	226	CMS138v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	National Committee for Quality Assurance
* !	N/A / N/A	236	CMS165v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Intermediate Outcome	Controlling High Blood Pressure	National Committee for Quality Assurance
*	N/A / N/A	374	CMS50v15	eCQM, MIPS CQM	Process	Closing the Referral Loop: Receipt of Specialist Report	Centers for Medicare & Medicaid Services

B.12. Endocrinology

PROPOSED MEASURES IN THE ENDOCRINOLOGY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
	0053 / N/A	418	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Osteoporosis Management in Women Who Had a Fracture	National Committee for Quality Assurance
*	N/A / N/A	438	CMS347v10	eCQM, MIPS CQM	Process	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease Disease	Centers for Medicare & Medicaid Services
!	N/A / N/A	462	CMS645v10	eCQM	Process	Bone Density Evaluation for Patients with Prostate Cancer and Receiving Androgen Deprivation Therapy	Oregon Urology Institute
!	N/A / N/A	488	CMS951v5	eCQM, MIPS CQM	Process	Kidney Health Evaluation	National Kidney Foundation
	3620 / N/A	493	N/A	MIPS CQM	Process	Adult Immunization Status	National Committee for Quality Assurance
	2483 / N/A	503	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Gains in Patient Activation Measure (PAM®) Scores at 12 Months	Insignia Health, LLC, a wholly owned subsidiary of Phreesia
+ !	N/A / N/A	TBD	N/A	MIPS CQM	Intermediate Outcome	Low Density Lipoprotein Cholesterol (LDL-C) Monitoring and Management	American Heart Association
+	N/A / N/A	TBD	N/A	MIPS CQM	Process	SGLT2 Inhibitors for Patients with Chronic Kidney Disease (CKD) With or Without Type 2 Diabetes Mellitus	A Value-Based Care Registry

B.13. Family Medicine

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Family Medicine specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable.

We are also proposing to add two existing MIPS quality measures to this specialty set:

- **Q205**: Sexually Transmitted Infection (STI) Testing for People with HIV: This MIPS quality measure assesses appropriate screening of STIs for patients with HIV. We agree with interested parties' feedback that this measure is clinically relevant to this clinician type and propose adding this measure to the Family Medicine specialty set. Clinical guidelines, such as those from the Centers for Disease Control and Prevention (CDC), recommend regular screening for STIs in individuals with HIV.[447] Despite the high incidence of STIs among people with HIV, screening rates remain suboptimal.[448] Including this measure emphasizes adherence to established best practices in care provision within family medicine. This measure would allow clinicians and health systems to track and benchmark their performance in meeting preventive care goals for patients with HIV. The measure being added to this specialty set would be contingent on the inclusion of applicable coding by the time of the CY 2027 PFS final rule publication. In the event appropriate coding is not included in the final specification, this measure would not be finalized for inclusion within this specialty measure set.
- **Q340**: HIV Annual Retention in Care: This MIPS quality measure promotes routine monitoring to track patient progress and ensure treatment efficacy. We agree with interested parties' feedback that this measure is clinically relevant to this clinician type and propose adding this measure to the Family Medicine specialty set. Incorporating this measure aligns with national goals such as the Ending the HIV Epidemic initiative, led by the CDC, which highlights retention and viral suppression as cornerstones for reducing transmission and new infections.[449] A study from the Centers for AIDS Research Network of Integrated Clinical Systems revealed that patients who missed more than two clinic visits over a two-year period had significantly higher mortality risks, even if they otherwise met institutional retention metrics.[450] These findings underscore the life-saving importance of retention in improving survival rates. By measuring and promoting retention in HIV care, the addition of this measure could drive system-wide improvements, support better patient outcomes, reduce preventable mortality, and contribute to public health efforts to end the HIV epidemic. The measure being added to this specialty set would be contingent on the inclusion of applicable coding by the time of the CY 2027 PFS final rule publication. In the event appropriate coding is not included in the final specification, this measure would not be finalized for inclusion within this specialty measure set.

Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.13. Family Medicine

PROPOSED MEASURES IN THE FAMILY MEDICINE SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**

[447] CDC. (2024a). Screening Recommendations and Considerations Referenced in Treatment Guidelines and Original Sources. https://www.cdc.gov/std/treatment-guidelines/screening-recommendations.htm.
[448] Gass, S. J., Chen, S., Zhang, J., Elliott, A. S., Wagner, K. D., White, K. P., & Magnus, M. (2025). Sexually Transmitted Infection (STI) Incidence and Risk Factors Among People with HIV (PWH): Insights From a 13-Year Cohort Study in South Carolina. *AIDS and Behavior, 29*, 2882–2890. https://doi.org/10.1007/s10461-025-04744-5.
[449] CDC. (2024b). About Ending the HIV Epidemic in the US. https://www.cdc.gov/ehe/php/about/index.html.
[450] Mugavero, M. J., Westfall, A. O., Cole, S. R., Geng, E. H., Crane, H. M., Kitahata, M. M., Mathews, W. C., Napravnik, S., Eron, J. J., Moore, R. D., Keruly, J. C., Mayer, K. H., Giordano, T. P., Raper, J. L., & Centers for AIDS Research Network of Integrated Clinical Systems (CNICS) (2014). Beyond Core Indicators of Retention in HIV Care: Missed Clinic Visits are Independently Associated with All-Cause Mortality. *Clinical Infectious Diseases: An Official Publication of the Infectious Diseases Society of America*, *59*(10), 1471–1479. https://doi.org/10.1093/cid/ciu603.

B.13. Family Medicine

PROPOSED MEASURES IN THE FAMILY MEDICINE SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
* !	0059 / N/A	001	CMS1 22v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Intermediate Outcome	Diabetes: Glycemic Status Assessment Greater Than 9%	National Committee for Quality Assurance
!	0081 / 0081e	005	CMS1 35v15	eCQM, MIPS CQM	Process	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) or Angiotensin Receptor-Neprilysin Inhibitor (ARNI) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	American Heart Association
!	0083 / 0083e	008	CMS1 44v15	eCQM, MIPS CQM	Process	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	American Heart Association
	N/A / N/A	009	CMS1 28v15	eCQM	Process	Antidepressant Medication Management	National Committee for Quality Assurance
	N/A / N/A	024	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Communication with the Physician or Other Clinician Managing On-Going Care Post-Fracture for Men and Women Aged 50 Years and Older	National Committee for Quality Assurance
!	0046 / N/A	039	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Screening for Osteoporosis for Women Aged 65-85 Years of Age	National Committee for Quality Assurance
!	0326 / N/A	047	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Advance Care Plan	National Committee for Quality Assurance
	N/A / N/A	048	N/A	MIPS CQM	Process	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	National Committee for Quality Assurance
!	N/A / N/A	050	N/A	MIPS CQM	Process	Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older	National Committee for Quality Assurance
	0069 / N/A	065	CMS1 54v15	eCQM, MIPS CQM	Process	Appropriate Treatment for Upper Respiratory Infection (URI)	National Committee for Quality Assurance
	N/A / N/A	066	CMS1 46v15	eCQM, MIPS CQM	Process	Appropriate Testing for Pharyngitis	National Committee for Quality Assurance
!	0058 / N/A	116	N/A	MIPS CQM	Process	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	National Committee for Quality Assurance
	0055 / N/A	117	CMS1 31v15	eCQM, MIPS CQM	Process	Diabetes: Eye Exam	National Committee for Quality Assurance
!	N/A / N/A	126	N/A	MIPS CQM	Process	Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation	American Podiatric Medical Association
*	N/A / N/A	130	CMS6 8v16	eCQM, MIPS CQM	Process	Documentation of Current Medications in the Medical Record	Centers for Medicare & Medicaid Services

B.13. Family Medicine

PROPOSED MEASURES IN THE FAMILY MEDICINE SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
* !	N/A / N/A	134	CMS2 v16	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Centers for Medicare & Medicaid Services
!	0101 / N/A	155	N/A	MIPS CQM	Process	Falls: Plan of Care	National Committee for Quality Assurance
* !	N/A / N/A	176	N/A	MIPS CQM	Process	Tuberculosis Screening Prior to First Course of Biologic and/or Immune Response Modifier Therapy	American College of Rheumatology
!	N/A / N/A	181	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Elder Maltreatment Screen and Follow-Up Plan	Centers for Medicare & Medicaid Services
	N/A / N/A	182	N/A	MIPS CQM	Process	Functional Outcome Assessment	Centers for Medicare & Medicaid Services
+ !	N/A / 3755e	205	CMS1 188v4	eCQM, MIPS CQM	Process	Sexually Transmitted Infection (STI) Testing for People with HIV	Health Resources and Services Administration
* !	N/A / N/A	236	CMS1 65v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Intermediate Outcome	Controlling High Blood Pressure	National Committee for Quality Assurance
!	0022 / N/A	238	CMS1 56v15	eCQM, MIPS CQM	Process	Use of High-Risk Medications in Older Adults	National Committee for Quality Assurance
	0643 / N/A	243	N/A	MIPS CQM	Process	Cardiac Rehabilitation Patient Referral from an Outpatient Setting	American Heart Association
!	N/A / N/A	305	CMS1 37v15	eCQM	Process	Initiation and Engagement of Substance Use Disorder Treatment	National Committee for Quality Assurance
	N/A / N/A	309	CMS1 24v15	eCQM	Process	Cervical Cancer Screening	National Committee for Quality Assurance
	0101 / N/A	318	CMS1 39v15	eCQM	Process	Falls: Screening for Future Fall Risk	National Committee for Quality Assurance
	0005 / N/A	321	N/A	CMS-approved Survey Vendor	Patient Engagement /Experience	CAHPS for MIPS Clinician/Group Survey	Centers for Medicare & Medicaid Services
!	N/A / N/A	331	N/A	MIPS CQM	Process	Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse)	American Academy of Otolaryngology – Head and Neck Surgery Foundation
!	N/A / N/A	338	CMS3 14v4	eCQM, MIPS CQM	Outcome	HIV Viral Suppression	Health Resources and Services Administration
+	N/A / N/A	340	CMS1 157v3	eCQM, MIPS CQM	Process	HIV Annual Retention in Care	Health Resources and Services Administration

B.13. Family Medicine

PROPOSED MEASURES IN THE FAMILY MEDICINE SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
!	0710 / 0710e	370	CMS159v15	eCQM, MIPS CQM	Outcome	Depression Remission at Twelve Months	Minnesota Community Measurement
*	N/A / N/A	374	CMS50v15	eCQM, MIPS CQM	Process	Closing the Referral Loop: Receipt of Specialist Report	Centers for Medicare & Medicaid Services
	N/A / N/A	377	CMS90v16	eCQM	Process	Functional Status Assessments for Heart Failure	Centers for Medicare & Medicaid Services
* !	1879 / N/A	383	N/A	MIPS CQM	Intermediate Outcome	Adherence to Antipsychotic Medications For Individuals with Schizophrenia	Centers for Medicare & Medicaid Services
	N/A / N/A	387	N/A	MIPS CQM	Process	Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users	American Gastroenterological Association
	N/A / N/A	394	N/A	MIPS CQM	Process	Immunizations for Adolescents	National Committee for Quality Assurance
* !	N/A / N/A	398	N/A	MIPS CQM	Outcome	Optimal Asthma Control	Minnesota Community Measurement
	N/A / N/A	400	N/A	MIPS CQM	Process	One-Time Screening for Hepatitis C Virus (HCV) and Treatment Initiation	American Gastroenterological Association
	N/A / N/A	401	N/A	MIPS CQM	Process	Hepatitis C: Screening for Hepatocellular Carcinoma (HCC) in Patients with Cirrhosis	American Gastroenterological Association
	0053 / N/A	418	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Osteoporosis Management in Women Who Had a Fracture	National Committee for Quality Assurance
	2152 / N/A	431	N/A	MIPS CQM	Process	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	National Committee for Quality Assurance
*	N/A / N/A	438	CMS347v10	eCQM, MIPS CQM	Process	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	Centers for Medicare & Medicaid Services
* !	N/A / N/A	441	N/A	MIPS CQM	Intermediate Outcome	Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control)	Wisconsin Collaborative for Healthcare Quality
*	0657 / N/A	464	N/A	MIPS CQM	Process	Otitis Media with Effusion: Systemic Antimicrobials – Avoidance of Inappropriate Use	American Academy of Otolaryngology – Head and Neck Surgery Foundation
	N/A / N/A	468	N/A	MIPS CQM	Process	Continuity of Pharmacotherapy for Opioid Use Disorder (OUD)	University of Southern California
*	N/A / N/A	475	CMS349v9	eCQM	Process	HIV Screening	Centers for Disease Control and Prevention

B.13. Family Medicine

PROPOSED MEASURES IN THE FAMILY MEDICINE SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
*	N/A / N/A	476	CMS771v8	eCQM	Patient-Reported Outcome-Based Performance Measure	Urinary Symptom Score Change 6-12 Months After Diagnosis of Benign Prostatic Hyperplasia	Large Urology Group Practice Association and Oregon Urology Institute
!	N/A / N/A	488	CMS951v5	eCQM, MIPS CQM	Process	Kidney Health Evaluation	National Kidney Foundation
	3620 / N/A	493	N/A	MIPS CQM	Process	Adult Immunization Status	National Committee for Quality Assurance
!	3665/ N/A	495	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood	American Academy of Hospice and Palliative Medicine (AAHPM)
*	N/A / N/A	497	N/A	MIPS CQM	Process	Preventive Care and Wellness (composite)	Centers for Medicare & Medicaid Services
	N/A / N/A	502	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Improvement or Maintenance of Functioning for Individuals with a Mental and/or Substance Use Disorder	American Psychiatric Association
	2483 / N/A	503	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Gains in Patient Activation Measure (PAM®) Scores at 12 Months	Insignia Health, LLC, a wholly owned subsidiary of Phreesia
	N/A / N/A	504	N/A	MIPS CQM	Process	Initiation, Review, and/or Update to Suicide Safety Plan for Individuals with Suicidal Thoughts, Behavior, or Suicide Risk	American Psychiatric Association
*	N/A / N/A	505	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Reduction in Suicidal Ideation or Behavior Symptoms	American Psychiatric Association
	N/A / 3749e	514	CMS1173v2	eCQM	Intermediate Outcome	Diagnostic Delay of Venous Thromboembolism in Primary Care	Brigham and Women's Hospital
	N/A / N/A	515	CMS1154v2	eCQM	Process	Screening for Abnormal Glucose Metabolism in Patients at Risk of Developing Diabetes	American Medical Association
!	N/A / N/A	516	N/A	MIPS CQM	Outcome	Hepatitis C Virus (HCV): Sustained Virological Response (SVR)	American Gastroenterological Association
+ !	N/A / N/A	TBD	N/A	MIPS CQM	Intermediate Outcome	Low Density Lipoprotein Cholesterol (LDL-C) Monitoring and Management	American Heart Association

B.13. Family Medicine

PROPOSED MEASURES IN THE FAMILY MEDICINE SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
+	N/A / N/A	TBD	N/A	MIPS CQM	Process	SGLT2 Inhibitors for Patients with Chronic Kidney Disease (CKD) With or Without Type 2 Diabetes Mellitus	A Value-Based Care Registry

B.14. Gastroenterology

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Gastroenterology specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.14. Gastroenterology

PROPOSED MEASURES IN THE GASTROENTEROLOGY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
!	0326 / N/A	047	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Advance Care Plan	National Committee for Quality Assurance
*	N/A / N/A	130	CMS68v16	eCQM, MIPS CQM	Process	Documentation of Current Medications in the Medical Record	Centers for Medicare & Medicaid Services
!	N/A / N/A	226	CMS138 v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	National Committee for Quality Assurance
!	NA / N/A	275	N/A	MIPS CQM	Process	Inflammatory Bowel Disease (IBD): Assessment of Hepatitis B Virus (HBV) Status Before Initiating Anti-TNF (Tumor Necrosis Factor) Therapy	American Gastroenterological Association
* !	N/A / N/A	317	CMS22v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Centers for Medicare & Medicaid Services
*	N/A / N/A	374	CMS50v15	eCQM, MIPS CQM	Process	Closing the Referral Loop: Receipt of Specialist Report	Centers for Medicare & Medicaid Services
	N/A / N/A	401	N/A	MIPS CQM	Process	Hepatitis C: Screening for Hepatocellular Carcinoma (HCC) in Patients with Cirrhosis	American Gastroenterological Association
	2152 / N/A	431	N/A	MIPS CQM	Process	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	National Committee for Quality Assurance
	2483 / N/A	503	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Gains in Patient Activation Measure (PAM®) Scores at 12 Months	Insignia Health, LLC, a wholly owned subsidiary of Phreesia
!	N/A / N/A	516	N/A	MIPS CQM	Outcome	Hepatitis C Virus (HCV): Sustained Virological Response (SVR)	American Gastroenterological Association

B.15. General Surgery

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the General Surgery specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.15. General Surgery

PROPOSED MEASURES IN THE GENERAL SURGERY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
!	0326 / N/A	047	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Advance Care Plan	National Committee for Quality Assurance
*	N/A / N/A	130	CMS68 v16	eCQM, MIPS CQM	Process	Documentation of Current Medications in the Medical Record	Centers for Medicare & Medicaid Services
!	N/A / N/A	226	CMS13 8v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	National Committee for Quality Assurance
* !	N/A / N/A	317	CMS22 v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Centers for Medicare & Medicaid Services
!	N/A / N/A	354	N/A	MIPS CQM	Outcome	Anastomotic Leak Intervention	American College of Surgeons
	N/A / N/A	355	N/A	MIPS CQM	Outcome	Unplanned Reoperation within the 30-Day Postoperative Period	American College of Surgeons
!	N/A / N/A	356	N/A	MIPS CQM	Outcome	Unplanned Hospital Readmission within 30 Days of Principal Procedure	American College of Surgeons
!	N/A / N/A	357	N/A	MIPS CQM	Outcome	Surgical Site Infection (SSI)	American College of Surgeons
!	N/A / N/A	358	N/A	MIPS CQM	Process	Patient-Centered Surgical Risk Assessment and Communication	American College of Surgeons
*	N/A / N/A	374	CMS50 v15	eCQM, MIPS CQM	Process	Closing the Referral Loop: Receipt of Specialist Report	Centers for Medicare & Medicaid Services

B.16. Geriatrics

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Geriatrics specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.16. Geriatrics

PROPOSED MEASURES IN THE GERIATRICS SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
!	0046 / N/A	039	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Screening for Osteoporosis for Women Aged 65-85 Years of Age	National Committee for Quality Assurance
!	0326 / N/A	047	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Advance Care Plan	National Committee for Quality Assurance
	N/A / N/A	048	N/A	MIPS CQM	Process	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	National Committee for Quality Assurance
!	N/A / N/A	050	N/A	MIPS CQM	Process	Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older	National Committee for Quality Assurance
*	N/A / N/A	130	CMS68v16	eCQM, MIPS CQM	Process	Documentation of Current Medications in the Medical Record	Centers for Medicare & Medicaid Services
* !	N/A / N/A	134	CMS2v16	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Centers for Medicare & Medicaid Services
!	0101 / N/A	155	N/A	MIPS CQM	Process	Falls: Plan of Care	National Committee for Quality Assurance
!	N/A / N/A	181	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Elder Maltreatment Screen and Follow-Up Plan	Centers for Medicare & Medicaid Services
!	N/A / N/A	226	CMS138v15	Medicare Part B Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	National Committee for Quality Assurance
!	0022 / N/A	238	CMS156v15	eCQM, MIPS CQM	Process	Use of High-Risk Medications in Older Adults	National Committee for Quality Assurance
	N/A / 2872e	281	CMS149v15	eCQM	Process	Dementia: Cognitive Assessment	American Academy of Neurology
!	N/A / N/A	282	N/A	MIPS CQM	Process	Dementia: Functional Status Assessment	American Academy of Neurology/ American Psychiatric Association

B.16. Geriatrics

PROPOSED MEASURES IN THE GERIATRICS SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
	N/A / N/A	286	N/A	MIPS CQM	Process	Dementia: Safety Concern Screening and Follow-Up for Patients with Dementia	American Psychiatric Association/ American Academy of Neurology
*	N/A / N/A	288	N/A	MIPS CQM	Process	Dementia: Education and Support of Caregivers for Patients with Dementia	American Academy of Neurology
	0101 / N/A	318	CMS139 v15	eCQM	Process	Falls: Screening for Future Fall Risk	National Committee for Quality Assurance
!	0710 / 0710e	370	CMS159 v15	eCQM, MIPS CQM	Outcome	Depression Remission at Twelve Months	Minnesota Community Measurement
*	N/A / N/A	476	CMS771 v8	eCQM	Patient-Reported Outcome-Based Performance Measure	Urinary Symptom Score Change 6-12 Months After Diagnosis of Benign Prostatic Hyperplasia	Large Urology Group Practice Association and Oregon Urology Institute
!	N/A / N/A	488	CMS951 v5	eCQM, MIPS CQM	Process	Kidney Health Evaluation	National Kidney Foundation
!	1662/ N/A	489	N/A	MIPS CQM	Process	Adult Kidney Disease: Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy	Renal Physicians Association
	3620 / N/A	493	N/A	MIPS CQM	Process	Adult Immunization Status	National Committee for Quality Assurance
!	3665 / N/A	495	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood	American Academy of Hospice and Palliative Medicine (AAHPM)
	2483 / N/A	503	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Gains in Patient Activation Measure (PAM®) Scores at 12 Months	Insignia Health, LLC, a wholly owned subsidiary of Phreesia
+ !	N/A / N/A	TBD	N/A	MIPS CQM	Intermediate Outcome	Low Density Lipoprotein Cholesterol (LDL-C) Monitoring and Management	American Heart Association
+	N/A / N/A	TBD	N/A	MIPS CQM	Process	SGLT2 Inhibitors for Patients with Chronic Kidney Disease (CKD) With or Without Type 2 Diabetes Mellitus	A Value-Based Care Registry

B.17. Hospitalists

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Hospitalists specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.17. Hospitalists

PROPOSED MEASURES IN THE HOSPITALISTS SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
!	0081 / 0081e	005	CMS13 5v15	eCQM, MIPS CQM	Process	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) or Angiotensin Receptor-Neprilysin Inhibitor (ARNI) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	American Heart Association
!	0083 / 0083e	008	CMS14 4v15	eCQM, MIPS CQM	Process	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	American Heart Association
!	0326 / N/A	047	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Advance Care Plan	National Committee for Quality Assurance
*	N/A / N/A	130	CMS68 v16	eCQM, MIPS CQM	Process	Documentation of Current Medications in the Medical Record	Centers for Medicare & Medicaid Services

B.18. Infectious Disease

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Infectious Disease specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.18. Infectious Disease

PROPOSED MEASURES IN THE INFECTIOUS DISEASE SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
	0069 / N/A	065	CMS154v15	eCQM, MIPS CQM	Process	Appropriate Treatment for Upper Respiratory Infection (URI)	National Committee for Quality Assurance
	N/A / N/A	066	CMS146v15	eCQM, MIPS CQM	Process	Appropriate Testing for Pharyngitis	National Committee for Quality Assurance
*	N/A / N/A	130	CMS68v16	eCQM, MIPS CQM	Process	Documentation of Current Medications in the Medical Record	Centers for Medicare & Medicaid Services
* !	N/A / N/A	176	N/A	MIPS CQM	Process	Tuberculosis Screening Prior to First Course of Biologic and/or Immune Response Modifier Therapy	American College of Rheumatology
!	N/A / 3755e	205	CMS1188v4	eCQM, MIPS CQM	Process	Sexually Transmitted Infection (STI) Testing for People with HIV	Health Resources and Services Administration
!	N/A / N/A	226	CMS138v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	National Committee for Quality Assurance
	N/A / N/A	240	CMS117v15	eCQM	Process	Childhood Immunization Status	National Committee for Quality Assurance
!	NA / N/A	338	CMS314v4	eCQM, MIPS CQM	Outcome	HIV Viral Suppression	Health Resources and Services Administration
	N/A / N/A	340	CMS1157v3	eCQM, MIPS CQM	Process	HIV Annual Retention in Care	Health Resources and Services Administration
	N/A / N/A	387	N/A	MIPS CQM	Process	Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users	American Gastroenterological Association
	N/A / N/A	394	N/A	MIPS CQM	Process	Immunizations for Adolescents	National Committee for Quality Assurance
*	N/A / N/A	475	CMS349v9	eCQM	Process	HIV Screening	Centers for Disease Control and Prevention
	3620 / N/A	493	N/A	MIPS CQM	Process	Adult Immunization Status	National Committee for Quality Assurance

B.18. Infectious Disease

PROPOSED MEASURES IN THE INFECTIOUS DISEASE SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
	2483 / N/A	503	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Gains in Patient Activation Measure (PAM®) Scores at 12 Months	Insignia Health, LLC, a wholly owned subsidiary of Phreesia
!	N/A / N/A	516	N/A	MIPS CQM	Outcome	Hepatitis C Virus (HCV): Sustained Virological Response (SVR)	American Gastroenterological Association

B.19. Internal Medicine

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Internal Medicine specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable.

We are also proposing to add two existing MIPS quality measures to this specialty set:

- **Q205**: Sexually Transmitted Infection (STI) Testing for People with HIV: This MIPS quality measure assesses appropriate screening of STIs for patients with HIV. We agree with interested parties' feedback that this measure is clinically relevant to this clinician type and propose adding this measure to the Internal Medicine specialty set. Clinical guidelines, such as those from the CDC, recommend regular screening for STIs in individuals with HIV.[451] Despite the high incidence of STIs among people with HIV, screening rates remain suboptimal.[452] Including this measure emphasizes adherence to established best practices in care provision within family medicine. This measure would allow clinicians and health systems to track and benchmark their performance in meeting preventive care goals for patients with HIV. The measure being added to this specialty set would be contingent on the inclusion of applicable coding by the time of the CY 2027 PFS final rule publication. In the event appropriate coding is not included in the final specification, this measure would not be finalized for inclusion within this specialty measure set.
- **Q340**: HIV Annual Retention in Care: This MIPS quality measure promotes routine monitoring to track patient progress and ensure treatment efficacy. We agree with interested parties' feedback that this measure is clinically relevant to this clinician type and propose adding this measure to the Internal Medicine specialty set. Incorporating this measure aligns with national goals such as the Ending the HIV Epidemic initiative, led by the CDC, which highlights retention and viral suppression as cornerstones for reducing transmission and new infections.[453] A study from the Centers for AIDS Research Network of Integrated Clinical Systems revealed that patients who missed more than two clinic visits over a two-year period had significantly higher mortality risks, even if they otherwise met institutional retention metrics.[454] These findings underscore the life-saving importance of retention in improving survival rates. By measuring and promoting retention in HIV care, the addition of this measure could drive system-wide improvements, support better patient outcomes, reduce preventable mortality, and contribute to public health efforts to end the HIV epidemic. The measure being added to this specialty set would be contingent on the inclusion of applicable coding by the time of the CY 2027 PFS final rule publication. In the event appropriate coding is not included in the final specification, this measure would not be finalized for inclusion within this specialty measure set.

Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.19. Internal Medicine

PROPOSED MEASURES IN THE INTERNAL MEDICINE SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
* !	0059 / N/A	001	CMS122v 15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Intermediate Outcome	Diabetes: Glycemic Status Assessment Greater Than 9%	National Committee for Quality Assurance
!	0081 / 0081e	005	CMS135v 15	eCQM, MIPS CQM	Process	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) or Angiotensin Receptor-Neprilysin Inhibitor (ARNI) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	American Heart Association

[451] See footnote CDC, 2024a.
[452] See footnote Gass et al., 2025.
[453] See footnote CDC, 2024b.
[454] See footnote Mugavero et al., 2014.

B.19. Internal Medicine

PROPOSED MEASURES IN THE INTERNAL MEDICINE SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
!	0083 / 0083e	008	CMS144 v15	eCQM, MIPS CQM	Process	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	American Heart Association
	N/A / N/A	009	CMS128 v15	eCQM	Process	Antidepressant Medication Management	National Committee for Quality Assurance
	N/A / N/A	024	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Communication with the Physician or Other Clinician Managing On-Going Care Post-Fracture for Men and Women Aged 50 Years and Older	National Committee for Quality Assurance
!	0046 / N/A	039	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Screening for Osteoporosis for Women Aged 65-85 Years of Age	National Committee for Quality Assurance
!	0326 / N/A	047	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Advance Care Plan	National Committee for Quality Assurance
	N/A / N/A	048	N/A	MIPS CQM	Process	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	National Committee for Quality Assurance
!	N/A / N/A	050	N/A	MIPS CQM	Process	Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older	National Committee for Quality Assurance
!	0058 / N/A	116	N/A	MIPS CQM	Process	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	National Committee for Quality Assurance
	0055 / N/A	117	CMS131 v15	eCQM, MIPS CQM	Process	Diabetes: Eye Exam	National Committee for Quality Assurance
!	N/A / N/A	126	N/A	MIPS CQM	Process	Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation	American Podiatric Medical Association
*	N/A / N/A	130	CMS68v 16	eCQM, MIPS CQM	Process	Documentation of Current Medications in the Medical Record	Centers for Medicare & Medicaid Services
* !	N/A / N/A	134	CMS2v1 6	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Centers for Medicare & Medicaid Services
!	0101 / N/A	155	N/A	MIPS CQM	Process	Falls: Plan of Care	National Committee for Quality Assurance
* !	N/A / N/A	176	N/A	MIPS CQM	Process	Tuberculosis Screening Prior to First Course of Biologic and/or Immune Response Modifier Therapy	American College of Rheumatology
!	N/A / N/A	181	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Elder Maltreatment Screen and Follow-Up Plan	Centers for Medicare & Medicaid Services
+ !	N/A / 3755e	205	CMS118 8v4	eCQM, MIPS CQM	Process	Sexually Transmitted Infection (STI) Testing for People with HIV	Health Resources and Services Administration
* !	N/A / N/A	236	CMS165 v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Intermediate Outcome	Controlling High Blood Pressure	National Committee for Quality Assurance

B.19. Internal Medicine

PROPOSED MEASURES IN THE INTERNAL MEDICINE SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
!	0022 / N/A	238	CMS156 v15	eCQM, MIPS CQM	Process	Use of High-Risk Medications in Older Adults	National Committee for Quality Assurance
	0643 / N/A	243	N/A	MIPS CQM	Process	Cardiac Rehabilitation Patient Referral from an Outpatient Setting	American Heart Association
	N/A / N/A	277	N/A	MIPS CQM	Process	Sleep Apnea: Severity Assessment at Initial Diagnosis	American Academy of Sleep Medicine
!	N/A / N/A	279	N/A	MIPS CQM	Process	Sleep Apnea: Assessment of Adherence to Obstructive Sleep Apnea (OSA) Therapy	American Academy of Sleep Medicine
!	N/A / N/A	305	CMS137 v15	eCQM	Process	Initiation and Engagement of Substance Use Disorder Treatment	National Committee for Quality Assurance
	N/A / N/A	309	CMS124 v15	eCQM	Process	Cervical Cancer Screening	National Committee for Quality Assurance
	0101 / N/A	318	CMS139 v15	eCQM	Process	Falls: Screening for Future Fall Risk	National Committee for Quality Assurance
	0005 / N/A	321	N/A	CMS-approved Survey Vendor	Patient Engagement/ Experience	CAHPS for MIPS Clinician/Group Survey	Centers for Medicare & Medicaid Services
!	N/A / N/A	331	N/A	MIPS CQM	Process	Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse)	American Academy of Otolaryngology – Head and Neck Surgery Foundation
!	N/A / N/A	338	CMS314 v4	eCQM, MIPS CQM	Outcome	HIV Viral Suppression	Health Resources and Services Administration
+	N/A / N/A	340	CMS1157v3	eCQM, MIPS CQM	Process	HIV Annual Retention in Care	Health Resources and Services Administration
!	0710 / 0710e	370	CMS159 v15	eCQM, MIPS CQM	Outcome	Depression Remission at Twelve Months	Minnesota Community Measurement
*	N/A / N/A	374	CMS50v 15	eCQM, MIPS CQM	Process	Closing the Referral Loop: Receipt of Specialist Report	Centers for Medicare & Medicaid Services
	N/A / N/A	377	CMS90v 16	eCQM	Process	Functional Status Assessments for Heart Failure	Centers for Medicare & Medicaid Services
* !	1879 / N/A	383	N/A	MIPS CQM	Intermediate Outcome	Adherence to Antipsychotic Medications For Individuals with Schizophrenia	Centers for Medicare & Medicaid Services
	N/A / N/A	387	N/A	MIPS CQM	Process	Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users	American Gastroenterological Association
* !	N/A / N/A	398	N/A	MIPS CQM	Outcome	Optimal Asthma Control	Minnesota Community Measurement
	N/A / N/A	400	N/A	MIPS CQM	Process	One-Time Screening for Hepatitis C Virus (HCV) and Treatment Initiation	American Gastroenterological Association
	N/A / N/A	401	N/A	MIPS CQM	Process	Hepatitis C: Screening for Hepatocellular Carcinoma (HCC) in Patients with Cirrhosis	American Gastroenterological Association

B.19. Internal Medicine

PROPOSED MEASURES IN THE INTERNAL MEDICINE SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
	0053 / N/A	418	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Osteoporosis Management in Women Who Had a Fracture	National Committee for Quality Assurance
	2152 / N/A	431	N/A	MIPS CQM	Process	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	National Committee for Quality Assurance
*	N/A / N/A	438	CMS347 v10	eCQM, MIPS CQM	Process	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	Centers for Medicare & Medicaid Services
* !	N/A / N/A	441	N/A	MIPS CQM	Intermediate Outcome	Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control)	Wisconsin Collaborative for Healthcare Quality
	N/A / N/A	468	N/A	MIPS CQM	Process	Continuity of Pharmacotherapy for Opioid Use Disorder (OUD)	University of Southern California
*	N/A / N/A	475	CMS349 v9	eCQM	Process	HIV Screening	Centers for Disease Control and Prevention
*	N/A / N/A	476	CMS771 v8	eCQM	Patient-Reported Outcome-Based Performance Measure	Urinary Symptom Score Change 6-12 Months After Diagnosis of Benign Prostatic Hyperplasia	Large Urology Group Practice Association and Oregon Urology Institute
!	N/A / N/A	488	CMS951 v5	eCQM, MIPS CQM	Process	Kidney Health Evaluation	National Kidney Foundation
	3620 / N/A	493	N/A	MIPS CQM	Process	Adult Immunization Status	National Committee for Quality Assurance
!	3665 / N/A	495	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood	American Academy of Hospice and Palliative Medicine (AAHPM)
*	N/A / N/A	497	N/A	MIPS CQM	Process	Preventive Care and Wellness (composite)	Centers for Medicare & Medicaid Services
	N/A / N/A	502	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Improvement or Maintenance of Functioning for Individuals with a Mental and/or Substance Use Disorder	American Psychiatric Association
	2483 / N/A	503	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Gains in Patient Activation Measure (PAM®) Scores at 12 Months	Insignia Health, LLC, a wholly owned subsidiary of Phreesia
	N/A / N/A	504	N/A	MIPS CQM	Process	Initiation, Review, and/or Update to Suicide Safety Plan for Individuals with Suicidal Thoughts, Behavior, or Suicide Risk	American Psychiatric Association
	N/A / N/A	515	CMS1154v2	eCQM	Process	Screening for Abnormal Glucose Metabolism in Patients at Risk of Developing Diabetes	American Medical Association
!	N/A / N/A	516	N/A	MIPS CQM	Outcome	Hepatitis C Virus (HCV): Sustained Virological Response (SVR)	American Gastroenterological Association

B.19. Internal Medicine

PROPOSED MEASURES IN THE INTERNAL MEDICINE SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
+ !	N/A / N/A	TBD	N/A	MIPS CQM	Intermediate Outcome	Low Density Lipoprotein Cholesterol (LDL-C) Monitoring and Management	American Heart Association
+	N/A / N/A	TBD	N/A	MIPS CQM	Process	SGLT2 Inhibitors for Patients with Chronic Kidney Disease (CKD) With or Without Type 2 Diabetes Mellitus	A Value-Based Care Registry

B.20. Interventional Radiology

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Interventional Radiology specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.20. Interventional Radiology

PROPOSED MEASURES IN THE INTERVENTIONAL RADIOLOGY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
	N/A / N/A	024	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Communication with the Physician or Other Clinician Managing On-Going Care Post-Fracture for Men and Women Aged 50 Years and Older	National Committee for Quality Assurance
*	N/A / N/A	130	CMS 68v16	eCQM, MIPS CQM	Process	Documentation of Current Medications in the Medical Record	Centers for Medicare & Medicaid Services
!	N/A / N/A	145	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Radiology: Exposure Dose Indices Reported for Procedures Using Fluoroscopy	American College of Radiology
	N/A / N/A	355	N/A	MIPS CQM	Outcome	Unplanned Reoperation within the 30-Day Postoperative Period	American College of Surgeons
!	N/A / N/A	356	N/A	MIPS CQM	Outcome	Unplanned Hospital Readmission within 30 Days of Principal Procedure	American College of Surgeons
!	N/A / N/A	357	N/A	MIPS CQM	Outcome	Surgical Site Infection (SSI)	American College of Surgeons
!	N/A / N/A	358	N/A	MIPS CQM	Process	Patient-Centered Surgical Risk Assessment and Communication	American College of Surgeons
*	N/A / N/A	374	CMS 50v15	eCQM, MIPS CQM	Process	Closing the Referral Loop: Receipt of Specialist Report	Centers for Medicare & Medicaid Services
!	N/A / N/A	413	N/A	MIPS CQM	Intermediate Outcome	Door to Puncture Time for Endovascular Stroke Treatment	Society of Interventional Radiology
	0053 / N/A	418	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Osteoporosis Management in Women Who Had a Fracture	National Committee for Quality Assurance
!	N/A / N/A	420	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Varicose Vein Treatment with Saphenous Ablation: Outcome Survey	Society of Interventional Radiology

B.20. Interventional Radiology

PROPOSED MEASURES IN THE INTERVENTIONAL RADIOLOGY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
	N/A / N/A	421	N/A	MIPS CQM	Process	Appropriate Assessment of Retrievable Inferior Vena Cava (IVC) Filters for Removal	Society of Interventional Radiology
	N/A / N/A	465	N/A	MIPS CQM	Process	Uterine Artery Embolization Technique: Documentation of Angiographic Endpoints and Interrogation of Ovarian Arteries	Society of Interventional Radiology

B.21. Mental/Behavioral Health and Psychiatry

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Mental/Behavioral Health and Psychiatry specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.21. Mental/Behavioral Health and Psychiatry

PROPOSED MEASURES IN THE MENTAL/BEHAVIORAL HEALTH AND PSYCHIATRY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
	N/A / N/A	009	CMS128v15	eCQM	Process	Antidepressant Medication Management	National Committee for Quality Assurance
*	N/A / N/A	130	CMS68v16	eCQM, MIPS CQM	Process	Documentation of Current Medications in the Medical Record	Centers for Medicare & Medicaid Services
* !	N/A / N/A	134	CMS2v16	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Centers for Medicare & Medicaid Services
!	N/A / N/A	181	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Elder Maltreatment Screen and Follow-Up Plan	Centers for Medicare & Medicaid Services
!	N/A / N/A	226	CMS138v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	National Committee for Quality Assurance
	N/A / 2872e	281	CMS149v15	eCQM	Process	Dementia: Cognitive Assessment	American Academy of Neurology
!	N/A / N/A	282	N/A	MIPS CQM	Process	Dementia: Functional Status Assessment	American Academy of Neurology/ American Psychiatric Association
	N/A / N/A	286	N/A	MIPS CQM	Process	Dementia: Safety Concern Screening and Follow-Up for Patients with Dementia	American Psychiatric Association/ American Academy of Neurology
*	N/A / N/A	288	N/A	MIPS CQM	Process	Dementia: Education and Support of Caregivers for Patients with Dementia	American Academy of Neurology
!	N/A / N/A	305	CMS137v15	eCQM	Process	Initiation and Engagement of Substance Use Disorder Treatment	National Committee for Quality Assurance
* !	N/A / N/A	317	CMS22v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Centers for Medicare & Medicaid Services
	N/A / N/A	366	CMS136v16	eCQM	Process	Follow-Up Care for Children Prescribed ADHD Medication	National Committee for Quality Assurance

B.21. Mental/Behavioral Health and Psychiatry

PROPOSED MEASURES IN THE MENTAL/BEHAVIORAL HEALTH AND PSYCHIATRY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
!	0710 / 0710e	370	CMS159v15	eCQM, MIPS CQM	Outcome	Depression Remission at Twelve Months	Minnesota Community Measurement
	N/A / N/A	382	CMS177v15	eCQM	Process	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	Centers for Medicare & Medicaid Services
* !	1879 / N/A	383	N/A	MIPS CQM	Intermediate Outcome	Adherence to Antipsychotic Medications For Individuals with Schizophrenia	Centers for Medicare & Medicaid Services
	2152 / N/A	431	N/A	MIPS CQM	Process	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	National Committee for Quality Assurance
	N/A / N/A	468	N/A	MIPS CQM	Process	Continuity of Pharmacotherapy for Opioid Use Disorder (OUD)	University of Southern California
	N/A / N/A	502	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Improvement or Maintenance of Functioning for Individuals with a Mental and/or Substance Use Disorder	American Psychiatric Association
	N/A / N/A	504	N/A	MIPS CQM	Process	Initiation, Review, and/or Update to Suicide Safety Plan for Individuals with Suicidal Thoughts, Behavior, or Suicide Risk	American Psychiatric Association
*	N/A / N/A	505	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Reduction in Suicidal Ideation or Behavior Symptoms	American Psychiatric Association

B.22. Nephrology

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Nephrology specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.22. Nephrology

PROPOSED MEASURES IN THE NEPHROLOGY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
* !	0059 / N/A	001	CMS122v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Intermediate Outcome	Diabetes: Glycemic Status Assessment Greater Than 9%	National Committee for Quality Assurance
!	0326 / N/A	047	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Advance Care Plan	National Committee for Quality Assurance
*	N/A / N/A	130	CMS68v16	eCQM, MIPS CQM	Process	Documentation of Current Medications in the Medical Record	Centers for Medicare & Medicaid Services
	N/A / N/A	182	N/A	MIPS CQM	Process	Functional Outcome Assessment	Centers for Medicare & Medicaid Services
!	N/A / N/A	226	CMS138v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	National Committee for Quality Assurance
* !	N/A / N/A	317	CMS22v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Centers for Medicare & Medicaid Services
	0101 / N/A	318	CMS139v15	eCQM	Process	Falls: Screening for Future Fall Risk	National Committee for Quality Assurance
	N/A / N/A	400	N/A	MIPS CQM	Process	One-Time Screening for Hepatitis C Virus (HCV) and Treatment Initiation	American Gastroenterological Association
!	N/A/ N/A	482	N/A	MIPS CQM	Intermediate Outcome	Hemodialysis Vascular Access: Practitioner Level Long-term Catheter Rate	Centers for Medicare & Medicaid Services
!	N/A / N/A	488	CMS951v5	eCQM, MIPS CQM	Process	Kidney Health Evaluation	National Kidney Foundation
!	1662/ N/A	489	N/A	MIPS CQM	Process	Adult Kidney Disease: Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy	Renal Physicians Association
	3620 / N/A	493	N/A	MIPS CQM	Process	Adult Immunization Status	National Committee for Quality Assurance

B.22. Nephrology

PROPOSED MEASURES IN THE NEPHROLOGY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
!	3665 / N/A	495	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood	American Academy of Hospice and Palliative Medicine (AAHPM)
	2483 / N/A	503	N/A	MIPS CQM	Patient-Reported Outcome-Based Performanc e Measure	Gains in Patient Activation Measure (PAM®) Scores at 12 Months	Insignia Health, LLC, a wholly owned subsidiary of Phreesia
	N/A / N/A	510	N/A	MIPS CQM	Process	First Year Standardized Kidney Transplant Waitlist Ratio (FYSWR)	Centers for Medicare & Medicaid Services
	N/A / N/A	511	N/A	MIPS CQM	Process	Percentage of Prevalent Patients Waitlisted for Kidney Transplant (PPPW) and Percentage of Prevalent Patients Waitlisted for Kidney Transplant in Active Status (aPPPW)	Centers for Medicare & Medicaid Services
	N/A / N/A	512	N/A	MIPS CQM	Process	Prevalent Standardized Kidney Transplant Waitlist Ratio (PSWR)	Centers for Medicare & Medicaid Services
+ !	N/A / N/A	TBD	N/A	MIPS CQM	Intermediat e Outcome	Low Density Lipoprotein Cholesterol (LDL-C) Monitoring and Management	American Heart Association
+	N/A / N/A	TBD	N/A	MIPS CQM	Process	SGLT2 Inhibitors for Patients with Chronic Kidney Disease (CKD) With or Without Type 2 Diabetes Mellitus	A Value-Based Care Registry

B.23. Neurology

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Neurology specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.23. Neurology

PROPOSED MEASURES IN THE NEUROLOGY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title and Description**	**Measure Steward**
!	0326 / N/A	047	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Advance Care Plan	National Committee for Quality Assurance
*	N/A / N/A	130	CMS68 v16	eCQM, MIPS CQM	Process	Documentation of Current Medications in the Medical Record	Centers for Medicare & Medicaid Services
* !	N/A / N/A	134	CMS2v 16	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Centers for Medicare & Medicaid Services
!	0101 / N/A	155	N/A	MIPS CQM	Process	Falls: Plan of Care	National Committee for Quality Assurance
!	N/A / N/A	181	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Elder Maltreatment Screen and Follow-Up Plan	Centers for Medicare & Medicaid Services
!	N/A / N/A	226	CMS13 8v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	National Committee for Quality Assurance
	N/A / N/A	268	N/A	MIPS CQM	Process	Epilepsy: Counseling for Women of Childbearing Potential with Epilepsy	American Academy of Neurology
	N/A / N/A	277	N/A	MIPS CQM	Process	Sleep Apnea: Severity Assessment at Initial Diagnosis	American Academy of Sleep Medicine
!	N/A / N/A	279	N/A	MIPS CQM	Process	Sleep Apnea: Assessment of Adherence to Obstructive Sleep Apnea (OSA) Therapy	American Academy of Sleep Medicine
	N/A / 2872e	281	CMS14 9v15	eCQM	Process	Dementia: Cognitive Assessment	American Academy of Neurology

B.23. Neurology

PROPOSED MEASURES IN THE NEUROLOGY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title and Description**	**Measure Steward**
!	N/A / N/A	282	N/A	MIPS CQM	Process	Dementia: Functional Status Assessment	American Academy of Neurology/ American Psychiatric Association
	N/A / N/A	286	N/A	MIPS CQM	Process	Dementia: Safety Concern Screening and Follow-Up for Patients with Dementia	American Psychiatric Association/ American Academy of Neurology
*	N/A / N/A	288	N/A	MIPS CQM	Process	Dementia: Education and Support of Caregivers for Patients with Dementia	American Academy of Neurology
*	N/A / N/A	291	N/A	MIPS CQM	Process	Assessment of Cognitive Impairment or Dysfunction for Patients with Parkinson's Disease	American Academy of Neurology
	N/A / N/A	293	N/A	MIPS CQM	Process	Rehabilitative Therapy Referral for Patients with Parkinson's Disease	American Academy of Neurology
* !	N/A / N/A	317	CMS22 v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Centers for Medicare & Medicaid Services
*	N/A / N/A	374	CMS50 v15	eCQM, MIPS CQM	Process	Closing the Referral Loop: Receipt of Specialist Report	Centers for Medicare & Medicaid Services
	N/A / N/A	386	N/A	MIPS CQM	Process	Amyotrophic Lateral Sclerosis (ALS) Patient Care Preferences	American Academy of Neurology
	2152 / N/A	431	N/A	MIPS CQM	Process	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	National Committee for Quality Assurance
!	3665 / N/A	495	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood	American Academy of Hospice and Palliative Medicine (AAHPM)
	2483 / N/A	503	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Gains in Patient Activation Measure (PAM®) Scores at 12 Months	Insignia Health, LLC, a wholly owned subsidiary of Phreesia
*	N/A / N/A	513	N/A	MIPS CQM	Process	Patient Reported Falls and Plan of Care	American Academy of Neurology
+ !	N/A / N/A	TBD	N/A	MIPS CQM	Intermediate Outcome	Low Density Lipoprotein Cholesterol (LDL-C) Monitoring and Management	American Heart Association

B.24. Neurosurgical

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Neurosurgical specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.24. Neurosurgical

PROPOSED MEASURES IN THE NEUROSURGICAL SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title and Description**	**Measure Steward**
*	N/A / N/A	130	CMS68 v16	eCQM, MIPS CQM	Process	Documentation of Current Medications in the Medical Record	Centers for Medicare & Medicaid Services
	N/A / N/A	187	N/A	MIPS CQM	Process	Stroke and Stroke Rehabilitation: Thrombolytic Therapy	American Heart Association
!	N/A / N/A	226	CMS13 8v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	National Committee for Quality Assurance
!	N/A / N/A	344	N/A	MIPS CQM	Outcome	Rate of Carotid Endarterectomy (CEA) or Carotid Artery Stenting (CAS) for Asymptomatic Patients, Without Major Complications (Discharged to Home by Post-Operative Day #2)	Society for Vascular Surgery
!	N/A / N/A	413	N/A	MIPS CQM	Intermediate Outcome	Door to Puncture Time for Endovascular Stroke Treatment	Society of Interventional Radiology
!	N/A / N/A	459	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Back Pain After Lumbar Surgery	Minnesota Community Measurement
	N/A / N/A	461	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Leg Pain After Lumbar Surgery	Minnesota Community Measurement
	N/A / N/A	471	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Functional Status After Lumbar Surgery	Minnesota Community Measurement

B.25. Nutrition/Dietician

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Nutrition/Dietician specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable.

We are also proposing to add one existing MIPS quality measure to this specialty set:

- **Q317**: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented: This MIPS quality measure supports screening for high blood pressure. We agree with interested parties' feedback that adding this measure to this specialty set would help empower registered dietician nutritionists (RDNs) to meaningfully participate in quality programs and value-based care, ensuring patients receive high-value nutritional care. Hypertension (HTN) is among the leading global preventable risk factors for cardiovascular disease and premature mortality.[455] Early detection and effective management of HTN have demonstrated significant reductions in mortality, morbidity, and health care costs.[456] RDNs provide medical nutrition therapy, which has demonstrated effectiveness in improving outcomes such as blood pressure control and reducing cardiovascular risks.[457] Including this measure within the Nutrition/Dietician specialty set recognizes the critical role of RDNs in managing HTN and promotes team-based, whole-person care. The measure being added to this specialty set would be contingent on the inclusion of applicable coding by the time of the CY 2027 PFS final rule publication. In the event appropriate coding is not included in the final specification, this measure would not be finalized for inclusion within this specialty measure set.

Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.25. Nutrition/Dietician

PROPOSED MEASURES IN THE NUTRITION/DIETICIAN SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title and Description**	**Measure Steward**
* !	0059 / N/A	001	CMS122v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Intermediate Outcome	Diabetes: Glycemic Status Assessment Greater Than 9%	National Committee for Quality Assurance
*	N/A / N/A	130	CMS68v16	eCQM, MIPS CQM	Process	Documentation of Current Medications in the Medical Record	Centers for Medicare & Medicaid Services
* !	NA / N/A	134	CMS2v16	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Centers for Medicare & Medicaid Services
!	N/A / N/A	181	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Elder Maltreatment Screen and Follow-Up Plan	Centers for Medicare & Medicaid Services
!	N/A / N/A	226	CMS138v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	National Committee for Quality Assurance
	N/A / N/A	239	CMS155v15	eCQM	Process	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	National Committee for Quality Assurance

[455] Severin, R., Sabbahi, A., Albarrati, A., Phillips, S. A., & Arena, S. (2020). Blood Pressure Screening by Outpatient Physical Therapists: A Call to Action and Clinical Recommendations. Physical Therapy, 100(6), 1008–1019. https://doi.org/10.1093/ptj/pzaa034.

[456] See footnote Severin et al., 2020.

[457] Senkus, K. E., Dudzik, J. M., Lennon, S. L., DellaValle, D. M., Moloney, L. M., Handu, D., & Rozga, M. (2024). *Medical Nutrition Therapy Provided by a Dietitian Improves Outcomes in Adults With Prehypertension or Hypertension: A Systematic Review and Meta-Analysis*. *The American Journal of Clinical Nutrition, 119*(6), 1417–1442. https://doi.org/10.1016/j.ajcnut.2024.04.012.

B.25. Nutrition/Dietician

PROPOSED MEASURES IN THE NUTRITION/DIETICIAN SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title and Description**	**Measure Steward**
*	N/A / N/A	288	N/A	MIPS CQM	Process	Dementia: Education and Support of Caregivers for Patients with Dementia	American Academy of Neurology
+ * !	N/A / N/A	317	CMS22 v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Centers for Medicare & Medicaid Services
	2152 / N/A	431	N/A	MIPS CQM	Process	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	National Committee for Quality Assurance

B.26. Obstetrics/Gynecology

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Obstetrics/Gynecology specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable.

We are also proposing to add two existing MIPS quality measures to this specialty set:

- **Q205**: Sexually Transmitted Infection (STI) Testing for People with HIV: This MIPS quality measure assesses appropriate screening of STIs for patients with HIV. We agree with interested parties' feedback that this measure is clinically relevant to this clinician type and propose adding this measure to the Obstetrics/Gynecology specialty set. Clinical guidelines, such as those from the CDC, recommend regular screening for STIs in individuals with HIV.[458] Despite the high incidence of STIs among people with HIV, screening rates remain suboptimal.[459] Adding measure Q205 to this specialty set would help address critical screening gaps, ensuring sexual health services are consistently delivered in settings managing patients' reproductive health. This measure would allow clinicians and health systems to track and benchmark their performance in meeting preventive care goals for patients with HIV. The measure being added to this specialty set would be contingent on the inclusion of applicable coding by the time of the CY 2027 PFS final rule publication. In the event appropriate coding is not included in the final specification, this measure would not be finalized for inclusion within this specialty measure set.
- **Q338**: HIV Viral Suppression: This MIPS quality measure promotes effective management of HIV viral load for patients diagnosed with HIV. We agree with interested parties' feedback that this measure is clinically relevant to this clinician type and are proposing to add this measure to the Obstetrics/Gynecology specialty set. This specialty plays an essential role in ensuring patients remain actively engaged in HIV care while accessing comprehensive prevention services that improve health outcomes. Viral suppression is widely recognized as the clinical goal of HIV treatment, reflecting successful management of the condition.[460] [461] Measuring viral suppression ensures clinicians are accountable for achieving this outcome across their patient population, which is directly linked to measurable preventive outcomes, such as reducing HIV transmission rates and decreasing HIV-related morbidity and mortality.[462] [463] The measure being added to this specialty set would be contingent on the inclusion of applicable coding by the time of the CY 2027 PFS final rule publication. In the event appropriate coding is not included in the final specification, this measure would not be finalized for inclusion within this specialty measure set.

Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.26. Obstetrics/Gynecology

PROPOSED MEASURES IN THE OBSTETRICS/GYNECOLOGY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title and Description**	**Measure Steward**
!	0046 / N/A	039	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Screening for Osteoporosis for Women Aged 65-85 Years of Age	National Committee for Quality Assurance

[458] See footnote CDC, 2024a.
[459] See footnote Gass et al., 2025.
[460] Panel on Antiretroviral Guidelines for Adults and Adolescents. (2025). Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. U.S. Department of Health and Human Services. https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/whats-new.
[461] CDC. (2023). Treating HIV. https://www.cdc.gov/hiv/treatment/?CDC_AAref_Val=https://www.cdc.gov/hiv/basics/livingwithhiv/treatment.html.
[462] Crawford, T. N., & Thornton, A. (2017). Retention in Continuous Care and Sustained Viral Suppression. *Journal of the International Association of Providers of AIDS Care*, *16*(1), 42–47. https://doi.org/10.1177/2325957416678929.
[463] CDC. (2024c). Effectiveness of HIV Treatment in Preventing HIV Transmission. https://www.cdc.gov/hivpartners/php/hiv-treatment/?CDC_AAref_Val=https://www.cdc.gov/hiv/risk/art/index.html.

B.26. Obstetrics/Gynecology

PROPOSED MEASURES IN THE OBSTETRICS/GYNECOLOGY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title and Description**	**Measure Steward**
!	0326 / N/A	047	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Advance Care Plan	National Committee for Quality Assurance
	N/A / N/A	048	N/A	MIPS CQM	Process	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	National Committee for Quality Assurance
!	N/A / N/A	050	N/A	MIPS CQM	Process	Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older	National Committee for Quality Assurance
*	N/A / N/A	130	CMS68v16	eCQM, MIPS CQM	Process	Documentation of Current Medications in the Medical Record	Centers for Medicare & Medicaid Services
+ !	N/A / 3755e	205	CMS1188v4	eCQM, MIPS CQM	Process	Sexually Transmitted Infection (STI) Testing for People with HIV	Health Resources and Services Administration
* !	N/A / N/A	236	CMS165v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Intermediate Outcome	Controlling High Blood Pressure	National Committee for Quality Assurance
	N/A / N/A	309	CMS124v15	eCQM	Process	Cervical Cancer Screening	National Committee for Quality Assurance
	N/A / N/A	310	CMS153v15	eCQM	Process	Chlamydia Screening in Women	National Committee for Quality Assurance
	N/A / N/A	335	N/A	MIPS CQM	Outcome	Maternity Care: Elective Delivery (Without Medical Indication) at < 39 Weeks (Overuse)	Centers for Medicare & Medicaid Services
*	N/A / N/A	336	N/A	MIPS CQM	Process	Maternity Care: Postpartum Follow-up and Care Coordination	Centers for Medicare & Medicaid Services
+ !	N/A / N/A	338	CMS314v4	eCQM, MIPS CQM	Outcome	HIV Viral Suppression	Health Resources and Services Administration
*	N/A / N/A	374	CMS50v15	eCQM, MIPS CQM	Process	Closing the Referral Loop: Receipt of Specialist Report	Centers for Medicare & Medicaid Services
	0053 / N/A	418	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Osteoporosis Management in Women Who Had a Fracture	National Committee for Quality Assurance
	2063 / N/A	422	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Performing Cystoscopy at the Time of Hysterectomy for Pelvic Organ Prolapse to Detect Lower Urinary Tract Injury	American Urogynecologic Society
	2152 / N/A	431	N/A	MIPS CQM	Process	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	National Committee for Quality Assurance
!	N/A / N/A	432	N/A	MIPS CQM	Outcome	Proportion of Patients Sustaining a Bladder or Bowel Injury at the time of any Pelvic Organ Prolapse Repair	American Urogynecologic Society

B.26. Obstetrics/Gynecology

PROPOSED MEASURES IN THE OBSTETRICS/GYNECOLOGY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title and Description**	**Measure Steward**
	N/A / N/A	448	N/A	MIPS CQM	Process	Appropriate Workup Prior to Endometrial Ablation	Centers for Medicare & Medicaid Services
*	N/A / N/A	475	CMS349v9	eCQM	Process	HIV Screening	Centers for Disease Control and Prevention
	3620 / N/A	493	N/A	MIPS CQM	Process	Adult Immunization Status	National Committee for Quality Assurance
	N/A / N/A	496	N/A	MIPS CQM	Process	Cardiovascular Disease (CVD) Risk Assessment Measure - Proportion of Pregnant/Postpartum Patients that Receive CVD Risk Assessment with a Standardized Instrument	University of California, Irvine
*	N/A / N/A	497	N/A	MIPS CQM	Process	Preventive Care and Wellness (composite)	Centers for Medicare & Medicaid Services
	2483 / N/A	503	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Gains in Patient Activation Measure (PAM®) Scores at 12 Months	Insignia Health, LLC, a wholly owned subsidiary of Phreesia
	N/A / N/A	504	N/A	MIPS CQM	Process	Initiation, Review, and/or Update to Suicide Safety Plan for Individuals with Suicidal Thoughts, Behavior, or Suicide Risk	American Psychiatric Association
*	N/A / N/A	505	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Reduction in Suicidal Ideation or Behavior Symptoms	American Psychiatric Association
+ !	N/A / N/A	TBD	N/A	MIPS CQM	Intermediate Outcome	Low Density Lipoprotein Cholesterol (LDL-C) Monitoring and Management	American Heart Association

B.27a. Oncology/Hematology

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Oncology/Hematology specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.27a. Oncology/Hematology

PROPOSED MEASURES IN THE ONCOLOGY/HEMATOLOGY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title and Description**	**Measure Steward**
!	0326 / N/A	047	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Advance Care Plan	National Committee for Quality Assurance
* !	N/A / N/A	102	CMS129v16	eCQM, MIPS CQM	Process	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	Centers for Medicare & Medicaid Services
*	N/A / N/A	130	CMS68v16	eCQM, MIPS CQM	Process	Documentation of Current Medications in the Medical Record	Centers for Medicare & Medicaid Services
* !	N/A / N/A	134	CMS2v16	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Centers for Medicare & Medicaid Services
* !	0383 / N/A	144	N/A	MIPS CQM	Process	Oncology: Medical and Radiation – Plan of Care for Pain	American Society of Clinical Oncology
!	N/A / N/A	226	CMS138v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	National Committee for Quality Assurance
!	0022 / N/A	238	CMS156v15	eCQM, MIPS CQM	Process	Use of High-Risk Medications in Older Adults	National Committee for Quality Assurance
*	N/A / N/A	250	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Radical Prostatectomy Pathology Reporting	College of American Pathologists
* !	N/A / N/A	317	CMS22v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Centers for Medicare & Medicaid Services
	0005 / N/A	321	N/A	CMS-approved Survey Vendor	Patient Engagement/Experience	CAHPS for MIPS Clinician/Group Survey	Centers for Medicare & Medicaid Services
*	N/A / N/A	374	CMS50v15	eCQM, MIPS CQM	Process	Closing the Referral Loop: Receipt of Specialist Report	Centers for Medicare & Medicaid Services
	2152 / N/A	431	N/A	MIPS CQM	Process	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	National Committee for Quality Assurance

B.27a. Oncology/Hematology

PROPOSED MEASURES IN THE ONCOLOGY/HEMATOLOGY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title and Description**	**Measure Steward**
	1858 / N/A	450	N/A	MIPS CQM	Process	Appropriate Treatment for Patients with Stage I (T1c) – III HER2 Positive Breast Cancer	American Society of Clinical Oncology
!	1859 / N/A	451	N/A	MIPS CQM	Process	RAS (KRAS and NRAS) Gene Mutation Testing Performed for Patients with Metastatic Colorectal Cancer who Receive Anti-epidermal Growth Factor Receptor (EGFR) Monoclonal Antibody Therapy	American Society of Clinical Oncology
*	0210 / N/A	453	N/A	MIPS CQM	Process	Percentage of Patients who Died with Cancer Receiving Systemic Cancer-Directed Therapy in the Last 14 Days of Life (lower score – better)	American Society of Clinical Oncology
* !	0216 / N/A	457	N/A	MIPS CQM	Process	Percentage of Patients who Died from Cancer Admitted to Hospice for Less than 3 Days (lower score – better)	American Society of Clinical Oncology
!	N/A / N/A	462	CMS645v10	eCQM	Process	Bone Density Evaluation for Patients with Prostate Cancer and Receiving Androgen Deprivation Therapy	Oregon Urology Institute
	N/A / N/A	490	N/A	MIPS CQM	Process	Appropriate Intervention of Immune-Related Diarrhea and/or Colitis in Patients Treated with Immune Checkpoint Inhibitors	Society for Immunotherapy of Cancer (SITC)
	3620 / N/A	493	N/A	MIPS CQM	Process	Adult Immunization Status	National Committee for Quality Assurance
!	3665 / N/A	495	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood	American Academy of Hospice and Palliative Medicine (AAHPM)
	2483 / N/A	503	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Gains in Patient Activation Measure (PAM®) Scores at 12 Months	Insignia Health, LLC, a wholly owned subsidiary of Phreesia
!	N/A / N/A	506	N/A	MIPS CQM	Process	Positive PD-L1 Biomarker Expression Test Result Prior to First-Line Immune Checkpoint Inhibitor Therapy	Society for Immunotherapy of Cancer (SITC)
*	N/A / N/A	507	N/A	MIPS CQM	Process	Appropriate Germline Testing for Ovarian Cancer Patients	American Society of Clinical Oncology

B.27b. Radiation Oncology

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Radiation Oncology specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.27b. Radiation Oncology

PROPOSED MEASURES IN THE RADIATION ONCOLOGY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title and Description**	**Measure Steward**
* !	N/A / N/A	102	CMS 129v16	eCQM, MIPS CQM	Process	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	Centers for Medicare & Medicaid Services
* !	0383 / N/A	144	N/A	MIPS CQM	Process	Oncology: Medical and Radiation – Plan of Care for Pain	American Society of Clinical Oncology
!	N/A / N/A	226	CMS 138v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	National Committee for Quality Assurance

B.28. Ophthalmology

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Ophthalmology specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.28. Ophthalmology

PROPOSED MEASURES IN THE OPHTHALMOLOGY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title and Description**	**Measure Steward**
!	N/A / 0086e	012	CMS143v15	eCQM	Process	Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation	American Academy of Ophthalmology
	N/A / N/A	019	CMS142v15	eCQM	Process	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	American Academy of Ophthalmology
	0055 / N/A	117	CMS131v15	eCQM, MIPS CQM	Process	Diabetes: Eye Exam	National Committee for Quality Assurance
*	N/A / N/A	130	CMS68v16	eCQM, MIPS CQM	Process	Documentation of Current Medications in the Medical Record	Centers for Medicare & Medicaid Services
* !	0563 / N/A	141	N/A	Medicare Part B Claims Measure, MIPS CQM	Outcome	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 20% OR Documentation of a Plan of Care	American Academy of Ophthalmology
*	0565 / 0565e	191	CMS133v15	eCQM, MIPS CQM	Outcome	Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery	American Academy of Ophthalmology
!	N/A / N/A	226	CMS138v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	National Committee for Quality Assurance
!	0022 / N/A	238	CMS156v15	eCQM, MIPS CQM	Process	Use of High-Risk Medications in Older Adults	National Committee for Quality Assurance
	N/A / N/A	303	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery	American Academy of Ophthalmology
!	N/A / N/A	304	N/A	MIPS CQM	Patient Engagement/ Experience	Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery	American Academy of Ophthalmology
*	N/A / N/A	374	CMS50v15	eCQM, MIPS CQM	Process	Closing the Referral Loop: Receipt of Specialist Report	Centers for Medicare & Medicaid Services

B.28. Ophthalmology

PROPOSED MEASURES IN THE OPHTHALMOLOGY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title and Description**	**Measure Steward**
!	N/A / N/A	385	N/A	MIPS CQM	Outcome	Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery	American Academy of Ophthalmology
	N/A / N/A	389	N/A	MIPS CQM	Outcome	Cataract Surgery: Difference Between Planned and Final Refraction	American Academy of Ophthalmology
	N/A / N/A	499	N/A	MIPS CQM	Process	Appropriate Screening and Plan of Care for Elevated Intraocular Pressure Following Intravitreal or Periocular Steroid Therapy	American Society of Retina Specialists
	N/A / N/A	500	N/A	MIPS CQM	Process	Acute Posterior Vitreous Detachment Appropriate Examination and Follow-up	American Society of Retina Specialists
!	N/A / N/A	501	N/A	MIPS CQM	Process	Acute Posterior Vitreous Detachment and Acute Vitreous Hemorrhage Appropriate Examination and Follow-up	American Society of Retina Specialists

B.29. Optometry

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Optometry specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.29. Optometry

PROPOSED MEASURES IN THE OPTOMETRY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title and Description**	**Measure Steward**
	N/A / N/A	019	CMS142v15	eCQM	Process	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	American Academy of Ophthalmology
	0055 / N/A	117	CMS131v15	eCQM, MIPS CQM	Process	Diabetes: Eye Exam	National Committee for Quality Assurance
*	N/A / N/A	130	CMS68v16	eCQM, MIPS CQM	Process	Documentation of Current Medications in the Medical Record	Centers for Medicare & Medicaid Services
!	N/A / N/A	226	CMS138v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	National Committee for Quality Assurance
!	0022 / N/A	238	CMS156v15	eCQM, MIPS CQM	Process	Use of High-Risk Medications in Older Adults	National Committee for Quality Assurance
*	N/A / N/A	374	CMS50v15	eCQM, MIPS CQM	Process	Closing the Referral Loop: Receipt of Specialist Report	Centers for Medicare & Medicaid Services

B.30. Orthopedic Surgery

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Orthopedic Surgery specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.30. Orthopedic Surgery

PROPOSED MEASURES IN THE ORTHOPEDIC SURGERY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
	N/A / N/A	024	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Communication with the Physician or Other Clinician Managing On-Going Care Post-Fracture for Men and Women Aged 50 Years and Older	National Committee for Quality Assurance
!	0326 / N/A	047	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Advance Care Plan	National Committee for Quality Assurance
*	N/A / N/A	130	CMS68 v16	eCQM, MIPS CQM	Process	Documentation of Current Medications in the Medical Record	Centers for Medicare & Medicaid Services
* !	N/A / N/A	134	CMS2v 16	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Centers for Medicare & Medicaid Services
!	0101 / N/A	155	N/A	MIPS CQM	Process	Falls: Plan of Care	National Committee for Quality Assurance
* !	N/A / N/A	178	N/A	MIPS CQM	Process	Rheumatoid Arthritis (RA): Functional Status Assessment	American College of Rheumatology
!	N/A / N/A	180	N/A	MIPS CQM	Process	Rheumatoid Arthritis (RA): Glucocorticoid Management	American College of Rheumatology
	N/A / N/A	182	N/A	MIPS CQM	Process	Functional Outcome Assessment	Centers for Medicare & Medicaid Services
!	N/A / N/A	226	CMS13 8v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	National Committee for Quality Assurance
* !	N/A / N/A	317	CMS22 v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Centers for Medicare & Medicaid Services
	0101 / N/A	318	CMS13 9v15	eCQM	Process	Falls: Screening for Future Fall Risk	National Committee for Quality Assurance
!	N/A / N/A	351	N/A	MIPS CQM	Process	Total Knee or Hip Replacement: Venous Thromboembolic and Cardiovascular Risk Evaluation	American Association of Hip and Knee Surgeons

B.30. Orthopedic Surgery

PROPOSED MEASURES IN THE ORTHOPEDIC SURGERY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
!	N/A / N/A	358	N/A	MIPS CQM	Process	Patient-Centered Surgical Risk Assessment and Communication	American College of Surgeons
*	N/A / N/A	374	CMS50 v15	eCQM, MIPS CQM	Process	Closing the Referral Loop: Receipt of Specialist Report	Centers for Medicare & Medicaid Services
	N/A / N/A	376	CMS56 v15	eCQM	Process	Functional Status Assessments for Total Hip Replacement	Centers for Medicare & Medicaid Services
	0053 / N/A	418	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Osteoporosis Management in Women Who Had a Fracture	National Committee for Quality Assurance
!	N/A / N/A	459	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Back Pain After Lumbar Surgery	Minnesota Community Measurement
	N/A / N/A	461	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Leg Pain After Lumbar Surgery	Minnesota Community Measurement
!	N/A / N/A	470	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Functional Status After Primary Total Knee Replacement	Minnesota Community Measurement
	N/A / N/A	471	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Functional Status After Lumbar Surgery	Minnesota Community Measurement
!	3493 / N/A	480	N/A	Administrative Claims	Outcome	Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) for Merit-based Incentive Payment System (MIPS)	Centers for Medicare & Medicaid Services

B.31. Otolaryngology

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Otolaryngology specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.31. Otolaryngology

PROPOSED MEASURES IN THE OTOLARYNGOLOGY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title and Description**	**Measure Steward**
!	0326 / N/A	047	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Advance Care Plan	National Committee for Quality Assurance
	N/A / N/A	066	CMS146v15	eCQM, MIPS CQM	Process	Appropriate Testing for Pharyngitis	National Committee for Quality Assurance
*	N/A / N/A	130	CMS68v16	eCQM, MIPS CQM	Process	Documentation of Current Medications in the Medical Record	Centers for Medicare & Medicaid Services
!	0101 / N/A	155	N/A	MIPS CQM	Process	Falls: Plan of Care	National Committee for Quality Assurance
!	N/A / N/A	226	CMS138v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	National Committee for Quality Assurance
!	0022 / N/A	238	CMS156v15	eCQM, MIPS CQM	Process	Use of High-Risk Medications in Older Adults	National Committee for Quality Assurance
	N/A / N/A	277	N/A	MIPS CQM	Process	Sleep Apnea: Severity Assessment at Initial Diagnosis	American Academy of Sleep Medicine
!	N/A / N/A	279	N/A	MIPS CQM	Process	Sleep Apnea: Assessment of Adherence to Obstructive Sleep Apnea (OSA) Therapy	American Academy of Sleep Medicine
* !	N/A / N/A	317	CMS22v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Centers for Medicare & Medicaid Services
	0101 / N/A	318	CMS139v15	eCQM	Process	Falls: Screening for Future Fall Risk	National Committee for Quality Assurance
!	N/A / N/A	331	N/A	MIPS CQM	Process	Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse)	American Academy of Otolaryngology-Head and Neck Surgery Foundation
	N/A / N/A	355	N/A	MIPS CQM	Outcome	Unplanned Reoperation within the 30-Day Postoperative Period	American College of Surgeons

B.31. Otolaryngology

PROPOSED MEASURES IN THE OTOLARYNGOLOGY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title and Description**	**Measure Steward**
!	N/A / N/A	357	N/A	MIPS CQM	Outcome	Surgical Site Infection (SSI)	American College of Surgeons
!	N/A / N/A	358	N/A	MIPS CQM	Process	Patient-Centered Surgical Risk Assessment and Communication	American College of Surgeons
*	N/A / N/A	374	CMS50 v15	eCQM, MIPS CQM	Process	Closing the Referral Loop: Receipt of Specialist Report	Centers for Medicare & Medicaid Services
* !	N/A / N/A	398	N/A	MIPS CQM	Outcome	Optimal Asthma Control	Minnesota Community Measurement
	2152 / N/A	431	N/A	MIPS CQM	Process	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	National Committee for Quality Assurance
*	0657 / N/A	464	N/A	MIPS CQM	Process	Otitis Media with Effusion: Systemic Antimicrobials – Avoidance of Inappropriate Use	American Academy of Otolaryngology – Head and Neck Surgery Foundation
	3620 / N/A	493	N/A	MIPS CQM	Process	Adult Immunization Status	National Committee for Quality Assurance
+ !	N/A / N/A	TBD	N/A	MIPS CQM	Process	Age-Related Hearing Loss: Comprehensive Audiometric Evaluation	American Academy of Otolaryngology – Head and Neck Surgery Foundation

B.32. Pathology

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Pathology specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.32. Pathology

PROPOSED MEASURES IN THE PATHOLOGY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title and Description**	**Measure Steward**
	N/A / N/A	249	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Barrett's Esophagus	College of American Pathologists
*	N/A / N/A	250	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Radical Prostatectomy Pathology Reporting	College of American Pathologists
*	N/A / N/A	395	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Lung Cancer Reporting (Biopsy/Cytology Specimens)	College of American Pathologists
* !	N/A / N/A	396	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Lung Cancer Reporting (Resection Specimens)	College of American Pathologists
*	N/A / N/A	397	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Melanoma Reporting	College of American Pathologists
* !	N/A / N/A	440	N/A	MIPS CQM	Process	Skin Cancer: Biopsy Reporting Time – Pathologist to Clinician	American Academy of Dermatology
* !	3661 / N/A	491	N/A	MIPS CQM	Process	Mismatch Repair (MMR) or Microsatellite Instability (MSI) Biomarker Testing Status	College of American Pathologists

B.33. Pediatrics

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Pediatrics specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.33. Pediatrics

PROPOSED MEASURES IN THE PEDIATRICS SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title and Description**	**Measure Steward**
	0069 / N/A	065	CMS154v15	eCQM, MIPS CQM	Process	Appropriate Treatment for Upper Respiratory Infection (URI)	National Committee for Quality Assurance
	N/A / N/A	066	CMS146v15	eCQM, MIPS CQM	Process	Appropriate Testing for Pharyngitis	National Committee for Quality Assurance
!	0058 / N/A	116	N/A	MIPS CQM	Process	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	National Committee for Quality Assurance
* !	N/A / N/A	134	CMS2v16	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Centers for Medicare & Medicaid Services
!	N/A / 3755e	205	CMS1188v4	eCQM, MIPS CQM	Process	Sexually Transmitted Infection (STI) Testing for People with HIV	Health Resources and Services Administration
!	N/A / N/A	226	CMS138v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	National Committee for Quality Assurance
	N/A / N/A	239	CMS155v15	eCQM	Process	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	National Committee for Quality Assurance
	N/A / N/A	240	CMS117v15	eCQM	Process	Childhood Immunization Status	National Committee for Quality Assurance
!	N/A / N/A	305	CMS137v15	eCQM	Process	Initiation and Engagement of Substance Use Disorder Treatment	National Committee for Quality Assurance
	N/A / N/A	310	CMS153v15	eCQM	Process	Chlamydia Screening in Women	National Committee for Quality Assurance
	N/A / N/A	366	CMS136v16	eCQM	Process	Follow-Up Care for Children Prescribed ADHD Medication	National Committee for Quality Assurance
!	0710 / 0710e	370	CMS159v15	eCQM, MIPS CQM	Outcome	Depression Remission at Twelve Months	Minnesota Community Measurement
	N/A / N/A	382	CMS177v15	eCQM	Process	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	Centers for Medicare & Medicaid Services
	N/A / N/A	394	N/A	MIPS CQM	Process	Immunizations for Adolescents	National Committee for Quality Assurance
* !	N/A / N/A	398	N/A	MIPS CQM	Outcome	Optimal Asthma Control	Minnesota Community Measurement

B.33. Pediatrics

PROPOSED MEASURES IN THE PEDIATRICS SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title and Description**	**Measure Steward**
*	0657 / N/A	464	N/A	MIPS CQM	Process	Otitis Media with Effusion: Systemic Antimicrobials – Avoidance of Inappropriate Use	American Academy of Otolaryngology – Head and Neck Surgery Foundation

B.34. Physical Medicine

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Physical Medicine specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.34. Physical Medicine

PROPOSED MEASURES IN THE PHYSICAL MEDICINE SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title and Description**	**Measure Steward**
!	0326 / N/A	047	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Advance Care Plan	National Committee for Quality Assurance
*	N/A / N/A	130	CMS 68v16	eCQM, MIPS CQM	Process	Documentation of Current Medications in the Medical Record	Centers for Medicare & Medicaid Services
!	0101 / N/A	155	N/A	MIPS CQM	Process	Falls: Plan of Care	National Committee for Quality Assurance
	N/A / N/A	182	N/A	MIPS CQM	Process	Functional Outcome Assessment	Centers for Medicare & Medicaid Services
!	N/A / N/A	226	CMS 138v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	National Committee for Quality Assurance
* !	N/A / N/A	317	CMS 22v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Centers for Medicare & Medicaid Services
*	N/A / N/A	374	CMS 50v15	eCQM, MIPS CQM	Process	Closing the Referral Loop: Receipt of Specialist Report	Centers for Medicare & Medicaid Services
	2152 / N/A	431	N/A	MIPS CQM	Process	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	National Committee for Quality Assurance
	N/A / N/A	468	N/A	MIPS CQM	Process	Continuity of Pharmacotherapy for Opioid Use Disorder (OUD)	University of Southern California

B.35. Physical Therapy/Occupational Therapy

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Physical Therapy/Occupational Therapy specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.35. Physical Therapy/Occupational Therapy

PROPOSED MEASURES IN THE PHYSICAL THERAPY/OCCUPATIONAL THERAPY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
	N/A / N/A	048	N/A	MIPS CQM	Process	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	National Committee for Quality Assurance
!	N/A / N/A	050	N/A	MIPS CQM	Process	Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older	National Committee for Quality Assurance
!	N/A / N/A	126	N/A	MIPS CQM	Process	Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation	American Podiatric Medical Association
	N/A / N/A	127	N/A	MIPS CQM	Process	Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear	American Podiatric Medical Association
*	N/A / N/A	130	CMS68 v16	eCQM, MIPS CQM	Process	Documentation of Current Medications in the Medical Record	Centers for Medicare & Medicaid Services
* !	N/A / N/A	134	CMS2v 16	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Centers for Medicare & Medicaid Services
!	0101 / N/A	155	N/A	MIPS CQM	Process	Falls: Plan of Care	National Committee for Quality Assurance
!	N/A / N/A	181	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Elder Maltreatment Screen and Follow-Up Plan	Centers for Medicare & Medicaid Services
	N/A / N/A	182	N/A	MIPS CQM	Process	Functional Outcome Assessment	Centers for Medicare & Medicaid Services
!	N/A / N/A	226	CMS13 8v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	National Committee for Quality Assurance
	N/A / 2872e	281	CMS14 9v15	eCQM	Process	Dementia: Cognitive Assessment	American Academy of Neurology

B.35. Physical Therapy/Occupational Therapy

PROPOSED MEASURES IN THE PHYSICAL THERAPY/OCCUPATIONAL THERAPY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
	N/A / N/A	286	N/A	MIPS CQM	Process	Dementia: Safety Concern Screening and Follow-Up for Patients with Dementia	American Academy of Neurology/ American Psychiatric Association
*	N/A / N/A	288	N/A	MIPS CQM	Process	Dementia: Education and Support of Caregivers for Patients with Dementia	American Academy of Neurology
*	N/A / N/A	291	N/A	MIPS CQM	Process	Assessment of Cognitive Impairment or Dysfunction for Patients with Parkinson's Disease	American Academy of Neurology
* !	N/A / N/A	317	CMS22 v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Centers for Medicare & Medicaid Services
	0101 / N/A	318	CMS13 9v15	eCQM	Process	Falls: Screening for Future Fall Risk	National Committee for Quality Assurance
	N/A / N/A	502	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Improvement or Maintenance of Functioning for Individuals with a Mental and/or Substance Use Disorder	American Psychiatric Association
	2483 / N/A	503	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Gains in Patient Activation Measure (PAM®) Scores at 12 Months	Insignia Health, LLC, a wholly owned subsidiary of Phreesia
+	N/A / N/A	TBD	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Functional Improvement for Patients with Neck Impairments	Limber Health, Inc. and Patient360, LLC
+	N/A / N/A	TBD	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Functional Improvement for Patients with Upper Extremity Impairments	Limber Health, Inc. and Patient360, LLC
+ !	N/A / N/A	TBD	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Functional Improvement for Patients with Back Impairments	Limber Health, Inc. and Patient360, LLC
+	N/A / N/A	TBD	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Functional Improvement for Patients with Lower Extremity Impairments	Limber Health, Inc. and Patient360, LLC
+	N/A / N/A	TBD	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Functional Improvement for Patients with Knee Impairments	Limber Health, Inc. and Patient360, LLC

B.36. Plastic Surgery

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Plastic Surgery specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.36. Plastic Surgery

PROPOSED MEASURES IN THE PLASTIC SURGERY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title and Description**	**Measure Steward**
*	N/A / N/A	130	CMS68 v16	eCQM, MIPS CQM	Process	Documentation of Current Medications in the Medical Record	Centers for Medicare & Medicaid Services
!	N/A / N/A	226	CMS13 8v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	National Committee for Quality Assurance
* !	N/A / N/A	317	CMS22 v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Centers for Medicare & Medicaid Services
	N/A / N/A	355	N/A	MIPS CQM	Outcome	Unplanned Reoperation within the 30-Day Postoperative Period	American College of Surgeons
!	N/A / N/A	356	N/A	MIPS CQM	Outcome	Unplanned Hospital Readmission within 30 Days of Principal Procedure	American College of Surgeons
!	N/A / N/A	357	N/A	MIPS CQM	Outcome	Surgical Site Infection (SSI)	American College of Surgeons
!	N/A / N/A	358	N/A	MIPS CQM	Process	Patient-Centered Surgical Risk Assessment and Communication	American College of Surgeons

B.37. Podiatry

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Podiatry specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.37. Podiatry

PROPOSED MEASURES IN THE PODIATRY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title and Description**	**Measure Steward**
!	N/A / N/A	126	N/A	MIPS CQM	Process	Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation	American Podiatric Medical Association
	N/A / N/A	127	N/A	MIPS CQM	Process	Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear	American Podiatric Medical Association
!	0101 / N/A	155	N/A	MIPS CQM	Process	Falls: Plan of Care	National Committee for Quality Assurance
!	N/A / N/A	226	CMS 138v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	National Committee for Quality Assurance
* !	N/A / N/A	317	CMS 22v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Centers for Medicare & Medicaid Services
	0101 / N/A	318	CMS 139v15	eCQM	Process	Falls: Screening for Future Fall Risk	National Committee for Quality Assurance
!	N/A / N/A	358	N/A	MIPS CQM	Process	Patient-Centered Surgical Risk Assessment and Communication	American College of Surgeons
	2483 / N/A	503	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Gains in Patient Activation Measure (PAM®) Scores at 12 Months	Insignia Health, LLC, a wholly owned subsidiary of Phreesia

B.38. Preventive Medicine

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Preventive Medicine specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable.

We are also proposing to add two existing MIPS quality measures to this specialty set:

- **Q205**: Sexually Transmitted Infection (STI) Testing for People with HIV: This MIPS quality measure assesses appropriate screening of STIs for patients with HIV. We agree with interested parties' feedback that this measure is clinically relevant to this clinician type and propose adding this measure to the Preventive Medicine specialty set. Clinical guidelines, such as those from the CDC, recommend regular screening for STIs in individuals with HIV.[464] Despite the high incidence of STIs among people with HIV, screening rates remain suboptimal.[465] Including this measure emphasizes adherence to established best practices in care provision within preventive medicine. This measure would allow clinicians and health systems to track and benchmark their performance in meeting preventive care goals for patients with HIV. The measure being added to this specialty set would be contingent on the inclusion of applicable coding by the time of the CY 2027 PFS final rule publication. In the event appropriate coding is not included in the final specification, this measure would not be finalized for inclusion within this specialty measure set.
- **Q338**: HIV Viral Suppression: This MIPS quality measure promotes effective management of HIV viral load for patients diagnosed with HIV. We agree with interested parties' feedback that this measure is clinically relevant to this clinician type and are proposing to add this measure to the Preventive Medicine specialty set. This specialty plays an essential role in ensuring patients remain actively engaged in HIV care while accessing comprehensive prevention services that improve health outcomes. Viral suppression is widely recognized as the clinical goal of HIV treatment, reflecting successful management of the condition.[466] [467] Measuring viral suppression ensures clinicians are accountable for achieving this outcome across their patient populations, which is directly linked to measurable preventive outcomes, such as reducing HIV transmission rates and decreasing HIV-related morbidity and mortality.[468] [469] The measure being added to this specialty set would be contingent on the inclusion of applicable coding by the time of the CY 2027 PFS final rule publication. In the event appropriate coding is not included in the final specification, this measure would not be finalized for inclusion within this specialty measure set.

Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.38. Preventive Medicine

PROPOSED MEASURES IN THE PREVENTIVE MEDICINE SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title and Description**	**Measure Steward**
* !	0059 / N/A	001	CMS 122v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Intermediate Outcome	Diabetes: Glycemic Status Assessment Greater Than 9%	National Committee for Quality Assurance
	N/A / N/A	024	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Communication with the Physician or Other Clinician Managing On-Going Care Post-Fracture for Men and Women Aged 50 Years and Older	National Committee for Quality Assurance
!	0046 / N/A	039	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Screening for Osteoporosis for Women Aged 65-85 Years of Age	National Committee for Quality Assurance

[464] See footnote CDC, 2024a.
[465] See footnote Gass et al., 2025.
[466] See footnote Panel on Antiretroviral Guidelines for Adults and Adolescents, 2025.
[467] See footnote CDC, 2023.
[468] See footnote Crawford & Thornton, 2017.
[469] See footnote CDC, 2024c.

B.38. Preventive Medicine

PROPOSED MEASURES IN THE PREVENTIVE MEDICINE SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title and Description**	**Measure Steward**
!	0326 / N/A	047	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Advance Care Plan	National Committee for Quality Assurance
	N/A / N/A	048	N/A	MIPS CQM	Process	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	National Committee for Quality Assurance
!	0058 / N/A	116	N/A	MIPS CQM	Process	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	National Committee for Quality Assurance
!	N/A / N/A	126	N/A	MIPS CQM	Process	Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation	American Podiatric Medical Association
*	N/A / N/A	130	CMS 68v16	eCQM, MIPS CQM	Process	Documentation of Current Medications in the Medical Record	Centers for Medicare & Medicaid Services
* !	N/A / N/A	134	CMS 2v16	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Centers for Medicare & Medicaid Services
!	0101 / N/A	155	N/A	MIPS CQM	Process	Falls: Plan of Care	National Committee for Quality Assurance
	N/A / N/A	182	N/A	MIPS CQM	Process	Functional Outcome Assessment	Centers for Medicare & Medicaid Services
+ !	N/A / 3755e	205	CMS 1188v 4	eCQM, MIPS CQM	Process	Sexually Transmitted Infection (STI) Testing for People with HIV	Health Resources and Services Administration
	0643 / N/A	243	N/A	MIPS CQM	Process	Cardiac Rehabilitation Patient Referral from an Outpatient Setting	American Heart Association
+ !	N/A / N/A	338	CMS 314v4	eCQM, MIPS CQM	Outcome	HIV Viral Suppression	Health Resources and Services Administration
*	N/A / N/A	374	CMS 50v15	eCQM, MIPS CQM	Process	Closing the Referral Loop: Receipt of Specialist Report	Centers for Medicare & Medicaid Services
	2152 / N/A	431	N/A	MIPS CQM	Process	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	National Committee for Quality Assurance
	N/A / N/A	438	CMS 347v1 0	eCQM, MIPS CQM	Process	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	Centers for Medicare & Medicaid Services
*	N/A / N/A	475	CMS 349v9	eCQM	Process	HIV Screening	Centers for Disease Control and Prevention
!	N/A / N/A	488	CMS 951v5	eCQM, MIPS CQM	Process	Kidney Health Evaluation	National Kidney Foundation

B.38. Preventive Medicine

PROPOSED MEASURES IN THE PREVENTIVE MEDICINE SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title and Description**	**Measure Steward**
	3620 / N/A	493	N/A	MIPS CQM	Process	Adult Immunization Status	National Committee for Quality Assurance
*	N/A / N/A	497	N/A	MIPS CQM	Process	Preventive Care and Wellness (composite)	Centers for Medicare & Medicaid Services
	2483 / N/A	503	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Gains in Patient Activation Measure (PAM®) Scores at 12 Months	Insignia Health, LLC, a wholly owned subsidiary of Phreesia
+ !	N/A / N/A	TBD	N/A	MIPS CQM	Intermediate Outcome	Low Density Lipoprotein Cholesterol (LDL-C) Monitoring and Management	American Heart Association

B.39. Pulmonology

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Pulmonology specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.39. Pulmonology

PROPOSED MEASURES IN THE PULMONOLOGY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title and Description**	**Measure Steward**
!	0326 / N/A	047	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Advance Care Plan	National Committee for Quality Assurance
!	0102 / N/A	052	N/A	MIPS CQM	Process	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation and Long-Acting Inhaled Bronchodilator Therapy	American Thoracic Society
*	N/A / N/A	130	CMS68 v16	eCQM, MIPS CQM	Process	Documentation of Current Medications in the Medical Record	Centers for Medicare & Medicaid Services
!	N/A / N/A	226	CMS13 8v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	National Committee for Quality Assurance
* !	N/A / N/A	236	CMS16 5v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Intermediate Outcome	Controlling High Blood Pressure	National Committee for Quality Assurance
!	0022 / N/A	238	CMS15 6v15	eCQM, MIPS CQM	Process	Use of High-Risk Medications in Older Adults	National Committee for Quality Assurance
	N/A / N/A	277	N/A	MIPS CQM	Process	Sleep Apnea: Severity Assessment at Initial Diagnosis	American Academy of Sleep Medicine
!	N/A / N/A	279	N/A	MIPS CQM	Process	Sleep Apnea: Assessment of Adherence to Obstructive Sleep Apnea (OSA) Therapy	American Academy of Sleep Medicine
*	N/A / N/A	374	CMS50 v15	eCQM, MIPS CQM	Process	Closing the Referral Loop: Receipt of Specialist Report	Centers for Medicare & Medicaid Services
* !	N/A / N/A	398	N/A	MIPS CQM	Outcome	Optimal Asthma Control	Minnesota Community Measurement
	2152 / N/A	431	N/A	MIPS CQM	Process	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	National Committee for Quality Assurance
	3620 / N/A	493	N/A	MIPS CQM	Process	Adult Immunization Status	National Committee for Quality Assurance

B.39. Pulmonology

PROPOSED MEASURES IN THE PULMONOLOGY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title and Description**	**Measure Steward**
!	3665 / N/A	495	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood	American Academy of Hospice and Palliative Medicine (AAHPM)
	2483 / N/A	503	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Gains in Patient Activation Measure (PAM®) Scores at 12 Months	Insignia Health, LLC, a wholly owned subsidiary of Phreesia

B.40. Rheumatology

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Rheumatology specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.40. Rheumatology

PROPOSED MEASURES IN THE RHEUMATOLOGY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
	N/A / N/A	024	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Communication with the Physician or Other Clinician Managing On-Going Care Post-Fracture for Men and Women Aged 50 Years and Older	National Committee for Quality Assurance
!	0046 / N/A	039	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Screening for Osteoporosis for Women Aged 65-85 Years of Age	National Committee for Quality Assurance
!	0326 / N/A	047	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Advance Care Plan	National Committee for Quality Assurance
*	N/A / N/A	130	CMS68 v16	eCQM, MIPS CQM	Process	Documentation of Current Medications in the Medical Record	Centers for Medicare & Medicaid Services
* !	N/A / N/A	176	N/A	MIPS CQM	Process	Tuberculosis Screening Prior to First Course of Biologic and/or Immune Response Modifier Therapy	American College of Rheumatology
	2523 / N/A	177	N/A	MIPS CQM	Process	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity	American College of Rheumatology
* !	N/A / N/A	178	N/A	MIPS CQM	Process	Rheumatoid Arthritis (RA): Functional Status Assessment	American College of Rheumatology
!	N/A / N/A	180	N/A	MIPS CQM	Process	Rheumatoid Arthritis (RA): Glucocorticoid Management	American College of Rheumatology
!	N/A / N/A	226	CMS13 8v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	National Committee for Quality Assurance
* !	N/A / N/A	236	CMS16 5v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Intermediate Outcome	Controlling High Blood Pressure	National Committee for Quality Assurance
!	0022 / N/A	238	CMS15 6v15	eCQM, MIPS CQM	Process	Use of High-Risk Medications in Older Adults	National Committee for Quality Assurance

B.40. Rheumatology

PROPOSED MEASURES IN THE RHEUMATOLOGY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title**	**Measure Steward**
* !	N/A / N/A	317	CMS22 v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Centers for Medicare & Medicaid Services
*	N/A / N/A	374	CMS50 v15	eCQM, MIPS CQM	Process	Closing the Referral Loop: Receipt of Specialist Report	Centers for Medicare & Medicaid Services
	3620 / N/A	493	N/A	MIPS CQM	Process	Adult Immunization Status	National Committee Quality Assurance
	2483 / N/A	503	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Gains in Patient Activation Measure (PAM®) Scores at 12 Months	Insignia Health, LLC, a wholly owned subsidiary of Phreesia

B.41. Skilled Nursing Facility

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Skilled Nursing Facility specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.41. Skilled Nursing Facility

PROPOSED MEASURES IN THE SKILLED NURSING FACILITY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title and Description**	**Measure Steward**
!	0083 / 0083e	008	CMS1 44v15	eCQM, MIPS CQM	Process	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	American Heart Association
!	0326 / N/A	047	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Advance Care Plan	National Committee for Quality Assurance
	0066 / N/A	118	N/A	MIPS CQM	Process	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF ≤ 40%)	American Heart Association
!	0101 / N/A	155	N/A	MIPS CQM	Process	Falls: Plan of Care	National Committee for Quality Assurance
!	N/A / N/A	181	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Elder Maltreatment Screen and Follow-Up Plan	Centers for Medicare & Medicaid Services
!	0022 / N/A	238	CMS1 56v15	eCQM, MIPS CQM	Process	Use of High-Risk Medications in Older Adults	National Committee for Quality Assurance
* !	N/A / N/A	317	CMS2 2v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Centers for Medicare & Medicaid Services
	3620 / N/A	493	N/A	MIPS CQM	Process	Adult Immunization Status	National Committee for Quality Assurance
!	3665 / N/A	495	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood	American Academy of Hospice and Palliative Medicine (AAHPM)

B.42. Speech Language Pathology

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Speech Language Pathology specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.42. Speech Language Pathology

PROPOSED MEASURES IN THE SPEECH LANGUAGE PATHOLOGY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title and Description**	**Measure Steward**
*	N/A / N/A	130	CMS68 v16	eCQM, MIPS CQM	Process	Documentation of Current Medications in the Medical Record	Centers for Medicare & Medicaid Services
* !	N/A / N/A	134	CMS2v 16	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Centers for Medicare & Medicaid Services
!	N/A / N/A	181	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Elder Maltreatment Screen and Follow-Up Plan	Centers for Medicare & Medicaid Services
	N/A / N/A	182	N/A	MIPS CQM	Process	Functional Outcome Assessment	Centers for Medicare & Medicaid Services
!	N/A / N/A	226	CMS13 8v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	National Committee for Quality Assurance
!	N/A / N/A	282	N/A	MIPS CQM	Process	Dementia: Functional Status Assessment	American Academy of Neurology/ American Psychiatric Association
	N/A / N/A	286	N/A	MIPS CQM	Process	Dementia: Safety Concern Screening and Follow-Up for Patients with Dementia	American Academy of Neurology/ American Psychiatric Association
*	N/A / N/A	288	N/A	MIPS CQM	Process	Dementia: Education and Support of Caregivers for Patients with Dementia	American Academy of Neurology
*	N/A / N/A	291	N/A	MIPS CQM	Process	Assessment of Cognitive Impairment or Dysfunction for Patients with Parkinson's Disease	American Academy of Neurology
	N/A / N/A	386	N/A	MIPS CQM	Process	Amyotrophic Lateral Sclerosis (ALS) Patient Care Preferences	American Academy of Neurology

B.43. Thoracic Surgery

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Thoracic Surgery specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.43. Thoracic Surgery

PROPOSED MEASURES IN THE THORACIC SURGERY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title and Description**	**Measure Steward**
!	0326 / N/A	047	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Advance Care Plan	National Committee for Quality Assurance
*	N/A / N/A	130	CMS 68v16	eCQM, MIPS CQM	Process	Documentation of Current Medications in the Medical Record	Centers for Medicare & Medicaid Services
!	0129 / N/A	164	N/A	MIPS CQM	Outcome	Coronary Artery Bypass Graft (CABG): Prolonged Intubation	Society of Thoracic Surgeons
*	0114 / N/A	167	N/A	MIPS CQM	Outcome	Coronary Artery Bypass Graft (CABG): Postoperative Renal Failure	Society of Thoracic Surgeons
*	0115 / N/A	168	N/A	MIPS CQM	Outcome	Coronary Artery Bypass Graft (CABG): Surgical Re-Exploration	Society of Thoracic Surgeons
!	N/A / N/A	226	CMS 138v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	National Committee for Quality Assurance
!	N/A / N/A	356	N/A	MIPS CQM	Outcome	Unplanned Hospital Readmission within 30 Days of Principal Procedure	American College of Surgeons
!	N/A / N/A	358	N/A	MIPS CQM	Process	Patient-Centered Surgical Risk Assessment and Communication	American College of Surgeons
*	N/A / N/A	374	CMS 50v15	eCQM, MIPS CQM	Process	Closing the Referral Loop: Receipt of Specialist Report	Centers for Medicare & Medicaid Services
	0119 / N/A	445	N/A	MIPS CQM	Outcome	Risk-Adjusted Operative Mortality for Coronary Artery Bypass Graft (CABG)	Society of Thoracic Surgeons

B.44. Urgent Care

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Urgent Care specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.44. Urgent Care

PROPOSED MEASURES IN THE URGENT CARE SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title and Description**	**Measure Steward**
	0069 / N/A	065	CMS154v15	eCQM, MIPS CQM	Process	Appropriate Treatment for Upper Respiratory Infection (URI)	National Committee for Quality Assurance
	N/A / N/A	066	CMS146v15	eCQM, MIPS CQM	Process	Appropriate Testing for Pharyngitis	National Committee for Quality Assurance
!	0058 / N/A	116	N/A	MIPS CQM	Process	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	National Committee for Quality Assurance
*	N/A / N/A	130	CMS68v16	eCQM, MIPS CQM	Process	Documentation of Current Medications in the Medical Record	Centers for Medicare & Medicaid Services
!	N/A / N/A	226	CMS138v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	National Committee for Quality Assurance
* !	N/A / N/A	317	CMS22v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Centers for Medicare & Medicaid Services
!	N/A / N/A	331	N/A	MIPS CQM	Process	Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse)	American Academy of Otolaryngology – Head and Neck Surgery Foundation
	2152 / N/A	431	N/A	MIPS CQM	Process	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	National Committee for Quality Assurance
*	0657 / N/A	464	N/A	MIPS CQM	Process	Otitis Media with Effusion: Systemic Antimicrobials – Avoidance of Inappropriate Use	American Academy of Otolaryngology – Head and Neck Surgery Foundation
!	N/A / N/A	488	CMS951v5	eCQM, MIPS CQM	Process	Kidney Health Evaluation	National Kidney Foundation

B.45. Urology

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Urology specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.45. Urology

PROPOSED MEASURES IN THE UROLOGY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title and Description**	**Measure Steward**
!	0326 / N/A	047	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Advance Care Plan	National Committee for Quality Assurance
	N/A / N/A	048	N/A	MIPS CQM	Process	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	National Committee for Quality Assurance
!	N/A / N/A	050	N/A	MIPS CQM	Process	Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older	National Committee for Quality Assurance
* !	N/A / N/A	102	CMS129v16	eCQM, MIPS CQM	Process	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	Centers for Medicare & Medicaid Services
*	N/A / N/A	130	CMS68v16	eCQM, MIPS CQM	Process	Documentation of Current Medications in the Medical Record	Centers for Medicare & Medicaid Services
* !	N/A / N/A	134	CMS2v16	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Centers for Medicare & Medicaid Services
!	N/A / N/A	226	CMS138v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	National Committee for Quality Assurance
!	0022/ N/A	238	CMS156v15	eCQM, MIPS CQM	Process	Use of High-Risk Medications in Older Adults	National Committee for Quality Assurance
* !	N/A / N/A	317	CMS22v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Centers for Medicare & Medicaid Services
	0005/ N/A	321	N/A	CMS-approved Survey Vendor	Patient Engagement/ Experience	CAHPS for MIPS Clinician/Group Survey	Centers for Medicare & Medicaid Services

B.45. Urology

PROPOSED MEASURES IN THE UROLOGY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title and Description**	**Measure Steward**
!	N/A / N/A	358	N/A	MIPS CQM	Process	Patient-Centered Surgical Risk Assessment and Communication	American College of Surgeons
*	N/A / N/A	374	CMS50v15	eCQM, MIPS CQM	Process	Closing the Referral Loop: Receipt of Specialist Report	Centers for Medicare & Medicaid Services
	2152 / N/A	431	N/A	MIPS CQM	Process	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	National Committee for Quality Assurance
!	N/A / N/A	432	N/A	MIPS CQM	Outcome	Proportion of Patients Sustaining a Bladder or Bowel Injury at the time of any Pelvic Organ Prolapse Repair	American Urogyneco-logic Society
*	0210/ N/A	453	N/A	MIPS CQM	Process	Percentage of Patients who Died with Cancer Receiving Systemic Cancer-Directed Therapy in the Last 14 Days of Life (lower score – better)	American Society of Clinical Oncology
* !	0216/ N/A	457	N/A	MIPS CQM	Process	Percentage of Patients who Died from Cancer Admitted to Hospice for Less than 3 days (lower score – better)	American Society of Clinical Oncology
!	N/A / N/A	462	CMS645v10	eCQM	Process	Bone Density Evaluation for Patients with Prostate Cancer and Receiving Androgen Deprivation Therapy	Oregon Urology Institute
*	N/A / N/A	476	CMS771v8	eCQM	Patient-Reported Outcome-Based Performance Measure	Urinary Symptom Score Change 6-12 Months After Diagnosis of Benign Prostatic Hyperplasia	Large Urology Group Practice Association and Oregon Urology Institute
*	N/A/ N/A	481	CMS646v7	eCQM	Process	Intravesical Bacillus-Calmette -Guerin for Non-Muscle Invasive Bladder Cancer	Oregon Urology
!	N/A / N/A	488	CMS951v5	eCQM, MIPS CQM	Process	Kidney Health Evaluation	National Kidney Foundation
	2483 / N/A	503	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Gains in Patient Activation Measure (PAM®) Scores at 12 Months	Insignia Health, LLC, a wholly owned subsidiary of Phreesia

B.46. Vascular Surgery

In addition to the considerations discussed in the introductory language of Table Group B of this Appendix to this proposed rule, the Vascular Surgery specialty set takes additional criteria into consideration, which includes, but is not limited to, whether a measure reflects current clinical guidelines and the coding of the measure includes relevant clinician types. We may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set. The measure table for this specialty set includes previously finalized measures we are maintaining within the set and modifications proposed for the CY 2027 performance period/2029 MIPS payment year.

Measures proposed for addition to this specialty set under Table Group A of this Appendix, or previously finalized measures proposed for addition, are indicated by a + in the Indicator column, as applicable. Measures proposed for removal under Table Group C of this Appendix have been removed from this specialty set, as applicable. Measures with proposed substantive changes under Table Group D of this Appendix are indicated with a * in the Indicator column, as applicable. Below would be the specialty set for this specialty for the CY 2027 performance period if everything is finalized as proposed. We request comments on these proposals.

B.46. Vascular Surgery

PROPOSED MEASURES IN THE VASCULAR SURGERY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title and Description**	**Measure Steward**
!	0326 / N/A	047	N/A	Medicare Part B Claims Measure, MIPS CQM	Process	Advance Care Plan	National Committee for Quality Assurance
*	N/A / N/A	130	CMS 68v16	eCQM, MIPS CQM	Process	Documentation of Current Medications in the Medical Record	Centers for Medicare & Medicaid Services
!	N/A / N/A	226	CMS 138v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	National Committee for Quality Assurance
* !	N/A / N/A	236	CMS 165v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Intermediate Outcome	Controlling High Blood Pressure	National Committee for Quality Assurance
	N/A / N/A	259	N/A	MIPS CQM	Outcome	Rate of Endovascular Aneurysm Repair (EVAR) of Small or Moderate Non-Ruptured Infrarenal Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post Operative Day #2)	Society for Vascular Surgery
* !	N/A / N/A	317	CMS 22v15	Medicare Part B Claims Measure, eCQM, MIPS CQM	Process	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Centers for Medicare & Medicaid Services
!	N/A / N/A	344	N/A	MIPS CQM	Outcome	Rate of Carotid Endarterectomy (CEA) or Carotid Artery Stenting (CAS) for Asymptomatic Patients, Without Major Complications (Discharged to Home by Post-Operative Day #2)	Society for Vascular Surgery
!	N/A / N/A	357	N/A	MIPS CQM	Outcome	Surgical Site Infection (SSI)	American College of Surgeons
!	N/A / N/A	358	N/A	MIPS CQM	Process	Patient-Centered Surgical Risk Assessment and Communication	American College of Surgeons
*	N/A / N/A	374	CMS 50v15	eCQM, MIPS CQM	Process	Closing the Referral Loop: Receipt of Specialist Report	Centers for Medicare & Medicaid Services

B.46. Vascular Surgery

PROPOSED MEASURES IN THE VASCULAR SURGERY SPECIALTY SET							
Indicator	**CBE # / eCQM CBE #**	**Quality #**	**CMS eCQM ID**	**Collection Type**	**Measure Type**	**Measure Title and Description**	**Measure Steward**
!	N/A / N/A	420	N/A	MIPS CQM	Patient-Reported Outcome-Based Performance Measure	Varicose Vein Treatment with Saphenous Ablation: Outcome Survey	Society of Interventional Radiology
* !	N/A / N/A	441	N/A	MIPS CQM	Intermediate Outcome	Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control)	Wisconsin Collaborative for Healthcare Quality
+ !	N/A / N/A	TBD	N/A	MIPS CQM	Intermediate Outcome	Low Density Lipoprotein Cholesterol (LDL-C) Monitoring and Management	American Heart Association

Table Group C: Previously Finalized Quality Measures Proposed for Removal for the CY 2027 Performance Period/2029 MIPS Payment Year and Future Years

In this proposed rule, we are proposing to remove 20 previously finalized MIPS quality measures for the CY 2027 performance period/2029 MIPS payment year and future years. These measures are discussed in detail in the removal tables below. Note: Specialty sets impacted by each measure removal are indicated under Table Group C of this Appendix within the last row of each C table.

The CY 2019 PFS final rule (83 FR 59763 through 59765) and CY 2020 PFS final rule (84 FR 62957 through 62959) discuss our incremental approach to removing process measures. Further considerations are given in the evaluation of a measure's performance data to determine whether there is or no longer is variation in performance. As discussed in the CY 2019 PFS final rule (83 FR 59761 through 59763), an additional criterion we use for the removal of measures includes extremely topped-out measures, which refers to measures topped out with an average (mean) performance rate between 98-100 percent. For a measure proposed for removal due to criteria relating to the benchmark and performance data, further information regarding 2025 MIPS benchmarking data can be located at *https://qpp.cms.gov/reporting-requirements/measures-activities/benchmarks.*

As codified in the CY 2025 PFS final rule (89 FR 98561) at § 414.1330(c)(1), we list 12 criteria used to determine the removal of a quality measure.

(i) If the Secretary determines that the quality measure is no longer meaningful, such as measures that are topped out.
(ii) If a measure steward is no longer able to maintain the quality measure.
(iii) If the quality measure reached extremely topped out status.
(iv) If the quality measure does not meet case minimum and reporting volumes required for benchmarking after being in the program for 2 consecutive CY performance periods.
(v) If the quality measure is duplicative.
(vi) If the quality measure is not updated to reflect current clinical guidelines, which are not reflective of a clinician's scope of practice.
(vii) If the quality measure is a process measure.
(viii) If the quality measure addresses a measurement gap.
(ix) If the quality measure is a patient-reported outcome.
(x) If the quality measure is not available for MIPS quality reporting by or on behalf of all MIPS eligible clinicians.
(xi) The robustness of the quality measure.
(xii) Consideration of the quality measure in developing MIPS Value Pathways (MVPs).

Additionally, we codified at § 414.1330(c)(2) 6 instances when a quality measure that otherwise meets the criteria for removal in § 414.1330(c)(1) may nonetheless be retained based on the following considerations:

(i) Whether the removal of the process measure impacts the number of measures available for a specific specialty.
(ii) Whether the quality measure addresses a priority area.
(iii) Whether the quality measure promotes positive outcomes in patients.
(iv) Whether the quality measure is designated as high priority or not.
(v) Whether the quality measure has reached extremely topped out status.
(vi) Evaluation of the quality measure's performance data.

However, we would like to note that in section IV.A.4.d.(1)(c)(ii) of this proposed rule we are proposing to update the existing quality measure retention consideration at § 414.1330(c)(1)(iv) to state that we would consider whether the quality measure is designated as high priority or not through the CY 2026 performance period/CY 2028 MIPS payment year.

We request comments on these measure removals and the impacted specialty sets.

C.1 Coronary Artery Disease (CAD): Antiplatelet Therapy

Category	Description
CBE # / eCQM CBE #:	0067 / N/A
Quality#:	006
CMS eCQM ID:	N/A
Collection Type:	MIPS CQM
Measure Description:	Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease (CAD) seen within a 12-month period who were prescribed aspirin or clopidogrel.
Measure Steward:	American Heart Association
Measure Type:	Process
Rationale for Removal:	We are proposing the removal of this quality measure from MIPS, finalized in the CY 2017 Quality Payment Program final rule (81 FR 77558 through 77675), at the measure steward's request because it would no longer be maintained for inclusion.
In the Circumstance the Measure Is Retained:	There are no substantive changes for this measure. If the measure is not finalized for removal in the CY 2027 PFS final rule, it would be added back into the applicable previously finalized specialty set(s) under Table Group B of this Appendix and the reason for its retention would be addressed under Table Group C of this Appendix.
Proposed for Removal from the Following Specialty Sets:	Cardiology, Family Medicine, Internal Medicine, Skilled Nursing Facility

C.2 Coronary Artery Disease (CAD): Beta-Blocker Therapy – Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF ≤ 40%)

Category	Description
CBE # / eCQM CBE #:	0070 / 0070e
Quality#:	007
CMS eCQM ID:	CMS145v15
Collection Type:	eCQM / MIPS CQM
Measure Description:	Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12-month period who also have a prior MI or a current or prior LVEF ≤ 40% who were prescribed beta-blocker therapy.
Measure Steward:	American Heart Association
Measure Type:	Process
Rationale for Removal:	We are proposing the removal of this quality measure from MIPS, finalized in the CY 2017 Quality Payment Program final rule (81 FR 77558 through 77675), at the measure steward's request because it would no longer be maintained for inclusion.
In the Circumstance the Measure Is Retained:	There are no substantive changes for this measure. If the measure is not finalized for removal in the CY 2027 PFS final rule, it would be added back into the applicable previously finalized specialty set(s) under Table Group B of this Appendix and the reason for its retention would be addressed under Table Group C of this Appendix.
Proposed for Removal from the Following Specialty Sets:	Cardiology, Family Medicine, Internal Medicine, Skilled Nursing Facility

C.3 Oncology: Medical and Radiation – Pain Intensity Quantified

Category	Description
CBE # / eCQM CBE #:	0384 / 0384e
Quality#:	143
CMS eCQM ID:	CMS157v15
Collection Type:	eCQM / MIPS CQM
Measure Description:	Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified.
Measure Steward:	American Society of Clinical Oncology
Measure Type:	Process
Rationale for Removal:	We are proposing the removal of this quality measure from MIPS, finalized in the CY 2017 Quality Payment Program final rule (81 FR 77558 through 77675), because this measure has reached the end of the topped-out lifecycle (82 FR 53640) and has a limited opportunity to improve clinical outcomes. Topped-out process measures are those with a median performance rate of 95 percent or higher (81 FR 77286). This measure's continued topped-out status is based on the current 2026 MIPS benchmarking data located at *https://qpp.cms.gov/reporting-requirements/measures-activities/benchmarks*, in addition to previous years MIPS benchmarking data. For more information on benchmarks, see the MIPS 2026 Quality Benchmarks User Guide at *https://qpp-cm-prod-content.s3.amazonaws.com/uploads/3611/2026-Quality-Benchmarks-User-Guide.pdf*.
In the Circumstance the Measure Is Retained:	There are no substantive changes for this measure. If the measure is not finalized for removal in the CY 2027 PFS final rule, it would be added back into the applicable previously finalized specialty set(s) under Table Group B of this Appendix and the reason for its retention would be addressed under Table Group C of this Appendix.
Proposed for Removal from the Following Specialty Sets:	Oncology/Hematology, Radiation Oncology

C.4 Functional Status Change for Patients with Knee Impairments

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	217
CMS eCQM ID:	N/A
Collection Type:	MIPS CQM
Measure Description:	A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with knee impairments. The change in FS is assessed using the FOTO Lower Extremity Physical Function (LEPF) PROM. The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk-adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.
Measure Steward:	Focus on Therapeutic Outcomes, Inc.
Measure Type:	Patient-Reported Outcome-Based Performance Measure
Rationale for Removal:	We are proposing the removal of this quality measure from MIPS, finalized in the CY 2017 Quality Payment Program final rule (81 FR 77558 through 77675), because this measure is duplicative of the Functional Improvement for Patients with Knee Impairments measure being proposed in Table A.6 of this Appendix. Measure Q217 is specific to knee impairments and restricts clinicians to using the proprietary tool FOTO LEPF PROM or a manual crosswalk for numerator assessment. The new measure proposed in Table A.6 of this Appendix is a more comprehensive patient-reported outcome-based performance measure. The new measure allows the use of various validated assessments tools, including the Knee Outcome Survey, Patient-Reported Outcomes Measurement Information System (PROMIS) Physical Function, or equivalent tools. The new measure focuses on clinically meaningful outcomes by assessing improvement against the Predicted Moderate Clinical Improvement (P-MCI), a patient-specific, risk-adjusted threshold. This measure incorporates a risk adjustment model that would improve feasibility of reporting as all information to calculate performance would be provided by the measure steward.
In the Circumstance the Measure Is Retained:	There are no substantive changes for this measure. If the measure is not finalized for removal in the CY 2027 PFS final rule, it would be added back into the applicable previously finalized specialty set(s) under Table Group B of this Appendix and the reason for its retention would be addressed under Table Group C of this Appendix.
Proposed for Removal from the Following Specialty Sets:	Chiropractic Medicine, Orthopedic Surgery, Physical Therapy/Occupational Therapy

C.5 Functional Status Change for Patients with Hip Impairments

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	218
CMS eCQM ID:	N/A
Collection Type:	MIPS CQM
Measure Description:	A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with hip impairments. The change in FS is assessed using the FOTO Lower Extremity Physical Function (LEPF) PROM. The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.
Measure Steward:	Focus on Therapeutic Outcomes, Inc.
Measure Type:	Patient-Reported Outcome-Based Performance Measure
Rationale for Removal:	We are proposing the removal of this quality measure from MIPS, finalized in the CY 2017 Quality Payment Program final rule (81 FR 77558 through 77675), because this measure is duplicative of the Functional Improvement for Patients with Lower Extremity Impairments measure being proposed in Table A.5 of this Appendix. Measure Q218 is specific to hip impairments and restricts clinicians to using the proprietary tool FOTO LEPF PROM or a manual crosswalk for numerator assessment. The new measure proposed in Table A.5 of this Appendix is a more comprehensive patient-reported outcome-based performance measure that includes all lower extremity injuries. The new measure allows the use of various validated assessments tools, including the Lower Extremity Functional Scale (LEFS), PROMIS Physical Function, or equivalent tools. The new measure focuses on clinically meaningful outcomes by assessing improvement against the P-MCI, a patient-specific, risk-adjusted threshold. This measure incorporates a risk adjustment model that would improve feasibility of reporting as all information to calculate performance would be provided by the measure steward.
In the Circumstance the Measure Is Retained:	There are no substantive changes for this measure. If the measure is not finalized for removal in the CY 2027 PFS final rule, it would be added back into the applicable previously finalized specialty set(s) under Table Group B of this Appendix and the reason for its retention would be addressed under Table Group C of this Appendix.
Proposed for Removal from the Following Specialty Sets:	Chiropractic Medicine, Orthopedic Surgery, Physical Therapy/Occupational Therapy

C.6 Functional Status Change for Patients with Lower Leg, Foot or Ankle Impairments

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	219
CMS eCQM ID:	N/A
Collection Type:	MIPS CQM
Measure Description:	A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with foot, ankle or lower leg impairments. The change in FS is assessed using the FOTO Lower Extremity Physical Function (LEPF) PROM. The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk-adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.
Measure Steward:	Focus on Therapeutic Outcomes, Inc.
Measure Type:	Patient-Reported Outcome-Based Performance Measure
Rationale for Removal:	We are proposing the removal of this quality measure from MIPS, finalized in the CY 2017 Quality Payment Program final rule (81 FR 77558 through 77675), because this measure is duplicative of the Functional Improvement for Patients with Lower Extremity Impairments measure being proposed in Table A.5 of this Appendix. Measure Q219 is specific to lower leg, foot and ankle impairments and restricts clinicians to the use of the proprietary tool FOTO LEPF PROM or a manual crosswalk for numerator assessment. The new measure proposed in Table A.5 of this Appendix is a more comprehensive patient-reported outcome-based performance measure that includes all lower extremity injuries. The new measure allows the use of various validated assessments tools, including the LEFS, PROMIS Physical Function, or equivalent tools. The new measure focuses on clinically meaningful outcomes by assessing improvement against the P-MCI, a patient-specific, risk-adjusted threshold. This measure incorporates a risk adjustment model that would improve feasibility of reporting as all information to calculate performance would be provided by the measure steward.
In the Circumstance the Measure Is Retained:	There are no substantive changes proposed for this measure. If the measure is not finalized for removal in the CY 2027 PFS final rule, it would be added back into the applicable previously finalized specialty set(s) under Table Group B of this Appendix and the reason for its retention would be addressed under Table Group C of this Appendix.
Proposed for Removal from the Following Specialty Sets:	Chiropractic Medicine, Orthopedic Surgery, Physical Therapy/Occupational Therapy, Podiatry

C.7 Functional Status Change for Patients with Low Back Impairments

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	220
CMS eCQM ID:	N/A
Collection Type:	MIPS CQM
Measure Description:	A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with low back impairments. The change in FS is assessed using the FOTO Low Back FS PROM. The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.
Measure Steward:	Focus on Therapeutic Outcomes, Inc.
Measure Type:	Patient-Reported Outcome-Based Performance Measure
Rationale for Removal:	We are proposing the removal of this quality measure from MIPS, finalized in the CY 2017 Quality Payment Program final rule (81 FR 77558 through 77675), because this measure is duplicative of the Functional Improvement for Patients with Back Impairments measure being proposed in Table A.4 of this Appendix. Measure Q220 is specific to low back impairments and restricts clinicians to the use of the proprietary tool FOTO Low Back FS PROM or a manual crosswalk for numerator assessment. The new measure proposed in Table A.4 of this Appendix is a more comprehensive patient-reported outcome-based performance measure that includes all back impairments. The new measure allows the use of various validated assessment tools, such as the Modified Low Back Disability Questionnaire, PROMIS Pain Interference, or equivalent tools. The new measure focuses on clinically meaningful outcomes by assessing improvement against the P-MCI, a patient-specific, risk-adjusted threshold. This measure incorporates a risk adjustment model that would improve feasibility of reporting as all information to calculate performance would be provided by the measure steward.
In the Circumstance the Measure Is Retained:	There are no substantive changes proposed for this measure. If the measure is not finalized for removal in the CY 2027 PFS final rule, it would be added back into the applicable previously finalized specialty set(s) under Table Group B of this Appendix and the reason for its retention would be addressed under Table Group C of this Appendix.
Proposed for Removal from the Following Specialty Sets:	Chiropractic Medicine, Orthopedic Surgery, Physical Therapy/Occupational Therapy

C.8 Functional Status Change for Patients with Shoulder Impairments

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	221
CMS eCQM ID:	N/A
Collection Type:	MIPS CQM
Measure Description:	A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with shoulder impairments. The change in FS is assessed using the FOTO Shoulder FS PROM. The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.
Measure Steward:	Focus on Therapeutic Outcomes, Inc.
Measure Type:	Patient-Reported Outcome-Based Performance Measure
Rationale for Removal:	We are proposing the removal of this quality measure from MIPS, finalized in the CY 2017 Quality Payment Program final rule (81 FR 77558 through 77675), because this measure is duplicative of the Functional Improvement for Patients with Upper Extremity Impairments measure being proposed in Table A.3 of this Appendix. Measure Q221 is specific to shoulder impairments and restricts clinicians to the use of the proprietary tool FOTO Shoulder FS PROM or a manual crosswalk for numerator assessment. The new measure proposed in Table A.3 of this Appendix is a more comprehensive patient-reported outcome-based performance measure that includes all upper extremity injuries. The new measure allows the use of various validated assessment tools, such as the Quick Disabilities of the Arm, Shoulder, & Hand (QDASH) and PROMIS Upper Extremity, or equivalent tools. The new measure focuses on clinically meaningful outcomes by assessing improvement against the P-MCI, a patient-specific, risk-adjusted threshold. This measure incorporates a risk adjustment model that would improve feasibility of reporting as all information to calculate performance would be provided by the measure steward.
In the Circumstance the Measure Is Retained:	There are no substantive changes proposed for this measure. If the measure is not finalized for removal in the CY 2027 PFS final rule, it would be added back into the applicable previously finalized specialty set(s) under Table Group B of this Appendix and the reason for its retention would be addressed under Table Group C of this Appendix.
Proposed for Removal from the Following Specialty Sets:	Chiropractic Medicine, Orthopedic Surgery, Physical Therapy/Occupational Therapy

C.9 Functional Status Change for Patients with Elbow, Wrist or Hand Impairments

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	222
CMS eCQM ID:	N/A
Collection Type:	MIPS CQM
Measure Description:	A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with elbow, wrist, or hand impairments. The change in FS is assessed using the FOTO Elbow/Wrist/Hand FS PROM. The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.
Measure Steward:	Focus on Therapeutic Outcomes, Inc.
Measure Type:	Patient-Reported Outcome-Based Performance Measure
Rationale for Removal:	We are proposing the removal of this quality measure from MIPS, finalized in the CY 2017 Quality Payment Program final rule (81 FR 77558 through 77675), because this measure is duplicative of the Functional Improvement for Patients with Upper Extremity Impairments measure being proposed in Table A.3 of this Appendix. Measure Q222 is specific to elbow, wrist and hand impairments and restricts clinicians to the use of the proprietary tool FOTO Elbow/Wrist/Hand FS PROM or a manual crosswalk for numerator assessment. The new measure proposed in Table A.3 of this Appendix is a more comprehensive patient-reported outcome-based performance measure that includes all upper extremity injuries. The new measure allows the use of various validated assessment tools, such as QDASH and PROMIS Upper Extremity, or equivalent tools. The new measure focuses on clinically meaningful outcomes by assessing improvement against the P-MCI, a patient-specific, risk-adjusted threshold. This measure incorporates a risk adjustment model that would improve feasibility of reporting as all information to calculate performance would be provided by the measure steward.
In the Circumstance the Measure Is Retained:	There are no substantive changes proposed for this measure. If the measure is not finalized for removal in the CY 2027 PFS final rule, it would be added back into the applicable previously finalized specialty set(s) under Table Group B of this Appendix and the reason for its retention would be addressed under Table Group C of this Appendix.
Proposed for Removal from the Following Specialty Sets:	Chiropractic Medicine, Orthopedic Surgery, Physical Therapy/Occupational Therapy

C.10 Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

Category	Description
CBE # / eCQM CBE #:	0658 / N/A
Quality#:	320
CMS eCQM ID:	N/A
Collection Type:	Medicare Part B Claims Measure / MIPS CQM
Measure Description:	Percentage of patients aged 45 to 75 years of age receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of 10 years for repeat colonoscopy documented in their colonoscopy report.
Measure Steward	American Gastroenterological Association
Measure Type:	Process
Rationale for Removal:	We are proposing the removal of this quality measure from MIPS, finalized in the CY 2017 Quality Payment Program final rule (81 FR 77558 through 77675), because this measure has reached the end of the topped-out lifecycle (82 FR 53640) and has a limited opportunity to improve clinical outcomes. Topped-out process measures are those with a median performance rate of 95 percent or higher (81 FR 77286). This measure's continued topped-out status is based on the current 2026 MIPS benchmarking data located at *https://qpp.cms.gov/reporting-requirements/measures-activities/benchmarks*, in addition to previous years MIPS benchmarking data. For more information on benchmarks, see the MIPS 2026 Quality Benchmarks User Guide at *https://qpp-cm-prod-content.s3.amazonaws.com/uploads/3611/2026-Quality-Benchmarks-User-Guide.pdf*.
In the Circumstance the Measure Is Retained:	There are no substantive changes proposed for this measure. If the measure is not finalized for removal in the CY 2027 PFS final rule, it would be added back into the applicable previously finalized specialty set(s) under Table Group B of this Appendix and the reason for its retention would be addressed under Table Group C of this Appendix.
Proposed for Removal from the Following Specialty Sets:	Gastroenterology

C.11 Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	326
CMS eCQM ID:	N/A
Collection Type:	MIPS CQM
Measure Description:	Percentage of patients aged 18 years and older with atrial fibrillation (AF) or atrial flutter who were prescribed an FDA-approved oral anticoagulant drug for the prevention of thromboembolism during the measurement period.

Category	Description
Measure Steward	American Heart Association
Measure Type:	Process
Rationale for Removal:	We are proposing the removal of this quality measure from MIPS, finalized in the CY 2017 Quality Payment Program final rule (81 FR 77558 through 77675), at the measure steward's request because it would no longer be maintained for inclusion.
In the Circumstance the Measure Is Retained:	There are no substantive changes proposed for this measure. If the measure is not finalized for removal in the CY 2027 PFS final rule, it would be added back into the applicable previously finalized specialty set(s) under Table Group B of this Appendix and the reason for its retention would be addressed under Table Group C of this Appendix.
Proposed for Removal from the Following Specialty Sets:	Cardiology, Family Medicine, Internal Medicine, Skilled Nursing Facility

C.12 Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use)

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	332
CMS eCQM ID:	N/A
Collection Type:	MIPS CQM
Measure Description:	Percentage of patients aged 18 years and older with a diagnosis of acute bacterial sinusitis that were prescribed amoxicillin, with or without clavulanate, as a first line antibiotic at the time of diagnosis.
Measure Steward	American Academy of Otolaryngology – Head and Neck Surgery Foundation
Measure Type:	Process
Rationale for Removal:	We are proposing the removal of this quality measure from MIPS, finalized in the CY 2017 Quality Payment Program final rule (81 FR 77558 through 77675), because this measure is duplicative in clinical topic of measure Q331: Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse). Measure Q331 assesses patients with a diagnosis of acute viral sinusitis for receipt of antibiotics within 10 days of symptoms onset, highlighting inappropriate use of antibiotics in eligible patients. Measure Q331 is broader than measure Q332 as it encourages avoidance of prescribing any antibiotic for viral illnesses, capturing the patient populations found in both measures. Measure Q332 is narrower in scope, focusing only on patients with bacterial sinusitis appropriately receiving an antibiotic, impacting a smaller proportion of sinusitis cases.
In the Circumstance the Measure Is Retained:	There are no substantive changes proposed for this measure. If the measure is not finalized for removal in the CY 2027 PFS final rule, it would be added back into the applicable previously finalized specialty set(s) under Table Group B of this Appendix and the reason for its retention would be addressed under Table Group C of this Appendix.
Proposed for Removal from the Following Specialty Sets:	Allergy/Immunology, Emergency Medicine, Family Medicine, Internal Medicine, Otolaryngology, Urgent Care

C.13 Total Knee or Hip Replacement: Shared Decision-Making: Trial of Conservative (Non-surgical) Therapy

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	350
CMS eCQM ID:	N/A
Collection Type:	MIPS CQM
Measure Description:	Percentage of patients regardless of age undergoing a total knee or total hip replacement with documented shared decision-making with discussion of conservative (non-surgical) therapy (e.g., non-steroidal anti-inflammatory drug (NSAIDs), analgesics, weight loss, exercise, injections) prior to the procedure.
Measure Steward	American Association of Hip and Knee Surgeons
Measure Type:	Process
Rationale for Removal:	We are proposing the removal of this quality measure from MIPS, finalized in the CY 2017 Quality Payment Program final rule (81 FR 77558 through 77675), because it is a process measure. Removing this process measure would support the goal of prioritizing measures that improve patient outcomes and have meaningful impact. Additionally, this measure is not prescriptive to conservative therapy utilization; therefore, it only assesses for informed consent, which is a standard of care for any clinician. In the CY 2019 (83 FR 59763 through 59765) and CY 2020 (84 FR 62957) PFS final rules, we communicated to interested parties our desire to reduce the number of process measures within the MIPS quality measure set. In the CY 2017 QPP final rule (81 FR 77101), we explained that outcome measures are more valuable than clinical process measures and are instrumental to improving the quality-of-care patients receive. In the CY 2025 PFS final rule (89 FR 98561), we codified under § 414.1330(c)(1)(vii) that CMS uses the following criteria to determine the removal of a quality measure: If the quality measure is a process measure.
In the Circumstance the Measure Is Retained:	There are no substantive changes proposed for this measure. If the measure is not finalized for removal in the CY 2027 PFS final rule, it would be added back into the applicable previously finalized specialty set(s) under Table Group B of this Appendix and the reason for its retention would be addressed under Table Group C of this Appendix.
Proposed for Removal from the Following Specialty Sets:	Orthopedic Surgery

C.14 Children Who Have Dental Decay or Cavities

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	378
CMS eCQM ID:	CMS75v15
Collection Type:	eCQM
Measure Description:	Percentage of children, 1 - 20 years of age at the start of the measurement period, who have had tooth decay or cavities during the measurement period as determined by a dentist.
Measure Steward:	Centers for Medicare & Medicaid Services
Measure Type:	Outcome
Rationale for Removal:	We are proposing the removal of this quality measure from MIPS, finalized in the CY 2017 Quality Payment Program final rule (81 FR 77558 through 77675), due to the robustness of the measure. This measure lacks a quality action that can be attributed to the clinicians reporting it, and as a result, the current scoring methodology for determination of measure achievement points for this measure is not a reflection of the quality of care provided. This measure focuses on incidence of tooth decay or cavities rather than the quality of care delivered, as patients would be attributed to clinicians based on encounter and not whether they have been involved in the patient's care. Therefore, it would be likely they would have had no impact on the outcome being assessed. While tracking the incidence of tooth decay or cavities identifies the prevalence of the issue, it is not a reflection of the quality of care given, as currently specified, and does not promote meaningful dental care interventions that would drive improvements in oral health outcomes. The lack of an actionable quality assessment reduces the overall robustness of the measure.
In the Circumstance the Measure Is Retained:	There are no substantive changes proposed for this measure. If the measure is not finalized for removal in the CY 2027 PFS final rule, it would be added back into the applicable previously finalized specialty set(s) under Table Group B of this Appendix and the reason for its retention would be addressed under Table Group C of this Appendix.
Proposed for Removal from the Following Specialty Sets:	Dentistry

C.15 Adult Primary Rhegmatogenous Retinal Detachment Surgery: No Return to the Operating Room Within 90 Days of Surgery

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	384
CMS eCQM ID:	N/A
Collection Type:	MIPS CQM

Category	Description
Measure Description:	Patients aged 18 years and older who had surgery for primary rhegmatogenous retinal detachment who did not require a return to the operating room within 90 days of surgery.
Measure Steward:	American Academy of Ophthalmology
Measure Type:	Outcome
Rationale for Removal:	We are proposing the removal of this quality measure from MIPS, finalized in the CY 2017 Quality Payment Program final rule (81 FR 77558 through 77675), because this measure has reached the end of the topped-out lifecycle (82 FR 53640) and has a limited opportunity to improve clinical outcomes. This measure's continued topped-out status is based on the current 2026 MIPS benchmarking data located at *https://qpp.cms.gov/reporting-requirements/measures-activities/benchmarks*, in addition to previous years MIPS benchmarking data. For more information on benchmarks, see the MIPS 2026 Quality Benchmarks User Guide at *https://qpp-cm-prod-content.s3.amazonaws.com/uploads/3611/2026-Quality-Benchmarks-User-Guide.pdf*.
In the Circumstance the Measure Is Retained:	There are no substantive changes proposed for this measure. If the measure is not finalized for removal in the CY 2027 PFS final rule, it would be added back into the applicable previously finalized specialty set(s) under Table Group B of this Appendix and the reason for its retention would be addressed under Table Group C of this Appendix.
Proposed for Removal from the Following Specialty Sets:	Ophthalmology

C.16 Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	415
CMS eCQM ID:	N/A
Collection Type:	MIPS CQM
Measure Description:	Percentage of emergency department visits for patients aged 18 years and older who presented with a minor blunt head trauma who had a head CT for trauma ordered by an emergency care provider who have an indication for a head CT.
Measure Steward:	American College of Emergency Physicians
Measure Type:	Efficiency
Rationale for Removal:	We are proposing the removal of this quality measure from MIPS, finalized in the CY 2017 Quality Payment Program final rule (81 FR 77558 through 77675), because this measure has reached the end of the topped-out lifecycle (82 FR 53640) and has a limited opportunity to improve clinical outcomes. This measure's continued topped-out status is based on the current 2026 MIPS benchmarking data located at *https://qpp.cms.gov/reporting-requirements/measures-activities/benchmarks*, in addition to previous years MIPS benchmarking data. For more information on benchmarks, see the MIPS 2026 Quality Benchmarks User Guide at *https://qpp-cm-prod-content.s3.amazonaws.com/uploads/3611/2026-Quality-Benchmarks-User-Guide.pdf*.
In the Circumstance the Measure Is Retained:	There are no substantive changes proposed for this measure. If the measure is not finalized for removal in the CY 2027 PFS final rule, it would be added back into the applicable previously finalized specialty set(s) under Table Group B of this Appendix and the reason for its retention would be addressed under Table Group C of this Appendix.
Proposed for Removal from the Following Specialty Sets:	Emergency Medicine

C.17 Prevention of Post-Operative Nausea and Vomiting (PONV) – Combination Therapy

Category	Description
CBE # / eCQM CBE #:	N/A /N/A
Quality#:	430
CMS eCQM ID:	N/A
Collection Type:	MIPS CQM
Measure Description:	Percentage of patients, aged 18 years and older, who undergo a procedure under an inhalational general anesthetic, AND who have three or more risk factors for post-operative nausea and vomiting (PONV), who receive combination therapy consisting of at least two prophylactic pharmacologic antiemetic agents of different classes preoperatively and/or intraoperatively.
Measure Steward:	American Society of Anesthesiologists
Measure Type:	Process
Rationale for Removal:	We are proposing the removal of this quality measure from MIPS, finalized in the CY 2017 Quality Payment Program final rule (81 FR 77558 through 77675), because the quality action being measured has become a standard of care, based upon MIPS performance data, and thus has limited opportunity to improve clinical outcomes. The average performance for this measure, 99.34 percent, is extremely high and unvarying, making this measure extremely topped out as discussed in the CY 2019 PFS final rule (83 FR 59761 through 59763). The average performance rate is based on the current 2026 MIPS benchmarking data located at *https://qpp.cms.gov/reporting-requirements/measures-activities/benchmarks.* For more information on benchmarks, see the MIPS 2026 Quality Benchmarks User Guide at *https://qpp-cm-prod-content.s3.amazonaws.com/uploads/3611/2026-Quality-Benchmarks-User-Guide.pdf*.
In the Circumstance the Measure Is Retained:	There are no substantive changes proposed for this measure. If the measure is not finalized for removal in the CY 2027 PFS final rule, it would be added back into the applicable previously finalized specialty set(s) under Table Group B of this Appendix and the reason for its retention would be addressed under Table Group C of this Appendix.
Proposed for Removal from the Following Specialty Sets:	Anesthesiology

C.18 Prevention of Post-Operative Vomiting (POV) – Combination Therapy (Pediatrics)

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	463
CMS eCQM ID:	N/A
Collection Type:	MIPS CQM
Measure Description:	Percentage of patients aged 3 through 17 years, who undergo a procedure under general anesthesia in which an inhalational anesthetic is used for maintenance AND who have two or more risk factors for post-operative vomiting (POV), who receive combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively.
Measure Steward:	American Society of Anesthesiologists
Measure Type:	Process
Rationale for Removal:	We are proposing the removal of this quality measure from MIPS, finalized in the CY 2018 Quality Payment Program final rule (82 FR 53966 through 53975), because the quality action being measured has become a standard of care, based upon MIPS performance data, and thus has limited opportunity to improve clinical outcomes. The average performance for this measure, 98.99 percent, is extremely high and unvarying, making this measure extremely topped out as discussed in the CY 2019 PFS final rule (83 FR 59761 through 59763). The average performance rate is based on the current 2026 MIPS benchmarking data located at *https://qpp.cms.gov/reporting-requirements/measures-activities/benchmarks.* For more information on benchmarks, see the MIPS 2026 Quality Benchmarks User Guide at *https://qpp-cm-prod-content.s3.amazonaws.com/uploads/3611/2026-Quality-Benchmarks-User-Guide.pdf*.
In the Circumstance the Measure Is Retained:	There are no substantive changes proposed for this measure. If the measure is not finalized for removal in the CY 2027 PFS final rule, it would be added back into the applicable previously finalized specialty set(s) under Table Group B of this Appendix and the reason for its retention would be addressed under Table Group C of this Appendix.
Proposed for Removal from the Following Specialty Sets:	Anesthesiology

C.19 Functional Status Change for Patients with Neck Impairments

Category	Description
CBE # / eCQM CBE #:	3461 / N/A
Quality#:	478
CMS eCQM ID:	N/A
Collection Type:	MIPS CQM
Measure Description:	A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with neck impairments. The change in FS is assessed using the FOTO Neck FS PROM. The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk-adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.
Measure Steward:	Focus on Therapeutic Outcomes, Inc.
Measure Type:	Patient-Reported Outcome-Based Performance Measure
Rationale for Removal:	We are proposing the removal of this quality measure from MIPS, finalized in the CY 2020 Quality Payment Program final rule (84 FR 63205 through 63213), because this measure is duplicative of the Functional Improvement for Patients with Neck Impairments measure being proposed in Table A.2 of this Appendix. Measure Q478 is specific to neck impairments and restricts clinicians to the use of the proprietary tool FOTO Neck FS PROM or a manual crosswalk for numerator assessment. The new measure proposed in Table A.2 of this Appendix is a more comprehensive patient-reported outcome-based performance measure. The new measure allows the use of various validated assessment tools, such as the Neck Disability Index, PROMIS Pain Interference, or equivalent tools. The new measure focuses on clinically meaningful outcomes by assessing improvement against the P-MCI, a patient-specific, risk-adjusted threshold. This measure incorporates a risk adjustment model that would improve feasibility of reporting as all information to calculate performance would be provided by the measure steward.
In the Circumstance the Measure Is Retained:	There are no substantive changes proposed for this measure. If the measure is not finalized for removal in the CY 2027 PFS final rule, it would be added back into the applicable previously finalized specialty set(s) under Table Group B of this Appendix and the reason for its retention would be addressed under Table Group C of this Appendix.
Proposed for Removal from the Following Specialty Sets:	Chiropractic Medicine, Orthopedic Surgery, Physical Therapy/Occupational Therapy

C.20 Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM)

Category	Description
CBE # / eCQM CBE #:	3568 / N/A
Quality#:	483
CMS eCQM ID:	N/A
Collection Type:	MIPS CQM
Measure Description:	The Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM) uses the PCPCM Patient Reported Outcome Measure (PROM) a comprehensive and parsimonious set of 11 patient-reported items - to assess the broad scope of primary care. Unlike other primary care measures, the PCPCM PRO-PM measures the high value aspects of primary care based on a patient's relationship with the clinician or practice.
Measure Steward:	The American Board of Family Medicine
Measure Type:	Patient-Reported Outcome-Based Performance Measure
Rationale for Removal:	We are proposing the removal of this quality measure from MIPS, finalized in the CY 2020 Quality Payment Program final rule (84 FR 63205 through 63213), because the limited adoption of this quality measure does not allow for the creation of a benchmark after being in the program for two consecutive CY performance periods. For more information on benchmarks, see the MIPS 2026 Quality Benchmarks User Guide at *https://qpp-cm-prod-content.s3.amazonaws.com/uploads/3611/2026-Quality-Benchmarks-User-Guide.pdf*. The current 2026 MIPS benchmarking data is located at *https://qpp.cms.gov/reporting-requirements/measures-activities/benchmarks*.
In the Circumstance the Measure Is Retained:	There are no substantive changes proposed for this measure. If the measure is not finalized for removal in the CY 2027 PFS final rule, it would be added back into the applicable previously finalized specialty set(s) under Table Group B of this Appendix and the reason for its retention would be addressed under Table Group C of this Appendix.
Proposed for Removal from the Following Specialty Sets:	Family Medicine, Internal Medicine

Table Group D: Proposed Substantive Changes to Previously Finalized MIPS Quality Measures for the CY 2027 Performance Period/2029 MIPS Payment Year and Future Years

The D Tables within this proposed rule provide the substantive changes proposed for the MIPS quality measures for CY 2027. Two measures have proposed substantive changes that would result in a new benchmark. All measures with substantive changes are discussed in detail in the tables below. In addition, measures that are endorsed by a CBE are shown in Table D of this Appendix as follows: CBE # / eCQM CBE #.

We note that some MIPS quality measures available in traditional MIPS and MVPs are adopted by the Medicare Shared Savings Program for utilization in the Alternative Payment Model (APM) Performance Pathway (APP), specifically the inclusion of such measures in the APP measure set and/or APP Plus measure set, as finalized in the CY 2025 PFS final rule (89 FR 98363 through 98371). For such measures, the collection types solely applicable for purposes of the APP measure set and/or APP Plus measure set (Medicare Clinical Quality Measures for Accountable Care Organizations (ACOs) Participating in the Medicare Shared Savings Program (Medicare CQMs) collection type and newly proposed Medicare Electronic Clinical Quality Measures for ACOs Participating in the Medicare Shared Savings Program (Medicare eCQMs) collection type as described in section IV.A.4.d.(1)(c)(v) of this proposed rule) are also specified as a collection type available for such relevant measures described in Table Group D.

Changes made to denominator code sets are generalizations of the revisions communicated from the measure stewards to CMS. Additionally, International Classification of Diseases Tenth Edition (ICD-10) and Current Procedural Terminology (CPT) codes that are identified as invalid for CY 2027 may not be identified within this proposed rule due to their later publication. Coding revisions to the denominator may be postponed until CY 2028, if measure steward review and their ability to implement the coding changes are impacted due to the timing of 2027 CPT and ICD-10 updates. The 2027 Quality Measure Release Notes provide a comprehensive, detailed reference of exact code changes to the denominators of the quality measures. The Quality Measure Release Notes are available for each of the collection types on the Quality Payment Program website at *https://qpp.cms.gov*.

In addition to the proposed substantive changes, there may be changes to the coding utilized within the denominator that are not considered substantive in nature, but they are important to communicate to interested parties. These changes align with the scope of the current coding; however, though not substantive in nature, these changes would expand or contract the measure's current eligible population. Therefore, please refer to the current year measure specification and the 2027 Quality Measure Release Notes or the eCQM Technical Release Notes once posted to review all coding changes to ensure correct implementation. Language has been added to all quality measure specifications in the form of a revised 'Instructions Note' to clearly identify if telehealth encounters are allowed for denominator eligibility regardless of changes in coding or billing practices that may occur. Eligibility of telehealth encounters would be based on the intent of the measure and those settings that are appropriate for inclusion.

The eCQM Technical Release Notes should also be carefully reviewed for revisions within the logic portion of the measure. In addition to the proposed substantive changes, there may be revisions within the logic that are not considered substantive in nature; however, it is important to review to ensure proper implementation of the measure. As not all systems and clinical workflows are the same, it is important to review these changes in the context of a specific system and/or clinical workflow for the most accurate implementation.

We request comments on these substantive changes.

D.1 Diabetes: Glycemic Status Assessment Greater Than 9%

Category	Description
CBE # / eCQM CBE #:	0059 / N/A
Quality#:	001
CMS eCQM ID:	CMS122v15
Current Collection Type:	Medicare Part B Claims Measure / eCQM / Medicare CQM / MIPS CQM
Current Measure Description:	Percentage of patients 18-75 years of age with diabetes who had a glycemic status assessment (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) > 9.0% during the measurement period.
Substantive Change:	**Modified collection type:** Medicare Part B Claims Measure, eCQM, Medicare CQM, MIPS CQM, Medicare eCQM collection types. **Updated logic: For the eCQM collection type: Revised:** to prioritize identifying numerical glycemic status results over null values.
Measure Steward:	National Committee for Quality Assurance
MIPS Core Measure:	Yes
Measure Type:	Intermediate Outcome
Rationale:	We are proposing to update the logic of the eCQM collection type to ensure clinically meaningful data is prioritized for inclusion in the measure, better aligning with the measure intent. We are also proposing to update the collection types available for this measure to include the Medicare eCQM collection type to allow choice in submission method for Medicare Shared Savings Program ACOs reporting the APP Plus measure set. See section IV.A.4.d.(1)(c)(v) of this proposed rule for further information on the Medicare eCQM collection type.

D.2 Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	102
CMS eCQM ID:	CMS129v16
Current Collection Type:	eCQM / MIPS CQM
Current Measure Description:	Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low (or very low) risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy who did not have a bone scan performed at any time since diagnosis of prostate cancer.
Substantive Change:	**Updated measure logic and logic definitions: For the eCQM collection type: Added:** Gleason Grade Group and anatomical site specificity for tumor staging. **Updated value set/coding: For the eCQM collection type: Added:** two direct reference codes representing Gleason Grade Group and value set 'Prostate Anatomical Site' (2.16.840.1.113762.1.4.1248.411). **Updated definition: For the MIPS CQM collection type**: **Added:** PET/CT, Ga-68 PSMA-11, F-18 flotufolastat PSMA PET/CT, PET/MRI (full body imaging) to 'Bone Scan'.
Measure Steward:	Centers for Medicare & Medicaid Services
MIPS Core Measure:	Yes
Measure Type:	Process
Rationale:	For the eCQM collection type, we are proposing the addition of Gleason Grade Group and anatomical site specificity for tumor staging to facilitate the capture of low or very low risk of prostate cancer. With this addition to the eCQM, we also propose revising the measure logic to include coding that would capture Gleason Grade Group as an option for assessing prostate cancer risk, as well as the addition of value set 'Prostate Anatomical Site,' which would ensure anatomical site specificity for tumor staging. For the MIPS CQM collection type, we are proposing the addition of PET/CT, Ga-68 PSMA-11, F-18 flotufolastat PSMA PET/CT imaging, and PET/MRI (full body imaging). By incorporating PET/CT, Ga-68 PSMA-11, F-18 flotufolastat PSMA PET/CT imaging, and PET/MRI (full body imaging) into the measure, to align with guideline-directed avoidance of advanced imaging related to low or very low risk prostate cancer.

D.3 Documentation of Current Medications in the Medical Record

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	130
CMS eCQM ID:	CMS68v16
Current Collection Type:	eCQM / MIPS CQM
Current Measure Description:	Percentage of visits for which the eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter.
Substantive Change:	**Updated value set/coding**: **For the eCQM collection type: Revised:** Direct Reference Code (DRC) "Acute health crisis (finding)" (SNOMEDCT Code (705016005)) to value set 'Acute Health Crisis' (OID: 2.16.840.1.113762.1.4.1248.429) to allow for additional conditions to qualify for the exception. **Updated value set/coding**: **For the eCQM collection type: Revised:** 'Encounter to Document Medications' (2.16.840.1.113883.3.600.1.1609) to remove CPT code 99211 and add CPT code 92622 as outlined in the previous EKI.[470]
Measure Steward:	Centers for Medicare & Medicaid Services
MIPS Core Measure:	No
Measure Type:	Process
Rationale:	We are proposing to update the coding for the eCQM collection type to ensure the measure includes additional coding for the denominator exception, aligning with measure intent and allowing for mapping to equivalent appropriate clinical circumstances. Additionally, the encounter coding has been revised to ensure the appropriate patient population is being captured in the denominator for assessment.

[470] See eCQM Known Issue (EKI) #39 at https://oncprojectracking.healthit.gov/support/browse/EKI-39.

D.4 Preventive Care and Screening: Screening for Depression and Follow-Up Plan

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	134
CMS eCQM ID:	CMS2v16
Current Collection Type:	Medicare Part B Claims Measure / eCQM / Medicare CQM / MIPS CQM
Current Measure Description:	Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter.
Substantive Change:	**Modified collection type:** Medicare Part B Claims Measure, eCQM, Medicare CQM, MIPS CQM, Medicare eCQM collection types. **The measure description is revised to read: For the eCQM collection type:** Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented from the date of the screening to two days after the date of the qualifying encounter or an active depression medication or active depression management intervention was active or prescribed at any time on the date of qualifying encounter. **Updated definition: For the eCQM collection type: Added:** Active Depression Medication or Active Depression Management Intervention Documentation that patient is actively receiving interventions designed to treat depression such as behavioral health evaluation, psychotherapy, pharmacological interventions, or additional treatment options. **Updated guidance: For the eCQM collection type: Added:** clarifying language on screening tool to be used for screening a 17-year-old, and which screening should be used to satisfy the numerator. **The measure numerator is revised to read: For the eCQM collection type:** Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented from the date of the screening to two days after the date of the qualifying encounter or an active depression medication or active depression management intervention was active or prescribed at any time during the qualifying encounter. **Updated numerator definition: For the MIPS CQM, Medicare CQM, and the Medicare Part B Claims Measure collection types: Added:** Prior screening within performance period: Patient previously screened by another clinician using an age-appropriate standardized depression screening tool with documented results within the performance period AND if positive, a follow-up plan is documented. **Updated denominator exception: For the MIPS CQM, Medicare CQM, and the Medicare Part B Claims Measure collection types: Added:** Screening for depression not completed, previous patient screening with results documented within performance period.
Measure Steward:	Centers for Medicare & Medicaid Services
MIPS Core Measure:	Yes
Measure Type:	Process
Rationale:	For the eCQM collection type, we are proposing to expand the numerator so that an active depression medication or depression management intervention that is prescribed or in place at any time on the date of the qualifying encounter may meet the numerator quality action.[471] We propose to revise the language in the description, definitions, and numerator statement to reflect the proposed revision and align with measure logic. We are also proposing to clarify the screening tools that may be used to satisfy the measure for patients who are 17 years old at the start of the measurement period, as this age group may fall into a transitional category requiring unique considerations for tool selection. For the MIPS CQM, Medicare CQM, and Medicare Part B Claims Measure collection types, we are proposing to add a new denominator exception for patients with documentation of being previously screened, with a follow-up care plan documented if appropriate, in accordance with the measure requirements, by another clinician within the performance period to enhance team-based, coordinated, and patient-centered care processes between clinicians.[472] We are also proposing to update the collection types available for this measure to include the Medicare eCQM collection type to allow choice in submission method for Medicare Shared Savings Program ACOs reporting

[471] Zuckerbrot, R. A., Cheung, A., Jensen, P. S., Stein, R. E. K., Laraque, D., GLAD-PC Steering Group, Levitt, A., Birmaher, B., Campo, J., Clarke, G., Emslie, G., Kaufman, M., Kelleher, K. J., Kutcher, S., Malus, M., Sacks, D., Waslick, B., & Sarvet, B. (2018). Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice Preparation, Identification, Assessment, and Initial Management. *Pediatrics*, *141*(3), e20174081. https://doi.org/10.1542/peds.2017-4081.

[472] Department of Veterans Affairs, & Department of Defense. (2022). VA/DoD Clinical Practice Guideline for the Management of Major Depressive Disorder (Version 4.0). https://www.healthquality.va.gov/guidelines/MH/mdd/VADODMDDCPGFinal508.pdf.

Category	Description
	the APP Plus measure set. See section IV.A.4.d.(1)(c)(v) of this proposed rule for further information on the Medicare eCQM collection type.

D.5 Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 20% OR Documentation of a Plan of Care

Category	Description
CBE # / eCQM CBE #:	0563 / N/A
Quality#:	141
CMS eCQM ID:	N/A
Current Collection Type:	Medicare Part B Claims Measure / MIPS CQM
Current Measure Description:	Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) whose glaucoma treatment has not failed (the most recent IOP was reduced by at least 20% from the pre-intervention level) OR if the most recent IOP was not reduced by at least 20% from the pre-intervention level, a plan of care was documented within the 12 month performance period.
Substantive Change:	**Measure description revised to read: For all collection types:** Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) whose glaucoma treatment has not failed (the most recent IOP was reduced by at least 20% from the pre-intervention level) OR if the most recent IOP was not reduced by at least 20% from the pre-intervention level, a plan of care was documented within 7 days after the patient encounter when IOP was assessed. **Updated denominator exclusions: For all collection types: Added:** 1. Eyes with absolute glaucoma blindness 2. Pre-existing visual acuity findings include: Count fingers (CF or FC), Hand motion (HM), Light perception (LP), No light perception (NLP) **Updated numerator: For all collection types: Added:** a plan of care was documented within 7 days after the patient encounter when IOP was assessed. **Updated numerator definition**: **For all collection types: Revised:** definition for Plan of Care to include: The plan of care must be documented within 7 days after the patient encounter when IOP was assessed. **Updated numerator options: For all collection types: Revised:** **Performance Met:** Glaucoma plan of care documented within 7 days after the patient encounter when IOP was assessed
Measure Steward:	American Academy of Ophthalmology
MIPS Core Measure:	Yes
Measure Type:	Outcome
Rationale:	We are proposing to update multiple components of the measure for all collection types to align with the added numerator definition that specifies the timing of when the plan of care must be documented in the patient's medical record after the IOP is assessed. This would ensure timely and optimal patient care across clinicians for measure performance, as well as reduce variability in how the measure is applied. We are proposing to add denominator exclusions for patients with absolute glaucoma blindness or specific visual acuity findings because they represent end-stage clinical conditions characterized by absolute blindness or profound vision loss, in which further IOP reduction is unlikely to provide meaningful benefit in preserving visual function or slowing glaucoma progression. The exclusions would align with the intent of the measure to assess IOP management in support of preserving remaining visual function and limiting disease progression, and would refine the denominator to reflect patients who may reasonably benefit from vision-preserving IOP management and related care planning.[473]

[473] Kastner, A., & King, A. J. (2020). Advanced Glaucoma at Diagnosis: Current Perspectives. *Eye (London, England)*, *34*(1), 116–128. https://doi.org/10.1038/s41433-019-0637-2.

D.6 Oncology: Medical and Radiation - Plan of Care for Pain

Category	Description
CBE # / eCQM CBE #:	0383 / N/A
Quality#:	144
CMS eCQM ID:	N/A
Current Collection Type:	MIPS CQM
Current Measure Description:	Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain.
Substantive Change:	**Updated denominator note: For Submission Criteria 2: Added:** definition for lookback period in the instance a code has a billing date different from the face-to-face encounter.
Measure Steward:	American Society of Clinical Oncology
MIPS Core Measure:	Yes
Measure Type:	Process
Rationale:	We are proposing to add a defined look-back window to identify the encounter at which the plan of care to address pain should be documented for numerator assessment. This would clarify implementation of the numerator assessment, which would ensure reporting is appropriate and consistent across clinician submissions. Addressing treatment-induced pain improves patients' health, quality of life, and long-term survival,[474] and reduces interruption in radiation therapy due to pain, thereby ensuring treatment compliance.

[474] Konopka-Filippow, M., Polityńska, B., Wojtukiewicz, A. M., & Wojtukiewicz, M. Z. (2025). Cancer Pain: Radiotherapy as a Double-Edged Sword. *International Journal of Molecular Sciences*, *26*(11), 5223. https://doi.org/10.3390/ijms26115223.

D.7 Coronary Artery Bypass Graft (CABG): Postoperative Renal Failure

Category	Description
CBE # / eCQM CBE #:	0114 / N/A
Quality#:	167
CMS eCQM ID:	N/A
Current Collection Type:	MIPS CQM
Current Measure Description:	Percentage of patients aged 18 years and older undergoing isolated coronary artery bypass graft (CABG) surgery (without pre-existing renal failure) who develop postoperative renal failure or require dialysis.
Substantive Change:	**Updated definitions: Added:** **Denominator:** **Baseline serum creatinine –** Most recent creatinine level obtained prior to the operating room entry **Numerator:** **Postoperative period –** Period begins upon operating room exit and continues to discharge from the hospital after cardiac surgery.
Measure Steward:	Society of Thoracic Surgeons
MIPS Core Measure:	No
Measure Type:	Outcome
Rationale:	We are proposing to add two definitions to clarify implementation of the denominator exclusion for documented history of baseline serum creatinine and the numerator assessment timeframe for patients who develop postoperative renal failure or require dialysis. The first definition (baseline serum creatinine) would ensure the denominator eligible patient population is appropriately identified, and the second definition (postoperative period) would clarify the numerator assessment timeframe. These additions would ensure appropriate and consistent implementation across clinician submissions.

D.8 Coronary Artery Bypass Graft (CABG): Surgical Re-Exploration

Category	Description
CBE # / eCQM CBE #:	0115 / N/A
Quality#:	168
CMS eCQM ID:	N/A
Current Collection Type:	MIPS CQM
Current Measure Description:	Percentage of patients aged 18 years and older undergoing isolated coronary artery bypass graft (CABG) surgery who require a return to the operating room (OR) for mediastinal bleeding with or without tamponade, unplanned coronary artery intervention (native vessel, graft or both), valve dysfunction, aortic reintervention or other cardiac reason during the current hospitalization.
Substantive Change:	**Updated definition: Added:** **Postoperative period –** Period for surgical re-exploration begins upon OR exit and continues to discharge from the hospital after cardiac surgery.
Measure Steward:	Society of Thoracic Surgeons
MIPS Core Measure:	No
Measure Type:	Outcome
Rationale:	We are proposing to add a definition of postoperative period to clarify the numerator assessment timeframe, which would ensure appropriate and consistent implementation across clinician submissions.

D.9 Tuberculosis Screening Prior to First Course of Biologic and/or Immune Response Modifier Therapy

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	176
CMS eCQM ID:	N/A
Current Collection Type:	MIPS CQM
Current Measure Description:	If a patient has been newly prescribed a biologic and/or immune response modifier that includes a warning for potential reactivation of a latent infection, then the medical record should indicate TB testing in the preceding 12-month period.
Substantive Change:	**The measure numerator is revised to read:** Patients for whom any record of TB testing is documented or performed (PPD, Tspot or QuantiFERON-TB Gold Plus) in the medical record in the 12 months preceding the biologic and/or immune response modifier prescription.
Measure Steward:	American College of Rheumatology
MIPS Core Measure:	Yes
Measure Type:	Process
Rationale:	We are proposing changes to the measure numerator to clarify the appropriate tests for TB screening to meet the numerator quality action. This revision would ensure the intent of the measure was met and numerator compliance is consistently assessed across all clinician submissions.

D.10 Rheumatoid Arthritis (RA): Functional Status Assessment

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	178
CMS eCQM ID:	N/A
Current Collection Type:	MIPS CQM
Current Measure Description:	Percentage of patients aged 18 years and older with two or more diagnoses of rheumatoid arthritis (RA) at least 90 days apart for whom a functional status assessment was performed at least once during the performance period.
Substantive Change:	**The measure title is revised from Rheumatoid Arthritis (RA): Functional Status Assessment to:** Rheumatic Disease: Functional Status Assessment. **The measure description is revised to read:** Percentage of patients aged 18 years and older with two or more encounters with a diagnosis of rheumatoid arthritis (RA), psoriatic arthritis (PsA), or systemic lupus erythematosus (SLE) at least 90 days apart for whom a functional status assessment was performed at least once during the performance period. **Updated intent and clinical applicability: Revised:** to include PsA and SLE. **The measure denominator is revised to read:** Patients aged 18 years and older with two or more RA, PsA, or SLE diagnoses documented at least 90 days apart with at least one encounter with an RA, PsA, or SLE diagnosis occurring during the performance period and an additional encounter with an RA, PsA or SLE diagnosis occurring in the performance period or prior performance period. **Updated denominator criteria: Revised:** to include diagnosis coding for PsA and SLE. Added PsA and SLE to the additional encounter criteria. **Updated denominator definition: Revised:** definition for additional encounter to include PsA and SLE. **Updated numerator definition: Revised:** definition for functional status assessment to include PsA and SLE.
Measure Steward:	American College of Rheumatology
MIPS Core Measure:	Yes
Measure Type:	Process
Rationale:	We are proposing to revise multiple components of this measure by adding psoriatic arthritis (PsA) or systemic lupus erythematosus (SLE) to ensure that all patients diagnosed with rheumatic disease are included in the measure's denominator. The addition of PsA and SLE to the RA measure improves the comprehensiveness of the measure, aligns with shared disease characteristics and treatment approaches, and ensures appropriate care across rheumatic diseases. In the event the proposed substantive change(s) are finalized, the substantive changes would not allow for a direct comparison of performance data from prior years to performance data submitted after the implementation of these substantive changes. As such, if the performance data submitted meets the criteria for the creation of a performance period benchmark, a new benchmark would be used for scoring.

D.11 Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery

Category	Description
CBE # / eCQM CBE #:	0565 / 0565e
Quality#:	191
CMS eCQM ID:	CMS133v15
Current Collection Type:	eCQM / MIPS CQM
Current Measure Description:	Percentage of cataract surgeries for patients aged 18 years and older with a diagnosis of uncomplicated cataract and no significant ocular conditions impacting the visual outcome of surgery and had best-corrected visual acuity of 20/40 or better (distance or near) achieved in the operative eye within 90 days following the cataract surgery.
Substantive Change:	**Updated value set/coding**: **For the eCQM collection type: Updated:** to a single value set for significant ocular conditions denominator exclusion.
Measure Steward:	American Academy of Ophthalmology
MIPS Core Measure:	No
Measure Type:	Outcome
Rationale:	We are proposing to replace the individual condition specific value sets for the ocular conditions denominator exclusion with a single value set of significant ocular conditions to streamline implementation.

D.12 Controlling High Blood Pressure

Category	Description
CBE # / eCQM CBE #:	NA / N/A
Quality#:	236
CMS eCQM ID:	CMS165v15
Current Collection Type:	Medicare Part B Claims Measure / eCQM / Medicare CQM / MIPS CQM
Current Measure Description:	Percentage of patients 18-85 years of age who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period, and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period.
Substantive Change:	**Modified collection type:** Medicare Part B Claims Measure, eCQM, Medicare CQM, MIPS CQM, Medicare eCQM collection types.
Measure Steward:	National Committee for Quality Assurance
MIPS Core Measure:	Yes
Measure Type:	Intermediate Outcome
Rationale:	We are proposing to update the collection types available for this measure to include the Medicare eCQM collection type to allow choice in submission method for Medicare Shared Savings Program ACOs reporting the APP Plus measure set. See section IV.A.4.d.(1)(c)(v) of this proposed rule for further information on the Medicare eCQM collection type.

D.13 Radical Prostatectomy Pathology Reporting

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	250
CMS eCQM ID:	N/A
Current Collection Type:	Medicare Part B Claims Measure / MIPS CQM
Current Measure Description:	Percentage of radical prostatectomy pathology reports that include the pT category, the pN category, the Gleason score and a statement about margin status.
Substantive Change:	**Updated denominator exclusion**: **For all collection types: Removed:** Specimen site other than anatomic location of prostate. **Updated denominator exception: For all collection types: Added:** Specimen site other than anatomic location of prostate.
Measure Steward:	College of American Pathologists
MIPS Core Measure:	No
Measure Type:	Process
Rationale:	We are proposing to move the denominator exclusion for "Specimen site other than anatomic location of prostate" to the numerator options as a denominator exception. Moving this criteria from a denominator exclusion to a denominator exception would allow for more automated capture of the relevant cases for the measure with less manual intervention required for measure reporting.

D.14 Dementia: Education and Support of Caregivers for Patients with Dementia

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	288
CMS eCQM ID:	N/A
Current Collection Type:	MIPS CQM
Current Measure Description:	Percentage of patients with dementia whose caregiver(s) were provided with education on dementia disease management and health behavior changes AND were referred to additional resources for support in the last 12 months.
Substantive Change:	**The measure description is revised to read:** Percentage of patients with dementia whose caregiver(s), who are not part of the licensed care team, were provided with education on dementia disease management and health behavior changes AND were referred to additional resources for support in the last 12 months. **Updated intent and clinician applicability: Added:** whose caregiver(s), who are not part of the licensed care team, were provided with education on dementia disease. **The measure numerator is revised to read:** Patients with dementia whose caregiver(s), who are not part of the licensed care team, were provided with education on dementia disease management and health behavior changes AND were referred to additional resources for support in the last 12 months.
Measure Steward:	American Academy of Neurology
MIPS Core Measure:	No
Measure Type:	Process
Rationale:	We are proposing to update multiple components of this measure to clarify that the education and support required as part of the numerator quality action is intended for caregivers who are not part of the licensed clinical care team. Consistent with the measure's intent, educating caregivers that are not part of the licensed care team recognizes their essential role in patient care, improves patient-centered care outcomes, enhances caregiver well-being, and strengthens the overall continuity of care across both formal and informal settings.

D.15 Assessment of Cognitive Impairment or Dysfunction for Patients with Parkinson's Disease

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	291
CMS eCQM ID:	N/A
Current Collection Type:	MIPS CQM
Current Measure Description:	Percentage of all patients with a diagnosis of Parkinson's Disease (PD) who were assessed for cognitive impairment or dysfunction once during the measurement period.
Substantive Change:	**Updated denominator criteria: Added:** coding for physical therapy.
Measure Steward:	American Academy of Neurology
MIPS Core Measure:	No
Measure Type:	Process
Rationale:	We are proposing to add physical therapy coding as part of the denominator criteria for this measure as it is clinically appropriate for this clinician type to assess patients with a diagnosis of PD for cognitive impairment or dysfunction. Physical therapists play a critical role in identifying functional limitations linked to cognitive decline and tailoring interventions accordingly. These codes recognize that cognitive dysfunction significantly influences physical function and safety, and they integrate the expertise of physical therapists into the multidisciplinary care of PD.

D.16 Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	317
CMS eCQM ID:	CMS22v15
Current Collection Type:	Medicare Part B Claims Measure / eCQM / MIPS CQM
Current Measure Description:	Percentage of patient visits for patients aged 18 years and older seen during the measurement period who were screened for high blood pressure AND a recommended follow-up plan is documented, as indicated, if blood pressure is elevated or hypertensive.
Substantive Change:	**Updated denominator criteria: For all collection types: Added:** coding for physical and occupational therapy.
Measure Steward:	Centers for Medicare & Medicaid Services
MIPS Core Measure:	Yes
Measure Type:	Process
Rationale:	We are proposing to update the denominator criteria to include coding for physical and occupational therapy (PT/OT) as it is clinically appropriate for these clinician types to assess for high blood pressure. By adding PT/OT professionals in this measure, healthcare organizations can help ensure a more inclusive, proactive, and effective approach to managing cardiovascular health in patients aged 18 and older, while also capitalizing on all patient touchpoints to achieve comprehensive wellness and improved health outcomes.

D.17 Maternity Care: Postpartum Follow-up and Care Coordination

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	336
CMS eCQM ID:	N/A
Current Collection Type:	MIPS CQM
Current Measure Description:	Percentage of patients, regardless of age, who gave birth during a 12-month period who were seen for postpartum care before or at 12 weeks of giving birth and received the following at a postpartum visit: breastfeeding evaluation and education, postpartum depression screening, intimate partner violence screening, postpartum glucose screening for gestational diabetes patients, family and contraceptive planning counseling, tobacco use screening and cessation education, healthy lifestyle behavioral advice, and an immunization review and update.
Substantive Change:	**The measure numerator is revised to read:** Patients receiving the following at a postpartum visit: • Evaluating the physical recovery from birth, including pain and incontinence • Evaluating and counseling for sleep hygiene and fatigue • Breastfeeding evaluation and education, including patient-reported breastfeeding • Postpartum depression and anxiety screening • Intimate partner violence screening • Postpartum glucose screening for gestational diabetes patients • Family and contraceptive planning counseling, including same-day placement of a long-acting reversible contraceptive (LARC) if desired • Tobacco use screening and cessation education • Substance use disorder /opioid use disorder screening • Physical activity and exercise counseling • Immunization review and update **Updated definitions: Added:** **Evaluating Physical Recovery From Birth –** Patients who were evaluated for physical recovery from birth, including pain and incontinence, with referral as indicated (e.g., to physical therapy, urogynecology). **Evaluating and Counseling for Sleep Hygiene and Fatigue –** Patients were evaluated for sleep hygiene and fatigue and clinicians discussed coping options for fatigue and sleep disruption. **Substance Use Disorder/Opioid Use Disorder Screening –** Patients were screened for substance use/opioid use and referred to postpartum psychosocial support services, including substance use disorder treatment and relapse prevention programs. **Revised:** **Physical Activity and Exercise Counseling –** Patients with uncomplicated pregnancies who were encouraged to undertake regular physical activity and/or to engage in aerobic and strength-conditioning exercises (of any intensity) after pregnancy, as part of efforts to recommend and reinforce a healthy lifestyle. **Postpartum Depression and Anxiety Screening –** added anxiety screening via a self-reported validated anxiety tool. **Updated Numerator Instructions: Revised:** to include evaluating for physical recovery from birth, including pain and incontinence; evaluating and counseling for sleep hygiene and fatigue; postpartum anxiety screening; same-day placement of a long-acting reversible contraceptive (LARC) if desired; substance use disorder /opioid use disorder screening; and physical activity and exercise counseling..
Measure Steward:	Centers for Medicare & Medicaid Services
MIPS Core Measure:	No
Measure Type:	Process
Rationale:	We are proposing to revise the measure numerator by adding evaluations for physical recovery from birth, including pain and incontinence; evaluations and counseling for sleep hygiene and fatigue; postpartum anxiety screening; same-day placement of a long-acting reversible contraceptive (LARC) if desired; substance use disorder /opioid use disorder screening; and physical activity and exercise counseling as recommended by The American College of Obstetricians and Gynecologists (ACOG).[475] The additional evaluations provide significant added value to postpartum care by addressing broader aspects of maternal health that may impact recovery, well-being, and long-term outcomes. Additionally, we are proposing to reflect this revision in the definitions and numerator instructions sections of the measure to ensure appropriate assessment of quality actions and consistent implementation across clinician submissions.

D.18 Closing the Referral Loop: Receipt of Specialist Report

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	374
CMS eCQM ID:	CMS50v15

[475] American College of Obstetricians and Gynecologists. (2018). ACOG Committee Opinion No. 736: Optimizing Postpartum Care. *Obstetrics & Gynecology, 131*(5), e140–e150. https://doi.org/10.1097/AOG.0000000000002633.

Category	Description
Current Collection Type:	eCQM / MIPS CQM
Current Measure Description:	Percentage of patients with referrals, regardless of age, for which the referring clinician receives a report from the clinician to whom the patient was referred.
Substantive Change:	**Updated guidance: For the eCQM collection type: Added:** If two or more referrals have the same date/time stamp and are captured in the denominator as "first" referral, a consultant report for any of these "first" referrals will qualify the patient for the numerator. **Updated denominator criteria: For all collection types: Added:** coding for audiology visits. **Updated logic: For the eCQM collection type: Revised:** numerator logic to capture the 'first referral' when multiple instances of a "first referral" with the same date/time stamp are present.
Measure Steward:	Centers for Medicare & Medicaid Services
MIPS Core Measure:	No
Measure Type:	Process
Rationale:	We are proposing to update the denominator criteria to include audiology visits as this measure is applicable to their scope of care. By including audiology visits in the measure, it would ensure that referrals made by audiologists are tracked, especially as specialization continues to increase in the provision of patient care, facilitating better coordination of care. Additionally, we are proposing to update the measure guidance and logic for the eCQM collection type to clarify implementation when multiple referrals are received and ensure the logic is aligned. This would ensure consistent reporting across clinician submitters.

D.19 Adherence to Antipsychotic Medications For Individuals with Schizophrenia

Category	Description
CBE # / eCQM CBE #:	1879 / N/A
Quality#:	383
CMS eCQM ID:	N/A
Current Collection Type:	MIPS CQM
Current Measure Description:	Percentage of individuals at least 18 years of age as of the beginning of the performance period with schizophrenia or schizoaffective disorder who had at least two prescriptions filled for any antipsychotic medication and who had a Proportion of Days Covered (PDC) of at least 0.8 for antipsychotic medications during the performance period.
Substantive Change:	**Updated denominator: Revised:** (Table 1) added oral antipsychotic medications: - pimavanserin - pimozide - olanzapine-fluoxetine - xanomeline-tropisum chloride
Measure Steward:	Centers for Medicare & Medicaid Services
MIPS Core Measure:	Yes
Measure Type:	Intermediate Outcome
Rationale:	We are proposing to update the list of medications used to identify denominator eligible patients by adding four oral antipsychotic medications to the existing list in the denominator. This expansion would provide an up-to-date list of appropriate oral antipsychotic medications that clinicians may have prescribed for their patients, thereby ensuring that as many of the appropriate patients are identified in the denominator of this measure as possible.

D.20 Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation

Category	Description
CBE # / eCQM CBE #:	2474 / N/A
Quality#:	392
CMS eCQM ID:	N/A
Current Collection Type:	MIPS CQM
Current Measure Description:	Rate of cardiac tamponade and/or pericardiocentesis following atrial fibrillation ablation. This measure is submitted as four rates stratified by age and sex. • Submission Age Criteria 1: Females 18-64 years of age • Submission Age Criteria 2: Males 18-64 years of age • Submission Age Criteria 3: Females 65 years of age and older • Submission Age Criteria 4: Males 65 years of age and older
Substantive Change:	**Updated reporting frequency and implementation considerations: Revised:** measure is to be submitted each time a denominator eligible procedure is performed.
Measure Steward:	American College of Cardiology Foundation
MIPS Core Measure:	No
Measure Type:	Outcome
Rationale:	We are proposing to update the measure submission frequency to each time a denominator eligible procedure is performed as cardiac tamponade is a life-threatening emergency.[476] Requiring this measure to be submitted for each procedure would ensure MIPS eligible clinicians are monitoring and assessing patients for all instances of cardiac tamponade and/or pericardiocentesis occurring within 30 days following atrial fibrillation ablation, as well as adhering to evidence-based practices, which will improve clinical outcomes for patients. This change reflects a transition towards higher standards of care, increased accountability, and greater alignment with the goals of modern healthcare delivery systems.

[476] Khan Z. (2023). Cardiac Tamponade During Catheter Atrial Fibrillation Ablation: A Life-Threatening Complication. *Cureus*, *15*(9), e44989. https://doi.org/10.7759/cureus.44989.

D.21 Infection within 180 Days of Cardiac Implantable Electronic Device (CIED) Implantation, Replacement, or Revision

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	393
CMS eCQM ID:	N/A
Current Collection Type:	MIPS CQM
Current Measure Description:	Infection rate following CIED device implantation, replacement, or revision.
Substantive Change:	**Updated reporting frequency and implementation considerations: Revised:** measure is to be submitted each time a denominator eligible procedure is performed. **The measure denominator is revised to read:** **For Submission Criteria 1:** All patients with a new CIED from January July 1, 2026, through June 30, 2027, of the performance period. **For Submission Criteria 2:** All patients with replacement or revision of a CIED from July 1, 2026, through June 30, 2027, of the performance period. **Updated denominator definition: Added:** Denominator Identification Period – The twelve month period in which eligible patients have a procedure. The "denominator identification period" includes dates of procedure 7/1/2026 to 6/30/2027.
Measure Steward:	American College of Cardiology Foundation
MIPS Core Measure:	No
Measure Type:	Outcome
Rationale:	We are proposing to update the measure submission frequency to each time a denominator eligible procedure is performed as infections resulting from implantable cardiac devices are associated with substantial morbidity. Requiring this measure to be submitted for each procedure would ensure MIPS eligible clinicians are monitoring and assessing patients for all instances of an infection requiring device removal or surgical revision within 180 days following CIED implantation, replacement, or revision, as well as adhering to evidence-based practices, which will improve clinical outcomes for patient. This change reflects a transition towards higher standards of care, increased accountability, and greater alignment with the goals of modern healthcare delivery systems.[477] We are also proposing to lengthen the denominator identification period from July of the previous year through June of the measurement period to allow for a full year of denominator eligibility, ensuring the denominator eligible patient population being assessed for the numerator action is complete.

[477] Lakkireddy, D. R., Rao, A., Theriot, P., Darden, D., Pothineni, N. V. K., Ram, R., Gao, Y. R., Cheung, J. W., & Birgersdotter-Green, U. (2023). Contemporary Management of Cardiac Implantable Electronic Device Infection: The American College of Cardiology COGNITO Survey. *JACC. Advances*, *3*(2), 100773. https://doi.org/10.1016/j.jacadv.2023.100773.

D.22 Lung Cancer Reporting (Biopsy/Cytology Specimens)

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	395
CMS eCQM ID:	N/A
Current Collection Type:	Medicare Part B Claims Measure / MIPS CQM
Current Measure Description:	Pathology reports based on lung biopsy and/or cytology specimens with a diagnosis of primary non-small cell lung cancer classified into specific histologic type following the International Association for the Study of Lung Cancer (IASLC) guidance or classified as non-small cell lung cancer not otherwise specified (NSCLC-NOS) with an explanation included in the pathology report.
Substantive Change:	**Updated denominator exclusion: For all collection types: Removed:** Specimen site other than anatomic location of lung or is not classified as primary non-small cell lung cancer. **Updated denominator exception: For all collection types: Added:** Specimen site other than anatomic location of lung or is not classified as primary non-small cell lung cancer.
Measure Steward:	College of American Pathologists
MIPS Core Measure:	No
Measure Type:	Process
Rationale:	We are proposing to move the denominator exclusion for “specimen site other than anatomic location of lung or is not classified as primary non-small cell lung cancer” to the numerator options as a denominator exception. Moving this criteria from a denominator exclusion to a denominator exception would allow for more automated capture of the relevant cases for the measure with less manual intervention required for measure reporting.

D.23 Lung Cancer Reporting (Resection Specimens)

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	396
CMS eCQM ID:	N/A
Current Collection Type:	Medicare Part B Claims Measure / MIPS CQM
Current Measure Description:	Pathology reports based on lung resection specimens with a diagnosis of primary lung carcinoma that include the pT category, pN category and for non-small cell lung cancer (NSCLC), histologic type.
Substantive Change:	**Updated denominator exclusion: For all collection types: Removed:** Specimen site other than anatomic location of lung OR classified as non-small cell lung cancer, not otherwise specified (NSCLC-NOS). **Updated denominator exception: For all collection types: Added:** Specimen site other than anatomic location of lung OR classified as NSCLC-NOS.
Measure Steward:	College of American Pathologists
MIPS Core Measure:	Yes
Measure Type:	Process
Rationale:	We are proposing to move the denominator exclusion for “Specimen site other than anatomic location of lung OR classified as NSCLC-NOS” to the numerator options as a denominator exception. Moving this criteria from a denominator exclusion to a denominator exception would allow for more automated capture of the relevant cases for the measure with less manual intervention required for measure reporting.

D.24 Melanoma Reporting

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	397
CMS eCQM ID:	N/A
Current Collection Type:	Medicare Part B Claims Measure / MIPS CQM
Current Measure Description:	Pathology reports for primary malignant cutaneous melanoma that include the pT category, thickness, ulceration and mitotic rate, peripheral and deep margin status and presence or absence of microsatellitosis for invasive tumors.
Substantive Change:	**The measure description is revised to read**: **For all collection types:** Pathology reports for primary malignant cutaneous melanoma that include the thickness, ulceration and mitotic rate, peripheral and deep margin status and presence or absence of microsatellitosis for invasive tumors, and for excisions, pT category. **Updated intent and applicability: For all collection types: Revised:** to clarify pT category reporting is only required for excisions. **Updated denominator instructions: For the MIPS CQM collection type: Removed**: instructions moved to the numerator. **Updated denominator exclusion: For all collection types: Removed:** Specimen site other than anatomic cutaneous location. **The measure numerator is revised to read: For all collection types:** Pathology reports for primary malignant cutaneous melanoma that include the thickness, ulceration and mitotic rate, peripheral and deep margin status and presence or absence of microsatellitosis for invasive tumors, and in excisions, pT Category. **Updated numerator instructions: For all collection types: Revised:** to clarify pT category reporting is only required for excisions. **Updated numerator options: For all collection types: Revised:** to clarify pT category reporting is only required for excisions. **Updated denominator exception: For all collection types: Added:** Specimen site other than anatomic cutaneous location.
Measure Steward:	College of American Pathologists
MIPS Core Measure:	No
Measure Type:	Process
Rationale:	We are proposing to revise multiple components of the measure to align with the College of American Pathologists 2025 Protocols[478] [479] and improve the quality of care for melanoma patients by mandating the inclusion of specific, evidence-based pathological parameters in all reports. We are specifically requiring pT category reporting for excisions only. By standardizing and ensuring completeness in pathology reporting, clinicians would significantly enhance diagnostic accuracy, treatment planning, and patient outcomes. Additionally, we are proposing to move the denominator exclusion for "Specimen site other than anatomic cutaneous location" to the numerator options as a denominator exception. Moving this criteria from a denominator exclusion to a denominator exception would allow for more automated capture of the relevant cases for the measure with less manual intervention required for measure reporting.

[478] College of American Pathologists. (2025). Protocol for the Examination of Excision Specimens from Patients with Invasive Melanoma of the Skin. https://documents.cap.org/documents/New-Cancer-Protocols-March-2025/Skin.Inv_Melanoma.Res_1.2.0.0.REL.CAPCP.pdf.

[479] College of American Pathologists. (2025). Protocol for the Examination of Biopsy Specimens from Patients with Invasive Melanoma of the Skin. https://documents.cap.org/documents/New-Cancer-Protocols-March-2025/Skin.Inv_Melanoma.Bx_1.1.0.0.REL.CAPCP.pdf.

D.25 Optimal Asthma Control

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	398
CMS eCQM ID:	N/A
Current Collection Type:	MIPS CQM
Current Measure Description:	Composite measure of the percentage of pediatric and adult patients whose asthma is well-controlled as demonstrated by one of three age appropriate patient reported outcome tools and not at risk for exacerbation.
Substantive Change:	**Updated numerator and component options: For Submission Criteria 1: Component 1: Removed:** Asthma control Questionnaire (ACQ) **Added:** Asthma Impairment and Risk Questionnaire (AIRQ) and Pediatric Asthma Impairment and Risk Questionnaire (Peds-AIRQ) **Updated numerator note: For Submission Criteria 1: Component 2: Revised:** to base exacerbation on one of two methods. **Added:** Method 2: Asthma Impairment and Risk Questionnaire (AIRQ) result of 0 or 1 – ages 12 and older Pediatric Asthma Impairment and Risk Questionnaire (Peds-AIRQ) result of 0 or 1 – ages 5 – 11 **Updated component options: For Submission Criteria 1: Component 2: Added:** **Performance Met:** Not at elevated risk of exacerbation based on AIRQ or Peds-AIRQ score and results documented **Performance Not Met:** At elevated risk of exacerbation based on AIRQ or Peds-AIRQ score and results documented OR specified asthma control tool not used, reason not given **Updated numerator and component options: For Submission Criteria 2: Component 1: Removed:** Asthma control Questionnaire (ACQ) **Added:** Asthma Impairment and Risk Questionnaire (AIRQ) **Updated numerator note: For Submission Criteria 2: Component 2: Revised:** to base exacerbation on one of two methods. **Added:** Method 2: Asthma Impairment and Risk Questionnaire (AIRQ) result of 0 or 1 – ages 12 and older **Updated component options: For Submission Criteria 2: Component 2: Added:** **Performance Met:** Not at elevated risk of exacerbation based on AIRQ score and results documented **Performance Not Met:** At elevated risk of exacerbation based on AIRQ score and results documented OR specified asthma control tool not used, reason not given
Measure Steward:	Minnesota Community Measurement
MIPS Core Measure:	Yes
Measure Type:	Outcome
Rationale:	We are proposing to remove ACQ tools from the list of acceptable patient-reported outcome tools for all submission criteria. We are proposing to add the AIRQ (both submission criteria) and Peds-AIRQ (Submission Criteria 1 only) tools for COMPONENT 1: Asthma well-controlled. Additionally, we are proposing to add the AIRQ (both submission criteria) and Peds-AIRQ (Submission Criteria 1 only) tools as a second method for determining exacerbation risk for COMPONENT 2: Patient not at elevated risk of exacerbation. These changes would ensure that the tools used are better suited to current evidence-based practices for asthma management.[480] The AIRQ and Peds-AIRQ tools support the shift toward standardization, accuracy, and relevance in clinical decision-making.[481]

[480] Murphy, K. R., Chipps, B., Lanz, M. J., Bacharier, L. B., Guilbert, T. W., George, M., Mohammad, A., Winders, T., LeNoir, M., Gilbert, I. A., Eudicone, J. M., Coyne, K. S., Harding, G., & Zeiger, R. S. (2025). Pediatric Asthma Impairment and Risk Questionnaire: A Control Assessment for Children Aged 5 to 11 years. *The Journal of Allergy and Clinical Immunology: In Practice, 13*(10), 2659–2671. https://doi.org/10.1016/j.jaip.2025.06.039.

[481] AstraZeneca. Pediatric Asthma Impairment and Risk Questionnaire. https://www.asthmaresourcecenter.com/home/peds_airq_studies.html.

D.26 Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	438
CMS eCQM ID:	CMS347v10
Current Collection Type:	eCQM / MIPS CQM
Current Measure Description:	Percentage of the following patients - all considered at high risk of cardiovascular events - who were prescribed or were on statin therapy during the performance period: • All patients who were previously diagnosed with or currently have a diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD), including an ASCVD procedure; OR • Patients aged 20 to 75 years who have ever had a low-density lipoprotein cholesterol (LDL-C) level ≥ 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia; OR • Patients aged 40 to 75 years with a diagnosis of diabetes; OR • Patients aged 40 to 75 with a 10-year ASCVD risk score of ≥ 20 percent.
Substantive Change:	**The measure description is revised to read: For all collection types:** Percentage of the following patients - all considered at high risk of cardiovascular events - who were prescribed or were on statin therapy during the performance period: • Patients ≥18 years of age who were previously diagnosed with or currently have a diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD), including an ASCVD procedure; OR • Patients aged 20 to 75 years who have ever had a low-density lipoprotein cholesterol (LDL-C) level ≥ 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia; OR • Patients aged 40 to 75 years with a diagnosis of diabetes; OR • Patients aged 40 to 75 with a 10-year ASCVD risk score of ≥ 20 percent. **Updated rate aggregation: For eCQM collection type: Revised: For Population 1:** Patients greater than or equal to 18 years of age at the beginning of the measurement period were previously diagnosed with or currently have a diagnosis of clinical ASCVD, including an ASCVD procedure before the end of the measurement period. **Updated measure strata and performance rates: For MIPS CQM collection type: Revised: For Submission Criteria 1**: Patients ≥ 18 years of age at the beginning of the performance period and reporting timeframe for diagnosis of clinical ASCVD, including ASCVD procedure. **Updated guidance: For the eCQM collection type: Revised:** age for initial patient population 1 to greater than or equal to 18 years. **Updated initial patient population: For the eCQM collection type: Revised: For population 1:** age greater than or equal to 18 years. **The measure denominator is revised to read: For the MIPS CQM collection type: For Submission Criteria 1:** Patients ≥18 years of age who were previously diagnosed with or currently have a diagnosis of clinical ASCVD, including an ASCVD procedure. **Updated denominator criteria: For the MIPS CQM collection type:** **Revised: For Submission Criteria 1:** age ≥ 18 years at the beginning of the performance period and reporting timeframe for diagnosis of clinical ASCVD, including ASCVD procedure. **Removed**: **For Submission Criteria 3:** presymptomatic diabetes codes. **Updated denominator exclusion: For all collection types: Added: For all Submission Criteria:** Patients who are pregnant at any time during the performance period.
Measure Steward:	Centers for Medicare & Medicaid Services
MIPS Core Measure:	No
Measure Type:	Process
Rationale:	We are proposing to revise Patient Population 1 / Submission Criteria 1 for the eCQM and MIPS CQM collection types, to include patients 18 years of age and older who were previously diagnosed with or currently have a diagnosis of clinical ASCVD, including an ASCVD procedure before the end of the performance period to align with the intent of the measure and current guidelines for adults.[482] [483] In addition, we are proposing to

[482] de Ferranti, S. D., Steinberger, J., Ameduri, R., Baker, A., Gooding, H., Kelly, A. S., Mietus-Snyder, M., et al. (2019). Cardiovascular Risk Reduction in High-Risk Pediatric Patients: A Scientific Statement From the American Heart Association. *Circulation, 139*(13). https://doi.org/10.1161/CIR.0000000000000618.

[483] Blumenthal, R., Morris, P., Gaudino, M., et al. (2026). 2026 ACC/AHA/AACVPR/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Dyslipidemia: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. *Journal of the American College of Cardiology*, 0(0). https://doi.org/10.1016/j.jacc.2025.11.016.

Category	Description
	update the rate aggregation and guidance for the eCQM collection type to align with the updated Patient Population 1. For the MIPS CQM collection type, we are updating the denominator criteria for Submission Criteria 1 with the updated age criteria. These updates aim to refine the population targeted by the measure and enhance alignment with clinical guidelines.[484] Additionally, we are proposing to remove patients with presymptomatic diabetes from the denominator of Patient Population 3 / Submission Criteria 3 to focus on patients with established clinical diagnoses rather than those at risk or presymptomatic. Evidence suggests that use of statins may increase the risk of progression of prediabetes to type 2 diabetes.[485] Excluding these patients from Submission Criteria 3 would allow clinicians to use their clinical judgement and appropriately prescribe statin therapy to those patients who would benefit most without affecting their performance on the measure. We are also proposing to add patients who are pregnant to the denominator exclusions, for all collection types, to align with current recommendations. It is recommended that patients stop statin therapy as soon as pregnancy is discovered.[486] Excluding pregnant patients would allow clinicians to align with evidence-based practices, ensuring safe and appropriate care for this patient population, without affecting their performance on the measure. We are proposing to revise the measure description for all collection types, to improve the clarity, clinical utility, and applicability of the measure by explicitly defining high-risk patient populations. These enhancements aim to ensure more accurate identification of eligible patients, assess appropriate use of statin therapy, and ultimately drive improvements in cardiovascular health outcomes.

[484] See footnote Blumenthal et al., 2026.
[485] See footnote Blumenthal et al., 2026.
[486] See footnote Blumenthal et al., 2026.

D.27 Skin Cancer: Biopsy Reporting Time – Pathologist to Clinician

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	440
CMS eCQM ID:	N/A
Current Collection Type:	MIPS CQM
Current Measure Description:	Percentage of biopsies with a diagnosis of cutaneous basal cell carcinoma (BCC) and squamous cell carcinoma (SCC), or melanoma (including in situ disease) in which the pathologist communicates results to the clinician within 7 days from the time when the tissue specimen was received by the pathologist.
Substantive Change:	**The measure description is revised to read:** Percentage of biopsies with a diagnosis of cutaneous basal cell carcinoma (BCC) and squamous cell carcinoma (SCC), or melanoma (including in situ disease) in which the pathologist communicates results to the clinician within 5 business days from the time when the tissue specimen was received by the pathologist. **The measure numerator is revised to read:** Number of final pathology reports diagnosing cutaneous basal cell carcinoma or squamous cell carcinoma or melanoma (to include in situ disease) sent from the Pathologist/Dermatopathologist to the biopsying clinician for review within 5 business days from the time when the tissue specimen was received by the pathologist. **Updated the numerator option**: **Revised:** to within 5 business days.
Measure Steward:	American Academy of Dermatology
MIPS Core Measure:	Yes
Measure Type:	Process
Rationale:	We are proposing to revise multiple components of this measure to clarify the timing of when a pathologist must communicate the results to the biopsying clinician. Reporting the results within 5 business days would enable clinicians to make timely decisions regarding patient management, scheduling surgeries or therapies, and planning follow-up consultations.

D.28 Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control)

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	441
CMS eCQM ID:	N/A
Current Collection Type:	MIPS CQM
Current Measure Description:	The IVD All-or-None Measure is one outcome measure (optimal control). The measure contains four goals. All four goals within a measure must be reached in order to meet that measure. The numerator for the all-or-none measure should be collected from the organization's total IVD denominator. All-or-None Outcome Measure (Optimal Control) - Using the IVD denominator optimal results include: • Most recent blood pressure (BP) measurement is less than or equal to 130/80 mm Hg -- AND • Most recent tobacco status is Tobacco Free -- AND • Daily Aspirin or Other Antiplatelet Unless Contraindicated – AND • High Intensity Statin Use Unless Contraindicated
Substantive Change:	**Updated the measure strata and performance rates: Revised:** a patient will only be included in Submission Criteria 2 of the measure if they meet the denominator criteria for both Submission Criteria 1 and Submission Criteria 2.
Measure Steward:	Wisconsin Collaborative for Healthcare Quality
MIPS Core Measure:	Yes
Measure Type:	Intermediate Outcome
Rationale:	We are proposing to revise the measure strata and performance rates to clarify how to handle scenarios in which the patient meets denominator criteria for both Submission Criteria 1 and Submission Criteria 2. This change would ensure consistency in the abstraction of the measure's elements that support rigorous data for the calculation of MIPS performance rates.

D.29 Percentage of Patients Who Died from Cancer Receiving Systemic Cancer-Directed Therapy in the Last 14 Days of Life (lower score – better)

Category	Description
CBE # / eCQM CBE #:	0210 / N/A
Quality#:	453
CMS eCQM ID:	N/A
Current Collection Type:	MIPS CQM
Current Measure Description:	Percentage of patients who died from cancer receiving systemic cancer-directed therapy in the last 14 days of life.
Substantive Change:	**The measure title is revised from 'Percentage of Patients who Died from Cancer Receiving Systemic Cancer-Directed Therapy in the Last 14 Days of Life (lower score – better)' to:** Percentage of Patients who Died with Cancer Receiving Systemic Cancer-Directed Therapy in the Last 14 Days of Life (lower score – better) **The measure description is revised to read:** Percentage of patients, aged 18 years and older, who died with cancer receiving systemic cancer-directed therapy in the last 14 days of life. **Updated intent and clinician applicability: Revised:** patients aged 18 years and older. **Updated Implementation Considerations: Revised:** Measure type revised to Intermediate Outcome. **Updated denominator note: Revised:** The patient must have two encounters during the performance period and both eligible encounters must include a diagnosis of cancer. **The measure denominator is revised to read:** Patients, aged 18 years and older, who died with cancer. **Updated denominator criteria:** **Revised:** Patients aged ≥ 18 years and Diagnosis for cancer during the encounter. **Added:** Patients who died during performance period. **Removed:** Patients who died from cancer. **Updated denominator exclusion: Added:** Patients given hydroxyurea or bruton tyrosine kinase (BTK) inhibitors. **Updated numerator definition: Revised:** **Systemic Cancer-directed Therapy –** Includes: ▪ Cytotoxic chemotherapy ▪ Drugs and biologics which activate or inhibit the hallmarks of cancer (e.g., kinase inhibitors) ▪ Antineoplastic Agents • Alkylating agents (id: L01A) • Antimetabolites (id: L01B) • Cytotoxic antibiotics and related substances (id: L01D) • Monoclonal antibodies and antibody drug conjugates (id: L01F) • Other antineoplastic agents (id: L01X) • Plant alkaloids and other natural products (id: L01C) • Protein kinase inhibitors (id: L01E) o Exclude: Cyclin-dependent kinase (CDK) inhibitors (id: L01EF) ▪ Immunostimulants (Includes only those that apply to cancer) • Interferons (id: L03AB) o Include only: interferon alfa-2b, ropeginterferon alfa-2b, and ropeginterferon alfa-2b-njft • Interleukins (id: L03AC) o Include only: aldesleukin • Other immunostimulants (id: L03AX) o Include only: sipuleucel-T ▪ Immunosuppressants (Includes only those that apply to cancer) • Selective immunosuppressants (id: L04AA) o Include only: alemtuzumab, everolimus, and sirolimus • Other immunosuppressants (id: L04AX) o Include only: lenalidomide, pomalidomide, and thalidomide Excludes: • Hormones and hormone antagonists • Red Blood Cell (RBC) growth factors used to treat chemotherapy-induced anemia • White Blood Cell (WBC) growth factors used to treat chemotherapy-induced neutropenia • Bisphosphonates and biologics used to treat osteopenia or osteoporosis • Antiemetics and antinauseants • Pain medications Example: Drugs and biologics under the World Health Organization's (WHO) Anatomical Therapeutic Chemical (ATC) classification "Antineoplastic Agents" and select "Immunostimulants" and "Immunosuppressants". "Antineoplastic and Immunomodulating Agents" Drug Classes and Identifiers: Note: To find the drug members under each class, go to https://mor.nlm.nih.gov/RxClass/ and enter the class name or ID on the "Search" field of the RxClass browser.

Category	Description
	Updated numerator instructions: Added: • Receipt of systemic cancer-directed therapy in the last 14 days of life can be calculated as follows: • (Date of death minus Most Recent Systemic cancer-directed therapy Administration Date or Date Filled) < 14 days. **Updated numerator note: Added:** The measure includes intramuscular, intravenous, oral, and subcutaneous routes of administration of systemic cancer-directed therapy. Oral systemic cancer-directed therapy is oral prescription of extension of same oral drug or prescription of new oral drug. The measure is limited to medications approved by the United States Food and Drug Administration (FDA). Patients that are given bridging chemotherapy and other cancer-directed therapies while awaiting transplant or chimeric antigen receptor T-cell therapy (CAR T-cell therapy) should be reported as a denominator exception. For patients given Hydroxyurea and bruton tyrosine kinase (BTK) inhibitors, it may be inappropriate to withdraw at the end of life and/or are used for palliative purposes. For the purposes of reporting this inverse quality measure, this scenario is considered "performance not met" only in the absence of other systemic therapies. **Updated denominator exception: Added:** Patient received systemic cancer-directed therapy due to 1) receipt or in process of receipt of bone marrow or peripheral blood stem cell transplant (transplant status) in the last 60 days of life, or 2) receipt or in process of receipt of CAR T-cell therapy in the last 60 days of life. **Updated numerator options: Added:** **Performance Not Met:** Patients given hydroxyurea or BTK inhibitors.
Measure Steward:	American Society of Clinical Oncology
MIPS Core Measure:	No
Measure Type:	Process
Rationale:	We are proposing to update multiple components of this measure to ensure the appropriate patient population is identified by including an age, defined encounter eligibility, and additional guidance for defining the eligible patient population. We are proposing to revise the measure type to intermediate outcome to be reflective of the quality action. Additionally, we propose to add a denominator exclusion for common drugs given for palliation or to prevent rapid disease acceleration at the end of life as recommended by ASCO's End of Life Technical Expert Panel as this conflicts with the measure's intent. We are proposing to add further clarification and granularity to the numerator definition of systemic cancer-directed therapy to ensure numerator assessment is consistent across clinician submissions. Additionally, we are proposing to add a denominator exception to remove patients receiving bone marrow or peripheral blood stem cell transplant, or CAR T-cell therapy as these patients are appropriately given bridging chemotherapy and other types of cancer-directed therapy beforehand. We are proposing these changes to better align with the intent of the measure and to ensure consistent implementation across submissions. In the event the proposed substantive change(s) are finalized, the substantive changes would not allow for a direct comparison of performance data from prior years to performance data submitted after the implementation of these substantive changes. As such, if the performance data submitted meets the criteria for the creation of a performance period benchmark, a new benchmark would be used for scoring.

D.30 Percentage of Patients Who Died from Cancer Admitted to Hospice for Less than 3 days (lower score – better)

Category	Description
CBE # / eCQM CBE #:	0216 / N/A
Quality#:	457
CMS eCQM ID:	N/A
Current Collection Type:	MIPS CQM
Current Measure Description:	Percentage of patients who died from cancer, and admitted to hospice and spent less than 3 days there.
Substantive Change:	**The measure title is revised from Percentage of Patients who Died from Cancer Admitted to Hospice for Less than 3 Days (lower score – better) to:** Percentage of Patients who Died with Cancer Enrolled in Hospice for At Least 3 Days Immediately Before Death. **The measure description is revised to read:** Percentage of patients, aged 18 years and older, who died with cancer and were enrolled in hospice for at least 3 days immediately before and on date of death. **Updated Implementation Considerations: Revised:** Measure analytic to no longer be inverse and measure type to Intermediate Outcome. **The measure denominator is revised to read:** Patients, aged 18 years and older, who died with cancer. **Updated denominator note: Revised:** The patient must have two encounters during the performance period and both eligible encounters must include a diagnosis of cancer. **Updated denominator criteria:** **Revised:** Patients aged ≥ 18 years and Diagnosis for cancer during the encounter. **Removed:** Patients enrolled in hospice and Patients who died from cancer. **Added:** Patients who died during performance period. **The measure numerator is revised to read:** Patients enrolled in hospice for at least 3 days immediately before and on the date of death. **Updated numerator instructions: Removed:** Inverse measure analytic **Added:** • Patients should be currently enrolled in hospice on date of death to meet the numerator. • Enrolled in hospice for at least 3 days immediately before death can be calculated as follows: • (Date of death minus Most Recent Date of Hospice Admission) ≥ 3 days **Updated numerator note: Added:** • Receipt of or in the process of receipt of bone marrow transplant, peripheral blood stem cell transplant, or CAR T-cell therapy are typically not covered in hospice but may be appropriate for select patients at the end of life. In these scenarios, the denominator exception should be reported. • It may be inappropriate to withdraw Hydroxyurea and bruton tyrosine kinase (BTK) inhibitors at the end of life and/or are used for palliative purposes, however these treatments are not covered by hospice. In this situation, the denominator exception should be reported. **The measure numerator options are revised to read**: **Performance Met:** Patient enrolled in hospice for at least 3 days immediately before and on the date of death. **Denominator Exception:** Patient not enrolled in hospice due to 1) receipt or in process of receipt of bone marrow or peripheral blood stem cell transplant (transplant status) in the last 60 days of life, or 2) receipt or in process of receipt of CAR T-cell therapy in the last 60 days of life. **Denominator Exception:** Patients given hydroxyurea or BTK inhibitors. **Performance Not Met:** Patient enrolled in hospice less than 3 days immediately before death or on date of death.
Measure Steward:	American Society of Clinical Oncology
MIPS Core Measure:	Yes
Measure Type:	Process
Rationale:	We are proposing to revise the measure type to intermediate outcome and to allow for a proportional non-inverse analytic for the purpose of determining measure performance. We are proposing these changes to better align with the intent of the measure and to provide a performance rate reflective of appropriate resource utilization. We are proposing to update multiple components of this measure to ensure the appropriate patient population is identified by including an age, defined encounter eligibility, and additional guidance for defining the eligible patient population. We are also proposing to update the numerator options to align with a proportional non-inverse measure analytic such that a higher score indicates better quality care; and add denominator exceptions to remove patients 1) receiving bone marrow or peripheral blood stem cell transplant, or CAR T-cell therapy or 2) receiving drugs for palliation or to prevent rapid disease acceleration at the end of life as recommended by ASCO's End Of Life Technical Expert Panel. We are proposing these changes to better align with the intent of the measure and to ensure consistent implementation across clinician submissions. In the event the proposed substantive change(s) are finalized, the substantive changes would not allow for a direct comparison of performance data from prior years to performance data submitted after the implementation

Category	Description
	of these substantive changes. As such, if the performance data submitted meets the criteria for the creation of a performance period benchmark, a new benchmark would be used for scoring.

D.31 Otitis Media with Effusion: Systemic Antimicrobials - Avoidance of Inappropriate Use

Category	Description
CBE # / eCQM CBE #:	0657 / N/A
Quality#:	464
CMS eCQM ID:	N/A
Current Collection Type:	MIPS CQM
Current Measure Description:	Percentage of patients aged 2 months through 12 years with a diagnosis of OME who were not prescribed systemic antimicrobials.
Substantive Change:	**The measure description is revised to read**: Percentage of patients aged 2 months through 12 years with a diagnosis of otitis media with effusion (OME) who were not prescribed systemic antimicrobials within 3 months of diagnosis. **Updated implementation and considerations: Revised:** 90 days to 3 months. **The measure numerator is revised to read:** Patients who were not prescribed systemic antimicrobials within 3 months of diagnosis. **Updated numerator options**: **Revised:** to include timeframe of within 3 months of diagnosis.
Measure Steward:	American Academy of Otolaryngology – Head and Neck Surgery Foundation
MIPS Core Measure:	No
Measure Type:	Process
Rationale:	We are proposing to update multiple components of the measure by adding "within 3 months of diagnosis" to clarify the timeframe during which systemic antimicrobials were not prescribed to patients. This clarification, based on AAO-HNS's Clinical Practice Guideline on Otitis Media with Effusion (Update),[487] would ensure the numerator quality action is appropriately and consistently assessed.

[487] Rosenfeld, R. M., Shin, J. J., Schwartz, S. R., Coggins, R., Gagnon, L., Hackell, J. M., Hoelting, D., Hunter, L. L., Kummer, A. W., Payne, S. C., Poe, D. S., Veling, M., Vila, P. M., Walsh, S. A., & Corrigan, M. D. (2016). Clinical Practice Guideline: Otitis Media with Effusion (Update). *Otolaryngology--Head and Neck Surgery: Official Journal of American Academy of Otolaryngology-Head and Neck Surgery*, *154*(1 Suppl), S1–S41. https://doi.org/10.1177/0194599815623467.

D.32 HIV Screening

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	475
CMS eCQM ID:	CMS349v9
Current Collection Type:	eCQM
Current Measure Description:	Percentage of patients aged 15-65 at the start of the measurement period who were between 15-65 years old when tested for Human immunodeficiency virus (HIV).
Substantive Change:	**Updated initial patient population: Removed:** without an HIV diagnosis prior to the start of the measurement period.
Measure Steward:	Centers for Disease Control and Prevention
MIPS Core Measure:	No
Measure Type:	Process
Rationale:	We are proposing to revise the initial patient population language to better align with the logic of the measure as this patient population is removed by the denominator exclusion: Patients diagnosed with HIV prior to the day of the start of the measurement period.

D.33 Urinary Symptom Score Change 6-12 Months After Diagnosis of Benign Prostatic Hyperplasia

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	476
CMS eCQM ID:	CMS771v8
Current Collection Type:	eCQM
Current Measure Description:	Percentage of patients with an office visit within the measurement period and with a new diagnosis of clinically significant Benign Prostatic Hyperplasia who have International Prostate Symptoms Score (IPSS) or American Urological Association (AUA) Symptom Index (SI) documented at time of diagnosis and again 6-12 months later with an improvement of 3 points.
Substantive Change:	**The measure description is revised to read:** Percentage of patients with an office visit during the measurement period and a new diagnosis of clinically significant benign prostatic hyperplasia (BPH) who have International Prostate Symptom Score (IPSS) or American Urological Association Symptom Index (AUA-SI) documented within one month of diagnosis and again 6-12 months after diagnosis, with an improvement of at least 3 points. **The measure numerator is revised to read:** Patients with an improvement of at least 3 points in their IPSS or AUA-SI urinary symptom score from baseline to the 6-12 month follow-up assessment.
Measure Steward:	Large Urology Group Practice Association and Oregon Urology Institute
MIPS Core Measure:	No
Measure Type:	Patient-Reported Outcome-Based Performance Measure
Rationale:	We are proposing to revise both the description of the measure and the numerator to include specific timeframes for completion of the assessments. By explicitly detailing timeframes (baseline within one month of diagnosis and follow-up assessment within 6–12 months) and the outcome metric (3-point improvement), the measure reduces ambiguity in performance measurement and ensures consistency in reporting.

D.34 Hospital-wide, 30-day, All-cause Unplanned Readmission (HWR) Rate for the Merit-based Incentive Payment System (MIPS) Groups

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	479
CMS eCQM ID:	N/A
Current Collection Type:	Administrative Claims
Current Measure Description:	This measure is a re-specified version of the measure, "Risk-adjusted readmission rate (RARR) of unplanned readmission within 30 days of hospital discharge for any condition" (NQF 1789), which was developed for patients 65 years and older using Medicare claims. This re-specified measure attributes outcomes to MIPS participating clinician groups and assesses each group's readmission rate. The measure comprises a single summary score, derived from the results of five models, one for each of the following specialty cohorts (groups of discharge condition categories or procedure categories): medicine, surgery/gynecology, cardio-respiratory, cardiovascular, and neurology.
Substantive Change:	**Updated denominator exclusion: Removed:** With a principal or a secondary diagnosis code of COVID-19 coded as present on admission (POA) on the index admission claim.
Measure Steward:	Centers for Medicare & Medicaid Services
MIPS Core Measure:	No
Measure Type:	Outcome
Rationale:	We are proposing to remove the exclusion for admissions with either a principal or secondary diagnosis of COVID–19 present on admission from the measure denominator due to the end of the public health emergency. This proposed change would align this measure with language finalized under the Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2026 Rates; Changes to the FY 2025 IPPS Rates Due to Court Decision; Requirements for Quality Programs; and Other Policy Changes; Health Data, Technology, and Interoperability: Electronic Prescribing, Real-Time Prescription Benefit and Electronic Prior Authorization final rule (90 FR 36948 through 36950).

D.35 Intravesical Bacillus-Calmette-Guerin for Non-Muscle Invasive Bladder Cancer

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	481
CMS eCQM ID:	CMS646v7
Current Collection Type:	eCQM
Current Measure Description:	Percentage of patients initially diagnosed with non-muscle invasive bladder cancer and who received intravesical Bacillus-Calmette-Guerin (BCG) within 6 months of bladder cancer staging.
Substantive Change:	**Measure description is revised to read:** Percentage of patients initially diagnosed with non-muscle invasive bladder cancer and who received intravesical Bacillus-Calmette-Guerin (BCG) within 6 months of initial diagnosis of bladder cancer. **Updated denominator exclusion: Revised:** timing is centered around diagnosis. **Updated numerator: Revised:** timing is centered around diagnosis. **Updated denominator exception: Revised:** timing is centered around diagnosis. **Updated logic and logic definitions: Revised:** timing is centered around diagnosis.
Measure Steward:	Oregon Urology
MIPS Core Measure:	No
Measure Type:	Process
Rationale:	We are proposing to update multiple components of the measure to clarify that the timing for receipt of intravesical BCG is based on the initial diagnosis of bladder cancer and not staging. The revision to base the timing of intravesical BCG administration on the initial diagnosis of bladder cancer enhances clinical clarity, promotes consistency in care measurement and measure reporting, and encourages more timely treatment, all of which contributes to improved patient care.

D.36 Mismatch Repair (MMR) or Microsatellite Instability (MSI) Biomarker Testing Status

Category	Description
CBE # / eCQM CBE #:	3661 / N/A
Quality#:	491
CMS eCQM ID:	N/A
Current Collection Type:	MIPS CQM
Current Measure Description:	Percentage of surgical pathology reports for primary colorectal, endometrial, gastroesophageal or small bowel carcinoma, biopsy or resection, that contain impression or conclusion of or recommendation for testing of mismatch repair (MMR) by immunohistochemistry (biomarkers MLH1, MSH2, MSH6, and PMS2), or microsatellite instability (MSI) by DNA-based testing status, or both.
Substantive Change:	**Updated denominator criteria: Added:** coding to diagnosis criteria for genetic susceptibility.
Measure Steward:	College of American Pathologists
MIPS Core Measure:	Yes
Measure Type:	Process
Rationale:	We are proposing to add additional codes to the denominator criteria for genetic susceptibility as it would ensure better targeting of high-risk populations, optimize resources, and contribute to improved patient outcomes and data reliability for cancer care.[488]

[488] Robson, M. E., Storm, C. D., Weitzel, J., Wollins, D. S., & Offit, K. (2015). American Society of Clinical Oncology Policy Statement Update: Genetic and Genomic Testing for Cancer Susceptibility. *Journal of Clinical Oncology, 33*, 3660–3667. https://doi.org/10.1200/JCO.2015.63.0996.

D.37 Preventive Care and Wellness (composite)

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	497
CMS eCQM ID:	N/A
Current Collection Type:	MIPS CQM
Current Measure Description:	Percentage of patients who received age- and sex-appropriate preventive screenings and wellness services. This measure is a composite of seven component measures that are based on recommendations for preventive care by the U.S. Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP), American Association of Clinical Endocrinology (AACE), and American College of Endocrinology (ACE).
Substantive Change:	**Updated numerator definition: For Submission Criteria 3: Added: Reviewed** – to meet the quality action, there must be documentation in the medical record that the clinician reviewed the mammography report. The mammography report may also be provided by the patient for the clinician's review during the visit and should be documented in the medical record. **Updated numerator definition: For Submission Criteria 4: Added: Reviewed** – to meet the quality action, there must be documentation in the medical record that the clinician reviewed the colorectal screening report. The colorectal screening report may also be provided by the patient for the clinician's review during the visit and should be documented in the medical record. **Updated denominator criteria: For Submission Criteria 7: Added:** coding for physical and occupational therapy.
Measure Steward:	Centers for Medicare & Medicaid Services
MIPS Core Measure:	No
Measure Type:	Process
Rationale:	We are proposing to revise the measure numerator definition for Submission Criteria 3 and 4, the medical record must document the clinician's review of the mammography or colorectal screening report, whether obtained directly or provided by the patient, during the visit. By specifying that the review should be documented in the medical record, the measure ensures clinicians are confirming review of mammography and colorectal screening results, not just receipt, and the measure encourages standardization in documentation practices across different clinical settings, which promotes care coordination and appropriate patient follow-up if needed. We are also proposing to update the denominator criteria for Submission Criteria 7 with physical and occupational therapy codes to align with the eCQM measure specifications. By adding PT/OT coding in this measure, healthcare organizations can help ensure a more inclusive, proactive, and effective approach to managing cardiovascular health, while also capitalizing on all patient touchpoints to achieve comprehensive wellness and improve health outcomes.

D.38 Reduction in Suicidal Ideation or Behavior Symptoms

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	505
CMS eCQM ID:	N/A
Current Collection Type:	MIPS CQM
Current Measure Description:	The percentage of patients aged 18 and older with a mental and/or substance use disorder AND suicidal thoughts, behaviors or risk symptoms who demonstrated a reduction in suicidal ideation and/or behavior symptoms based on results from the Columbia-Suicide Severity Rating Scale (C-SSRS) 'Screen Version' or 'Since Last Visit' within 120 days after an index assessment.
Substantive Change:	**The measure description is revised to read**: The percentage of patients aged 12 years and older with a mental and/or substance use disorder AND suicidal thoughts, behaviors or risk symptoms who demonstrated a reduction in suicidal ideation and/or behavior symptoms based on results from the Columbia-Suicide Severity Rating Scale 'Screen Version' or 'Since Last Visit' (C-SSRS), or other clinician rating tools such as the Clinician Rating of Potential Suicide Risk (CRPSR) or the Suicide Assessment Five-step Evaluation & Triage (SAFE-T) protocol with C-SSRS, within 120 days after an index assessment. **The measure denominator is revised to read**: Patients aged 12 and older with a mental and/or substance use disorder with an index assessment completed who were identified as having suicidal ideation and/or behavior symptoms as determined by a non-zero score on the patient-rated C-SSRS OR deemed a suicide risk based on their clinician's evaluation using a clinician rating tool such as the CRPSR or the SAFE-T protocol with C-SSRS during the denominator identification period. **Updated denominator definitions: Revised:** **Suicide risk based on clinician rating tool –** clarified suicide risk to be based on a clinician-rating tool, which may be C-SSRS or other. **Denominator Identification Period** and **Index Assessment –** updated to reflect use of other clinician-rating tools. **Updated the denominator criteria: Revised:** age to 12 **Removed:** 'Suicidal Ideation and/or Behavior Symptoms based on the C-SSRS' and 'Suicide risk based on their clinician's evaluation or a clinician-rated tool' **Revised:** index assessment criteria to reflect use of other clinician-rating tools. **The measure numerator is revised to read**: Patients who demonstrated a reduction in suicidal ideation and/or behavior symptoms as demonstrated by results of a follow-up assessment using the patient-rated C-SSRS OR reduction in suicide risk based on their clinician's evaluation using a clinician rating tool such as the CRPSR or the SAFE-T protocol with C-SSRS, within 120 days after the index assessment during the measurement period. **Updated numerator definitions: Revised:** **Reduction –** to account for use of other clinician-rating tools. **Follow-up Assessment –** to account for use of other clinician-rating tools and require consistency in index and follow-up assessment.
Measure Steward:	American Psychiatric Association
MIPS Core Measure:	No
Measure Type:	Patient-Reported Outcome-Based Performance Measure
Rationale:	We are proposing to update multiple components of the measure to lower the denominator eligible age to 12 years and older and expand the denominator requirements to allow use of other clinician-rating tools for the index assessment and follow-up, to ensure inclusion of a critical demographic group in suicide prevention and substance use disorder interventions. This measure enhances alignment with CMS' mental health priorities, leverages validated tools like the C-SSRS and promotes actionable insights into improved care outcomes for a vulnerable population. We are also proposing to update the numerator definition to clarify that the same patient-rated C-SSRS or clinician rating tool must be used at a follow-up encounter after the index assessment. This would ensure consistent implementation and ensure direct comparability of data between assessments.

D.39 Appropriate Germline Testing for Ovarian Cancer Patients

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	507
CMS eCQM ID:	N/A
Current Collection Type:	MIPS CQM
Current Measure Description:	Percentage of patients, aged 18 and older, diagnosed with epithelial ovarian, fallopian tube, or primary peritoneal cancer who undergo germline testing within 6 months of diagnosis.
Substantive Change:	**Updated denominator criteria**: **Removed:** Audio only Telehealth codes.
Measure Steward:	American Society of Clinical Oncology
MIPS Core Measure:	No
Measure Type:	Process
Rationale:	We are proposing to remove audio only visits from the denominator criteria because they lack the visual assessment necessary to confirm a patient's physical condition (e.g., performance status; physical signs of toxicity, pain, and distress) and the physical assessment required by the clinician providing the care and responsible for conducting germline testing.

D.40 Melanoma: Tracking and Evaluation of Recurrence

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	509
CMS eCQM ID:	N/A
Current Collection Type:	MIPS CQM
Current Measure Description:	Percentage of patients who had an excisional surgery for melanoma or melanoma in situ with initial American Joint Committee on Cancer (AJCC) staging of 0, I, or II, in the past 5 years in which the operating provider examines and/or diagnoses the patient for recurrence of melanoma.
Substantive Change:	**The measure description is revised to read**: Percentage of patients who had an excisional surgery for melanoma or melanoma in situ with initial American Joint Committee on Cancer (AJCC) staging of 0, I, or II, in the past 5 years for whom the clinician or practice responsible for longitudinal care documents examination and/or diagnosis for recurrence of melanoma during the performance period. **Updated intent and clinician applicability: Revised:** The examination for recurrence may be performed by any qualified clinician, provided that the clinician or practice reporting the measure documents that the examination occurred in the medical record. **Updated denominator note**: **Added**: The excisional surgery may have been performed by any clinician or practice, provided documentation of the qualifying procedure and staging is present in the medical record of the clinician or practice reporting the measure.
Measure Steward:	American Academy of Dermatology
MIPS Core Measure:	No
Measure Type:	Process
Rationale:	We are proposing to revise this measure to address instances where one clinician may perform the excision and another performs the subsequent skin examinations. This measure revision would ensure inclusiveness, continuity, and accuracy in reporting excisional surgery outcomes by allowing documentation from any qualified clinician or practice, as is common in clinical practice.

D.41 Patient Reported Falls and Plan of Care

Category	Description
CBE # / eCQM CBE #:	N/A / N/A
Quality#:	513
CMS eCQM ID:	N/A
Current Collection Type:	MIPS CQM
Current Measure Description:	Percentage of patients (or caregivers as appropriate) with an active diagnosis of a movement disorder, multiple sclerosis, a neuromuscular disorder, dementia, or stroke who reported a fall occurred and those that fell had a plan of care for falls documented at every visit.
Substantive Change:	**Updated denominator criteria: Removed: For all Submission Criteria:** diagnosis coding not specific to an active diagnosis of a movement disorder, multiple sclerosis, a neuromuscular disorder, dementia, or stroke. **Updated definitions: For all Submission Criteria: Added:** **Last Visit –** if the patient is established, this would be since the last visit with the same clinician/group. If the patient is new, it would be since the patient's last visit with any clinician. **Updated denominator**: **For Submission Criteria 2: Added**: Patient reported a fall since last visit OR Accidental Fall **Updated numerator note: For Submission Criteria 1: Added:** Denominator Exception medical reason(s) should be documented at the time of the denominator eligible encounter. **Updated numerator options: For Submission Criteria 2: Revised:** **Performance Met:** Patients that reported a fall occurred who had a plan of care for falls documented **Performance Not Met:** Patients that had a fall who did not have a plan of care for falls documented **Removed:** Denominator Exception
Measure Steward:	American Academy of Neurology
MIPS Core Measure:	No
Measure Type:	Process
Rationale:	We are proposing to revise multiple components of this measure to ensure alignment with intent and clinical workflow. We are proposing to remove coding that is broad in nature and not specific to the diagnosis of a movement disorder, multiple sclerosis, a neuromuscular disorder, dementia, or stroke. Removal will ensure the denominator does not include patients beyond those in neurology with symptomology who would not be appropriate for assessment of the quality action. While patient safety in context of falls is important in all patients, the quality action for this measure is specific for the patient population intended and may not be appropriate for any falls patient. For clarity we are proposing to add a definition for 'Last Visit' so that all clinicians reporting are following the same timeline, ensuring consistent implementation across clinician submissions. Additionally, we are proposing to add to the Submission Criteria 1 numerator note to clarify that the medical reason should be documented as active or present on the day of the denominator eligible encounter. This will ensure that regardless of condition, whether it be chronic or acute, active or historical, it will be attributable to that interaction. Finally, we are proposing to revise Submission Criteria 2 to focus on those patients who reported a fall since their last visit as this is the at-risk patient population requiring the quality action; plan of care for falls. This revision aligns with measure intent as well as the structure of other screening measures in MIPS for better consistency.

Table Group DD: Proposed Substantive Changes to Previously Finalized MIPS Quality Measures Available Only for Use in Relevant MVPs for the CY 2027 Performance Period/2029 MIPS Payment Year and Future Years

As finalized for the CY 2024 performance period/2026 MIPS payment year and future years, the following three MIPS quality measures were retained for utilization in MVPs only while removed from traditional MIPS: Q112**:** Breast Cancer Screening, Q113: Colorectal Cancer Screening, and Q128**:** Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (88 FR 79897 through 79902). We note that measures Q112: Breast Cancer Screening and Q113: Colorectal Cancer Screening available only in MVPs are adopted by the Medicare Shared Savings Program for utilization in the Alternative Payment Model (APM) Performance Pathway (APP), specifically for inclusion in the APP Plus measure set, as finalized in the CY 2025 PFS final rule (89 FR 98363 through 98371). For such measures, the collection types solely applicable for purposes of the APP Plus measure set (Medicare Clinical Quality Measures for Accountable Care Organizations (ACOs) Participating in the Medicare Shared Savings Program (Medicare CQMs) collection type and newly proposed Medicare Electronic Clinical Quality Measures for ACOs Participating in the Medicare Shared Savings Program (Medicare eCQMs) collection type as described in section IV.A.4.d.(1)(c)(v) of this proposed rule) are also specified as a collection type available for such relevant measures described in Table Group DD of this Appendix.

Table Group DD within this proposed rule provides substantive changes proposed for the CY 2027 performance period/2029 MIPS payment year for MIPS quality measures available only in a relevant MVP. The changes that are made to the denominator codes sets are generalizations of the revisions communicated from the measure stewards to CMS. Additionally, International Classification of Diseases Tenth Edition (ICD-10) and Current Procedural Terminology (CPT) codes that are identified as invalid for CY 2025 may not be identified within this proposed rule due to the availability of these changes to the public. If coding revisions to the denominator are impacted due to the timing of 2027 CPT and ICD-10 updates and assessment of these codes' inclusion by the Measure Steward, these changes may be postponed until CY 2028. The 2026 Quality Measure Release Notes provide a comprehensive, detailed reference of exact codes changes to the denominators of the quality measures. The Quality Measure Release Notes are available for each of the collection types in the Quality Payment Program website at *https://qpp.cms.gov*.

Measures that are endorsed by a CBE are shown in Table DD of this Appendix as follows: CBE # / eCQM CBE #.

In addition to the proposed substantive changes, there may be changes to the coding utilized within the denominator that are not considered substantive in nature, but it is important to communicate to interested parties. These changes align with the scope of the current coding; however, though not substantive in nature, these changes would expand or contract the measure's current eligible patient population. Therefore, please refer to the current year measure specification and the 2027 Quality Measure Release Notes or the eCQM Technical Release Notes once posted to review all coding changes to ensure correct implementation.

The eCQM Technical Release Notes should also be carefully reviewed for revisions within the logic portion of the measure. In addition to the proposed substantive changes, there may be revisions within the logic that are not considered substantive in nature; however, it is important to review to ensure proper implementation of the measure. As not all systems and clinical workflows are the same, it is important to review these changes in the context of a specific system and/or clinical workflow.

There are no proposed substantive changes for measure Q128. We request comments on the substantive changes for the other measures outlined below.

DD.1 Breast Cancer Screening

Category	Description
CBE # / eCQM CBE #:	2372 / N/A
Quality#:	112
CMS eCQM ID:	CMS125v15
Current Collection Type:	Medicare Part B Claims Measure / eCQM / Medicare CQM / MIPS CQM
Current Measure Description:	Percentage of women 40-74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period.
Substantive Change:	**Modified collection type:** Medicare Part B Claims Measure, eCQM, Medicare CQM, MIPS CQM, Medicare eCQM collection types.
Measure Steward:	National Committee for Quality Assurance
Core Measure:	Yes
Measure Type:	Process
Rationale:	We are proposing to update the collection types available for this measure to include the Medicare eCQM collection type to allow choice in submission method for Medicare Shared Savings Program ACOs reporting the APP Plus measure set. See section IV.A.4.d.(1)(c)(v) of this proposed rule for further information on the Medicare eCQM collection type.

DD.2 Colorectal Cancer Screening

Category	Description
CBE # / eCQM CBE #:	0034 / N/A
Quality#:	113
CMS eCQM ID:	CMS130v15
Current Collection Type:	Medicare Part B Claims Measure / eCQM / Medicare CQM / MIPS CQM
Current Measure Description:	Percentage of patients 45-75 years of age who had appropriate screening for colorectal cancer.
Substantive Change:	**Modified collection type:** Medicare Part B Claims Measure, eCQM, Medicare CQM, MIPS CQM, Medicare eCQM collection types.
Measure Steward:	National Committee for Quality Assurance
Core Measure:	No
Measure Type:	Process
Rationale:	We are proposing to update the collection types available for this measure to include the Medicare eCQM collection type to allow choice in submission method for Medicare Shared Savings Program ACOs reporting the APP Plus measure set. See section IV.A.4.d.(1)(c)(v) of this proposed rule for further information on the Medicare eCQM collection type.

APPENDIX 2: IMPROVEMENT ACTIVITIES

In this proposed rule, for the CY 2027 performance period/2029 MIPS payment year and future years, we are proposing to add **6** new improvement activities, modify **5** previously finalized improvement activities, and remove **11** previously finalized improvement activities. These proposals are discussed in section IV.A.4.d.(3)(b) of this proposed rule and in more detail below. We request comment on our proposals.

TABLE F-B1: New Improvement Activities

New Improvement Activity	
Proposed Activity ID:	**IA_CC_XX**
Proposed Subcategory:	Care Coordination
Proposed Activity Title:	Use of Data to Improve Practice Workflows
Proposed Activity Description:	MIPS-eligible clinicians collaborate to design, implement, and continuously refine evidence based utilization pathways and clinical workflows that support the integration of current research and clinical guidelines into everyday practice. Eligible activities include the creation or maintenance of any algorithm, clinical pathway, process, or order set that is grounded in established clinical practice guidelines and/or peer reviewed literature. Actions that fulfill this activity may include: • Collecting and analyzing clinical data to identify the need for a new or revised pathway, order set, or process • Developing and deploying the updated pathway, order set, or process within clinical operations • Evaluating adoption, effectiveness, and clinical impact through ongoing monitoring and feedback. Additional qualifying activities may include, for example, conducting annual reviews of existing pathways or algorithms by a pathology group and/or in collaboration with ordering clinician, developing and disseminating educational materials, and identifying or engaging new stakeholders to support pathway improvement and implementation.
Rationale:	Promoting uptake of best clinical practices from guidelines and other resources is critical for improving quality of patient care. However, translating recommendation statements into action can be challenging for individual practices due to resource constraints. Clinical pathways and algorithms are effective ways to encourage implementation of guidelines.[489] Development of such pathways requires clinical expertise and time, although a 10-step process has been established by other organizations.[490] By including a multi-disciplinary team in pathway development, care coordination can be maximized and all stakeholders can ensure that the pathway is feasible to implement. Such guidance requires regular review as new clinical practice statements become available, especially if the pathway includes multiple specialties (e.g., oncology, radiology, pathology, pain management, etc.). Therefore, the effort involved in this activity is ongoing and requires input from many members of the care team.
New Improvement Activity	
Proposed Activity ID:	**IA_CC_XX**
Proposed Subcategory:	Care Coordination
Proposed Activity Title:	Understand and Improve Diagnostic Performance

[489] Fiordalisi, C., Borsky, A., Chang, S., & Guise, J.-M. (2019). AHRQ EPC Series on Improving Translation of Evidence into Practice for the Learning Health System: Introduction. Journal on Quality and Patient Safety, 45(8), 558-565. doi: 10.1016/j.jcjq.2019.05.006

[490] Flores, E. J., Jue, J. J., Giradi, G., Schoelles, K., Mull, N. K., & Umscheid, C. A. (2019). AHRQ EPC series on improving translation of evidence: use of a clinical pathway for C. Difficile treatment to facilitate the translation of research findings into practice. The Joint Commission Journal on Quality and Patient Safety, 45(12), 822-828. doi: 10.1016/j.jcjq.2019.10.002.

Proposed Activity Description:	This activity aims to improve patient safety by reducing diagnostic safety events, including delayed, inaccurate, or missed diagnoses, as well as failures to communicate correct diagnoses to patients and their families. This activity should support diagnostic transparency, build staff competency through training, and improve the completeness and accuracy of patient data. Understanding and improving diagnostic performance includes establishing a standardized process to monitor diagnostic discrepancies, diagnostic safety events, near misses, and miscommunications. Key components of this activity may include: • Identifying a metric to track (e.g., frozen section discrepancy rate) • Implementing a consistent tracking mechanism • Conducting ongoing monitoring • Initiating mitigation or education efforts when needed. Processes must incorporate both routine tracking and root cause analysis, followed by appropriate corrective actions such as workflow changes, education, and/or targeted training for individuals and/or groups.
Rationale:	Accurate and timely diagnosis is the cornerstone of effective patient care. Diagnostic performance directly influences treatment decisions, patient outcomes, and healthcare resource utilization. Recent studies have emphasized the importance of addressing diagnostic safety events in clinical settings.[491] A deeper understanding of diagnostic processes--including cognitive, systemic, and technological factors--enables healthcare providers to identify gaps, implement targeted interventions, and promote a culture of continuous learning and accountability. As healthcare becomes increasingly data-driven, integrating diagnostic improvement efforts with quality metrics, patient feedback, and interdisciplinary collaboration ensures that care is not only clinically sound but also patient-centered.
New Improvement Activity	
Proposed Activity ID:	**IA_AHW_XX**
Proposed Subcategory:	Advancing Health and Wellness
Proposed Activity Title:	Systematic Screening and Intervention for Nutrition and other Health-Impacting, Non-Clinical Issues
Proposed Activity Description:	This activity supports the implementation of standardized health-related, non-clinical issues screening tools and workflows to identify and address wellness-impacting factors such as poor nutrition, housing instability, transportation barriers, and financial strain. It may include: • Training staff on screening protocols • Embedding validated screening tools into the electronic health record (EHR) • Establishing referral pathways to community-based resources • Tracking follow-up and resolution of identified needs.
Rationale:	This activity addresses a gap for a nutrition-focused improvement activity. It aligns with CMS's focus on wellness and whole-person care, and supports Enhancing Oncology Model (EOM) and MVP efforts by integrating health-related, non-clinical issues into quality improvement strategies. This activity builds on existing patient navigation and care coordination activities but focuses specifically on upstream factors.
New Improvement Activity	
Proposed Activity ID:	**IA_AHW_XX**
Proposed Subcategory:	Advancing Health and Wellness
Proposed Activity Title:	Advance Care Planning Conversations to Support Patient Wellness and Care Preferences
Proposed Activity Description:	MIPS-eligible clinicians engage patients and their caregivers in structured, proactive discussions about end-of-life preferences, advance care planning, and palliative care options as part of comprehensive wellness and care management. This activity integrates conversations about goals of care, symptom management, and quality of life into routine encounters with patients who have serious or life limiting illness.CMS reminds clinicians

[491] Auerbach, A. D., Lee, T. M., Hubbard, C. C., Ranji, S. R., Raffel, K., Valdes, G., ... & Schnipper, J. L. (2024). Diagnostic errors in hospitalized adults who died or were transferred to intensive care. JAMA Internal Medicine, 184(2), 164-173.

	that they must not, under any circumstances, attempt to influence the ACP-related decisions of their patients. Participating clinicians must document: • Use of standardized communication tools or frameworks (e.g., Serious Illness Conversation Guide, Practitioner Orders for Life Sustaining Treatment (POLST)) to support consistent, high quality discussions; • Inclusion of wellness oriented topics, such as symptom relief, emotional wellbeing, social supports, and patient identified priorities; • Coordination and alignment of care plans across specialties, including primary care, palliative care, behavioral health, and other involved clinicians; and • Regular review and updates of advance directives or care preferences to ensure they remain accurate and reflective of the patient's evolving goals and clinical status.
Rationale:	End-of-life care planning discussions contribute to improved patient and caregiver well-being by reducing stress, enhancing understanding of care options, and ensuring treatment aligns with patient goals. Integrating these conversations into wellness and/or chronic care management visits supports a holistic approach to health, one that prioritizes quality of life, emotional and physical comfort, and patient autonomy. Evidence indicates that patients who engage in structured end-of-life care planning experience better symptom control, higher satisfaction, and reduced hospitalizations, aligning with MIPS goals of improved care coordination and patient-centered outcomes.
New Improvement Activity	
Proposed Activity ID:	**IA_AHW_XX**
Proposed Subcategory:	Advancing Health and Wellness
Proposed Activity Title:	Clinician Use of Artificial Intelligence (AI) to Improve Patient Care
Proposed Activity Description:	MIPS-eligible clinicians implement and participate in structured organizational initiatives that improve patient care through the responsible and transparent use of artificial intelligence (AI) in clinical and operational workflows. This activity supports the safe adoption of AI-enabled technologies while encouraging the development, evaluation, and refinement of AI resources designed to improve patient outcomes, care-team efficiency, and population health management. As part of this activity, participating clinicians and organizations must: • Establish and maintain organizational policies and procedures for AI use in healthcare settings that guide the evaluation, deployment, and monitoring of AI-enabled tools ○ These policies incorporate key AI model characteristics including fairness, appropriateness, validity, and effectiveness as foundational criteria for assessing model performance, identifying event patterns, and determining appropriate risk-mitigation and escalation actions and/or • Engage in or support innovative initiatives that encourage the creation, piloting, and/or enhancement of AI-enabled tools, workflows, and/or resources ○ Examples include developing risk-stratification models, AI-supported clinical decision support (CDS), predictive analytics for chronic-disease management, and/or tools that expand patient access, wellness interventions, and/or care-coordination capabilities. Additional examples include using AI tools to summarize medical literature for clinical decision making, support documentation (e.g., generate notes with AI for clinician review), and/or support population health management by identifying care gaps, determining patient eligibility for clinical trials, or generating draft responses to patient questions for clinician review.
Rationale:	The rapid expansion of artificial intelligence (AI) in healthcare presents significant opportunities to improve clinical outcomes, reduce clinician burden, and enhance population health management. However, realizing these benefits requires deliberate, responsible, and transparent implementation practices that ensure AI tools are safe, fair, reliable, and aligned with evidence-based care. This improvement activity encourages MIPS-eligible clinicians to adopt AI in a structured, governance-driven manner that promotes innovation while safeguarding patient well-being. Establishing organizational policies and procedures for AI use provides an essential foundation for ensuring that deployed tools are evaluated using key model characteristics (fairness, appropriateness, validity, and effectiveness). By incentivizing participation in innovation initiatives such as developing or piloting new AI-enabled tools and workflows, this activity further

	advances the field of applied clinical AI, encouraging clinicians and practices to collaborate in the creation and refinement of AI resources. This activity also aligns with the AI-related goals of the CMS ACCESS (Advancing Chronic Care with Effective, Scalable Solutions) Model, a 10-year voluntary Medicare program testing outcome-aligned payments to expand technology-supported chronic care for common conditions.[492]
New Improvement Activity	
Proposed Activity ID:	**IA_AHW_XX**
Proposed Subcategory:	Advancing Health and Wellness
Proposed Activity Title:	Lifestyle Approaches to Diabetes Remediation
Proposed Activity Description:	MIPS-eligible clinicians engage patients and their caregivers in structured, evidence-based lifestyle interventions to support the treatment and management of diabetes. Clinicians use the American College of Lifestyle Medicine's (ACLM) Lifestyle Empowerment Approach for Diabetes Remission (LEADR) or a similar diabetes-focused lifestyle program to help patients address modifiable behavioral factors and improve overall health status. These programs provide education, coaching, and support across key lifestyle domains such as nutrition, physical activity, sleep, stress management, and reducing harmful behaviors. Participating clinicians may use one or more of the following evidence-based programs and resources: • ACLM Lifestyle Empowerment Approach for Diabetes Remission (LEADR)[493] • CDC Diabetes Self-Management Education and Support (DSMES)[494] • American Diabetes Association Institute of Learning – Hands On Webinar: Diet, Lifestyle, Medicine, and Beyond—CardioKidneyMetabolic Strategies for Managing Obesity in People with Type 2 Diabetes[495]
Rationale:	This activity aligns with CMS's focus on wellness and whole-person care and supports MVP efforts by integrating health-related, non-clinical issues into quality improvement strategies.

In this proposed rule, we are proposing to modify **5** previously finalized improvement activities for the CY 2027 performance period/2029 MIPS payment year and future years. These proposed changes are discussed in section IV.A.4.d.(3)(b)(IV) of this proposed rule and in more detail below.

TABLE F-B2: Modifications to Previously Finalized Improvement Activities

Current Improvement Activity	
Current Activity ID:	**IA_PSPA_16**
Current Subcategory:	Patient Safety and Practice Assessment
Current Activity Title:	Use decision support—ideally platform-agnostic, interoperable clinical decision support (CDS) tools —and standardized treatment protocols to manage workflow on the care team to meet patient needs
Current Activity Description:	Use decision support—ideally platform-agnostic, interoperable clinical decision support (CDS) tools—and standardized treatment protocols to manage workflow on the care team to meet patient needs. Clinicians should focus on utilizing open-source, freely available, interoperable CDS in completing the requirements of this activity.
Proposed Change and Rationale:	Stakeholder comments on the CY 2026 PFS NPRM supported stronger oversight of clinical AI, including monitoring, root cause analysis, and mitigation of AI-related diagnostic safety events and near-misses. This activity, IA_PSPA_16, already contains

[492] https://www.cms.gov/priorities/innovation/innovation-models/access.
[493] American College of Lifestyle Medicine. (n.d.). Research and innovation. https://lifestylemedicine.org/about-aclm/research-innovation/.
[494] Centers for Disease Control and Prevention. (n.d.). Diabetes self-management education and support. https://www.cdc.gov/diabetes/education-support-programs/index.html.
[495] American Diabetes Association. (n.d.). Hands On: Diet, Lifestyle, Medicine, and Beyond CardioKidneyMetabolic Strategies for Managing Obesity in People with Type 2 Diabetes https://professionaleducation.diabetes.org/ProductInfo/HandsOnFeb25OD.

	core patient safety elements, making it a strong candidate for modification to explicitly include AI-enabled decision support, aligned with the Office of the National Coordinator for Health Information Technology (ONC) definition of predictive decision-support interventions in 45 CFR 170.102 and stakeholder concerns about safety, liability, and governance.
Proposed Revised Activity Title:	Use decision support—ideally platform-agnostic, interoperable clinical decision support (CDS) tools, including AI-enabled predictive decision-support interventions—and standardized treatment protocols to manage workflow on the care team to meet patient needs
Proposed Revised Activity Description:	MIPS-eligible clinicians use platform-agnostic, interoperable clinical decision support (CDS) tools—including artificial intelligence (AI)-enabled predictive decision-support interventions—to guide care-team workflow and support evidence-based, patient-centered decision-making. As part of this activity, clinicians prioritize open-source or freely available CDS tools where feasible and implement organizational policies to ensure the safe, appropriate, and effective use of these technologies. This activity may include: • Use of interoperable CDS tools, including AI-enabled technologies that meet the ONC definition of predictive decision-support interventions in 45 CFR 170.102: "technology that supports decision-making based on algorithms or models that derive relationships from training data and then produce an output that results in prediction, classification, recommendation, evaluation, or analysis"[7] • Organizational policies for safe CDS and AI use, including processes to identify, review, and mitigate AI-related adverse events or near-misses, and to address clinician concerns about liability, model reliability, and appropriate use • Evaluation of AI-enabled CDS tools using the following quality principles: ○ Fairness: outputs free from bias or undue risk ○ Appropriateness: relevance to the clinical context ○ Validity: accurate and reliable predictions or recommendations ○ Effectiveness: demonstrated benefit in real-world use • Workflow integration practices showing that CDS recommendations—whether originally human-curated or AI-generated—are applied consistently in treatment planning, patient counseling, and follow-up • Periodic review and updating of CDS tools and related protocols to maintain alignment with best practices, organizational policies, and patient-safety standards.
Current Improvement Activity	
Current Activity ID:	**IA_BMH_4**
Current Subcategory:	Behavioral And Mental Health
Current Activity Title:	Depression screening
Current Activity Description:	Depression screening and follow-up plan: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including depression screening and follow-up plan (refer to NQF #0418) for patients with co-occurring conditions of behavioral or mental health conditions
Proposed Change and Rationale:	IA_BMH_4 and IA_BMH_5 contain similar elements that could be combined into one, more robust activity.
Proposed Revised Activity Title:	Depression Screening, Treatment, and Prevention
Proposed Revised Activity Description:	MIPS-eligible clinicians or groups regularly engage in integrated screening, treatment, and/or prevention interventions for patients with behavioral or mental health conditions, with a focus on early identification and coordinated management of major depressive disorder and associated risks. This activity includes systematic depression screening and follow-up planning, along with suicide risk assessment for individuals at elevated risk. Clinicians participating in this activity should implement and document: • Use of validated depression screening tools administered at appropriate intervals for patients • Completion of suicide risk assessments when clinically indicated, using standardized tools for patients who screen positive for depression or exhibit mental-illness warning signs • Development and execution of evidence-based follow-up plans, including safety planning, symptom management, referral to behavioral health specialists, and monitoring of treatment response • Integrated, team-based coordination of care between primary care, behavioral health, psychiatry, and other relevant specialties to support continuity, patient safety, and

	positive patient outcomes • Routine monitoring and reassessment, including documentation of treatment adjustments, patient (and/or family/caregiver) engagement, and adherence to follow-up intervals consistent with clinical guidelines.
Current Improvement Activity	
Current Activity ID:	**IA_CC_8**
Current Subcategory:	Care Coordination
Current Activity Title:	Implementation of documentation improvements for practice/process improvements
Current Activity Description:	Implementation of practices/processes that document care coordination activities (e.g., a documented care coordination encounter that tracks all clinical staff involved and communications from date patient is scheduled for outpatient procedure through day of procedure).
Proposed Change and Rationale:	IA_CC_8, IA_CC_10, IA_CC_11, and IA_CC_12 all contain similar elements that could be combined into one, more robust activity.
Proposed Revised Activity Title:	Implementation of Documentation and/or Operational Improvements for Practice/Process Improvements
Proposed Revised Activity Description:	This activity aims to strengthen communication, transparency, and patient-centered care across all transitions—outpatient, inpatient, specialty, and community settings. It seeks to promote clinicians' proactively coordinating care, tracking patient progress, documenting actions taken, and maintaining clear, structured processes that reduce fragmentation and improve clinical outcomes. This activity may include: • Documentation of care coordination encounters that track all clinical staff involved, communication steps, and handoffs from the time a patient is scheduled for an outpatient procedure or referral through completion of the episode of care • Systematic tracking of patients referred to consultants or specialists, including confirmation that the referral was received, appointments were completed, and recommendations were integrated into the plan of care • Documentation of care transition practices reflecting a patient-centered action plan aligned with the patient's values, preferences, and social context • Implementation of care coordination agreements with frequently used consultants or facilities that set expectations for timely, bidirectional information sharing and clearly define responsibilities across settings.
Current Improvement Activity	
Current Activity ID:	**IA_CC_9**
Current Subcategory:	Care Coordination
Current Activity Title:	Implementation of practices/processes for developing regular individual care plans
Current Activity Description:	Implementation of practices/processes, including a discussion on care, to develop regularly updated individual care plans for at-risk patients that are shared with the beneficiary or caregiver(s). Individual care plans should include consideration of a patient's goals and priorities, as well as desired outcomes of care.
Proposed Change and Rationale:	IA_CC_9 and IA_BE_15 contain similar elements that could be combined into one, more robust activity.
Proposed Activity Title:	Implementation of Practices/Processes for Developing Regular Individual Care Plans
Proposed Revised Activity Description:	Implementation of practices/processes, including a discussion about care goals and preferences, to develop regularly updated individual care plans for at-risk patients that are developed and shared with the beneficiary and family and/or caregiver(s). Individual care plans should include consideration of a patient's (and family/caregiver's, as appropriate) goals and priorities, as well as desired outcomes of care.
Current Improvement Activity	
Current Activity ID:	**IA_PM_4**
Current Subcategory:	Population Management
Current Activity Title:	Glycemic management services
Current Activity Description:	For outpatient Medicare beneficiaries with diabetes and who are prescribed antidiabetic agents (e.g., insulin, sulfonylureas), MIPS eligible clinicians and groups must attest to having: For the first performance year, at least 60 percent of medical records with documentation of an individualized glycemic treatment goal that:

	a) Considers patient-specific factors, including, at least 1) age, 2) comorbidities, and 3) risk for hypoglycemia, and b) Is reassessed at least annually. The performance threshold will increase to 75 percent for the second performance year and onward. Clinician would attest that, 60 percent for first year, or 75 percent for the second year, of their medical records that document individualized glycemic treatment represent patients who are being treated for at least 90 days during the performance period.
Proposed Change and Rationale:	IA_PM_4, IA_PM_19, and IA_PM_20 all contain similar elements that could be combined into one, more robust activity.
Proposed Revised Activity Title:	Glycemic Screening, Referral, and Management
Proposed Revised Activity Description:	For outpatient Medicare beneficiaries, MIPS-eligible clinicians and groups must attest to having: For the first performance year, at least 60 percent of medical records with documentation of screening patients for abnormal blood glucose, referring eligible patients with prediabetes to a CDC-recognized diabetes prevention program, and developing individualized glycemic treatment plans that: a) Consider patient-specific factors, including, at least 1) age, 2) comorbidities, and 3) risk for hypoglycemia, and b) Are reassessed at least annually. The performance threshold will increase to 75 percent for the second performance year and onward. Clinicians must attest that 60 percent (for the first year) and 75 percent (for the second year and beyond) of their medical records include documentation of screening patients for abnormal blood glucose according to current US Preventive Services Task Force (USPSTF) and/or American Diabetes Association (ADA) guidelines. Clinicians must attest that 60 percent (for the first year) and 75 percent (for the second year and beyond) of their medical records include documentation of referring eligible patients with prediabetes to a CDC-recognized diabetes prevention program operating under the framework of the National Diabetes Prevention Program. Clinicians must attest that 60 percent (for the first year) and 75 percent (for the second year and beyond) of their medical records document individualized glycemic treatment plans representing patients who are being seen for at least 90 days during the performance period.

In this proposed rule, we are proposing to remove **11** previously finalized improvement activities beginning with the CY 2027 performance period/2029 MIPS payment year. These changes are discussed in section IV.A.4.d.(3)(b)(V) of this proposed rule and in more detail below; activity removal factors are discussed in the CY 2020 PFS final rule (84 FR 62568 through 63563).

TABLE F-B3: Improvement Activities Being Removed

Current Improvement Activity	
Current Activity ID:	**IA_BMH_5**
Current Subcategory:	Behavioral And Mental Health
Current Activity Title:	MDD prevention and treatment interventions
Current Activity Description:	Major depressive disorder: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including suicide risk assessment (refer to NQF #0104) for mental health patients with co-occurring conditions of behavioral or mental health conditions.
Removal Rationale:	Proposed removal to combine with IA_BMH_4; Factor 1, activity is duplicative
Current Improvement Activity	
Current Activity ID:	**IA_CC_10**
Current Subcategory:	Care Coordination
Current Activity Title:	Care transition documentation practice improvements
Current Activity Description:	In order to receive credit for this activity, a MIPS eligible clinician must document practices/processes for care transition with documentation of how a MIPS eligible clinician or group carried out an action plan for the patient with the patient's preferences in mind (that is, a "patient-centered" plan) during the first 30 days following a discharge. Examples of these practices/processes for care transition include: staff involved in the care transition; phone calls conducted in support of transition; accompaniments of patients to appointments or other navigation actions; home visits; patient information access to their medical records; real time communication between PCP and consulting clinicians; PCP included on specialist follow-up or transition communications.
Removal Rationale:	Proposed removal to combine with IA_CC_8; Factor 1, activity is duplicative
Current Improvement Activity	
Current Activity ID:	**IA_CC_11**
Current Subcategory:	Care Coordination
Current Activity Title:	Care transition standard operational improvements
Current Activity Description:	Establish standard operations to manage transitions of care that could include one or more of the following: • Establish formalized lines of communication with local settings in which empaneled patients receive care to ensure documented flow of information and seamless transitions in care; and/or • Partner with community or hospital-based transitional care services.
Removal Rationale:	Proposed removal to combine with IA_CC_8; Factor 1, activity is duplicative
Current Improvement Activity	
Current Activity ID:	**IA_CC_12**
Current Subcategory:	Care Coordination

Current Activity Title:	Care coordination agreements that promote improvements in patient tracking across settings
Current Activity Description:	Establish effective care coordination and active referral management that could include one or more of the following: • Establish care coordination agreements with frequently used consultants that set expectations for documented flow of information and MIPS eligible clinician or MIPS eligible clinician group expectations between settings. Provide patients with information that sets their expectations consistently with the care coordination agreements; • Track patients referred to specialist through the entire process; and/or • Systematically integrate information from referrals into the plan of care.
Removal Rationale:	Proposed removal to combine with IA_CC_8; Factor 1, activity is duplicative
Current Improvement Activity	
Current Activity ID:	**IA_PSPA_2**
Current Subcategory:	Patient Safety and Practice Assessment
Current Activity Title:	Participation in MOC Part IV
Current Activity Description:	In order to receive credit for this activity, a MIPS eligible clinician must participate in Maintenance of Certification (MOC) Part IV. Maintenance of Certification (MOC) Part IV requires clinicians to perform monthly activities across practice to regularly assess performance by reviewing outcomes addressing identified areas for improvement and evaluating the results. Some examples of activities that can be completed to receive MOC Part IV credit are: the American Board of Internal Medicine (ABIM) Approved Quality Improvement (AQI) Program, National Cardiovascular Data Registry (NCDR) Clinical Quality Coach, Quality Practice Initiative Certification Program, American Board of Medical Specialties Practice Performance Improvement Module or American Society of Anesthesiologists (ASA) Simulation Education Network, for improving professional practice including participation in a local, regional or national outcomes registry or quality assessment program; specialty- specific activities including Safety Certification in Outpatient Practice Excellence (SCOPE); American Psychiatric Association (APA) Performance in Practice modules.
Removal Rationale:	Many physicians are already required (e.g., by states) to participate in MOC; therefore, this activity is not likely to be driving additional meaningful clinical care improvement; Factors 1 & 7, activity is duplicative and/or obsolete
Current Improvement Activity	
Current Activity ID:	**IA_CC_16**
Current Subcategory:	Care Coordination
Current Activity Title:	Primary Care Physician and Behavioral Health Bilateral Electronic Exchange of Information for Shared Patients
Current Activity Description:	The primary care and behavioral health practices use the same electronic health record system for shared patients or have an established bidirectional flow of primary care and behavioral health records.
Removal Rationale:	Given advancements in EHR adoption and data-sharing practices, this activity is no longer likely driving additional meaningful clinical care improvement; Factor 7, activity is obsolete.
Current Improvement Activity	
Current Activity ID:	**IA_BE_15**
Current Subcategory:	Beneficiary Engagement
Current Activity Title:	Engagement of Patients, Family, and Caregivers in Developing a Plan of Care

Current Activity Description:	Engage patients, family, and caregivers in developing a plan of care and prioritizing their goals for action, documented in the electronic health record (EHR) technology.
Removal Rationale:	Proposed removal to combine with IA_CC_9; Factor 1, activity is duplicative
Current Improvement Activity	
Current Activity ID:	**IA_PM_19**
Current Subcategory:	Population Management
Current Activity Title:	Glycemic Screening Services
Current Activity Description:	For at-risk outpatient Medicare beneficiaries, individual MIPS eligible clinicians and groups must attest to implementation of systematic preventive approaches in clinical practice for at least 60 percent for the 2018 performance period and 75 percent in future years, of electronic medical records with documentation of screening patients for abnormal blood glucose according to current US Preventive Services Task Force (USPSTF) and/or American Diabetes Association (ADA) guidelines.
Removal Rationale:	Proposed removal to be combined with IA_PM_4; Factor 1, activity is duplicative
Current Improvement Activity	
Current Activity ID:	**IA_PM_20**
Current Subcategory:	Population Management
Current Activity Title:	Glycemic Referring Services
Current Activity Description:	For at-risk outpatient Medicare beneficiaries, individual MIPS eligible clinicians and groups must attest to implementation of systematic preventive approaches in clinical practice for at least 60 percent for the CY 2018 performance period and 75 percent in future years, of medical records with documentation of referring eligible patients with prediabetes to a CDC-recognized diabetes prevention program operating under the framework of the National Diabetes Prevention Program.
Removal Rationale:	Proposed removal to be combined with IA_PM_4; Factor 1, activity is duplicative
Current Improvement Activity	
Current Activity ID:	**IA_EPA_4**
Current Subcategory:	Expanded Practice Access
Current Activity Title:	Additional improvements in access as a result of QIN/QIO TA
Current Activity Description:	As a result of Quality Innovation Network(QIN)-Quality Improvement Organization (QIO) technical assistance, performance of additional activities that improve access to services or improve care coordination (for example, investment of on-site diabetes educator).
Removal Rationale:	This activity is one of several focused on improvements that can be supported and/or driven by QIN/QIOs. This particular activity could be attested to with relatively low levels of effort and without a need to measure specific outcomes. If this concept is important to eligible clinicians, they can attest to IA_PSPA_19. Other QIN/QIO-relevant activities will remain in the Inventory. Factor 2; There is an alternative activity with a stronger relationship to quality care or improvements in clinical practice.
Current Improvement Activity	
Current Activity ID:	**IA_PM_2**
Current Subcategory:	Population Management

Current Activity Title:	Anticoagulant management improvements
Current Activity Description:	Individual MIPS eligible clinicians and groups who prescribe anti-coagulation medications (including, but not limited to oral Vitamin K antagonist therapy, including warfarin or other coagulation cascade inhibitors) must attest that for 75 percent of their ambulatory care patients receiving these medications are being managed with support from one or more of the following improvement activities: • Participation in a systematic anticoagulation program (coagulation clinic, patient self-reporting program, or patient self-management program); • Patients are being managed by an anticoagulant management service, that involves systematic and coordinated care, incorporating comprehensive patient education, systematic prothrombin time (PT-INR) testing, tracking, follow-up, and patient communication of results and dosing decisions; • Patients are being managed according to validated electronic decision support and clinical management tools that involve systematic and coordinated care, incorporating comprehensive patient education, systematic PT-INR testing, tracking, follow-up, and patient communication of results and dosing decisions; • For rural or remote patients, patients are managed using remote monitoring or telehealth options that involve systematic and coordinated care, incorporating comprehensive patient education, systematic PT-INR testing, tracking, follow-up, and patient communication of results and dosing decisions; or • For patients who demonstrate motivation, competency, and adherence, patients are managed using either a patient self-testing (PST) or patient-self-management (PSM) program.
Removal Rationale:	Direct oral anticoagulant medications (DOACs) have dramatically changed clinical practice, with significantly decreased use of warfarin over the last decade. Despite these changes, there are still specific circumstances that require use of warfarin, including the presence of prosthetic valves, antiphospholipid syndrome, and a high risk of bleeding complications, particularly gastrointestinal bleeding. This activity drives ‘classic’ quality actions related to the use of warfarin. Given the transition away from warfarin’s common use, removing this activity is likely appropriate. We acknowledge the ongoing importance of medication management and will work to ensure that, going forward, improvement activities that support continued enhancement and maintenance of anticoagulation medication management are reflected in MIPS. Factor 7; activity is obsolete.

APPENDIX 3: MVP INVENTORY

MVP Development: Background

In the CY 2021 PFS final rule (85 FR 84849 through 84854), the CY 2022 PFS final rule (86 FR 65998 through 66031), and the CY 2023 PFS final rule (87 FR 70210 through 70211) we finalized a set of criteria to use in the development of MVPs. These criteria include MVP reporting requirements, MVP maintenance, and the selection of measures and activities within an MVP.

This appendix includes three groups of proposed MVP tables: Table 1 covers the MVP Foundational Layer, Group A presents 3 proposed new MVPs, and Group B outlines proposed modifications to 27 previously finalized MVPs.

Each MVP is composed of measures and activities from the quality, improvement activities, and cost performance categories relevant to the clinical specialty of the MVP. Additionally, every MVP includes a foundational layer which consists of population health measures and Promoting Interoperability performance category objectives and measures. The foundational layer is consistent across all MVPs and is detailed in Table 1: MVP Foundational Layer.

When applicable and substantive, we include a brief overview of the planned modifications to QCDR measures within relevant MVPs. Although QCDR measures are exempt from public notice and comment, providing this overview ensures transparency and offers interested parties an opportunity to provide comment on all aspects of each MVP prior to finalization. Final decisions regarding modifications to QCDR measure specifications are made by QCDR measure stewards independently of the rulemaking process, though these modifications may influence the finalized decisions in the final rule.

IA_PCMH: Electronic submission of Patient Centered Medical Home Accreditation is not listed in the newly proposed or previously finalized MVP tables. In accordance with § 414.1380(b)(3)(ii), MIPS eligible clinicians in practices certified or recognized as a patient-centered medical home or comparable specialty practice, as determined by the Secretary, may attest to this activity and receive an improvement activities performance category score of 100 percent (81 FR 77179 through 77180).

MVP Development: Performance Category Sources

Table 1, Group A, and Group B MVP tables include foundational measures and sets of MIPS quality measures, QCDR measures (as applicable), improvement activities, and cost measures organized around clinical topics. For further reference, the sources for the measures and activities included in the MVP tables can be found on the Quality Payment Program website, as detailed below:

- Existing MIPS quality measures are included in the 2026 MIPS Quality Measures List.[496] For details on proposed changes, refer to Appendix 1: MIPS Quality Measures in this proposed rule, which outlines the following: proposed additions (Table Group A), proposed removals (Table Group C), and proposed modifications to existing quality measures (Table Groups D and DD).
- Existing QCDR measures are derived from the latest publication of the 2026 QCDR Measure Specification file.[497] We anticipate updating the list of 2027 QCDR measures in December 2026.

---

[496] See the 2026 MIPS Quality Measures List: *https://qpp-cm-prod-content.s3.amazonaws.com/uploads/3570/2026-MIPS-Quality-Measures-List.xlsx.*

[497] See the 2026 QCDR Measure Specification file: *https://qpp-cm-prod-content.s3.amazonaws.com/uploads/3573/2026_QCDR_Measure_Specifications.xlsx* for QCDR measures.

● Existing improvement activities are included in the 2026 Improvement Activities Inventory and the 2026 MIPS Data Validation Criteria.[498] For details on proposed changes, refer to proposed changes Appendix 2: Improvement Activities in this proposed rule, which outlines the following: proposed additions (Table Group A), proposed modifications to existing improvement activities (Table Group B), and proposed removals (Table Group C).

● Existing cost measures are included in the 2026 Cost Measures Inventory.[499] There are no proposed changes to cost measures included in the proposed CY 2027 MVPs.

● Existing Promoting Interoperability measures and attestations, adopted in prior rulemaking and included in the foundational layer, can be found on the Quality Payment Program website.[500] For details on Promoting Interoperability performance category proposals, we refer readers to section IV.A.4.d.(4) of this proposed rule. Proposals include a modification to the definition of CEHRT, a reduction in requirements, and the following: A modification to the PI_HIE_7: Electronic Prior Authorization measure, which would change the measure from being a required measure to an optional measure for the CY 2027 performance period/2029 MIPS payment year (measure was previously finalized as a required measure in the CMS Interoperability and Prior Authorization final rule (89 FR 8915 through 8927); and the addition of a new measure, Electronic Prior Authorization for Prescription Drugs (PI_HIE_8), which would be a required measure starting with the CY 2028 performance period/2030 MIPS payment year.

● For more information on the population health measures, attributed to the quality performance category and included in the foundational layer, refer to the CY 2022 PFS final rule (86 FR 65408 through 65409).

MVP Development: Measure and Improvement Activity Updates

● Group A and Group B MVPs include an additional table to identify the proposed MIPS core measures within each MVP. For details on the MIPS core measure proposal and selection criteria for MVPs refer to section IV.A.4.d.(1)(c) of this proposed rule.

● Refer to Appendix 1: MIPS Quality Measures (Table Group C) in this proposed rule for details on the proposed removal of MIPS quality measures.

● Refer to Appendix 2: Improvement Activities (Table Group C) in this proposed rule for details on the proposed removal of improvement activities.

● Refer to section IV.A.4.d.(4) Promoting Interoperability Performance Category measures in this proposed rule for details on the proposed removal of Promoting Interoperability Performance Category measures. The following Promoting Interoperability measures, previously included in the foundational layer of MVPs, are now proposed for removal from MIPS: **PI_PPHI_1:** Security Risk Analysis, **PI_ONCDIR_1:** ONC Direct Review Attestation, and **PI_ONCACB_1:** ONC-ACB Surveillance Attestation (Optional).

MVP Symbol Information and Definitions

Please note the following symbols and definitions used within the MVP tables in this appendix:

● Quality measures proposed as MIPS core measures in an MVP are identified with a single exclamation point (!).

---

[498] See the 2026 Improvement Activities Inventory: *https://qpp-cm-prod-content.s3.amazonaws.com/uploads/3567/2026-Improvement-Activities-Inventory.zip* and 2026 MIPS Data Validation Criteria: *https://qpp-cm-prod-content.s3.amazonaws.com/uploads/3574/2026-MIPS-Data-Validation-Criteria.zip.* for improvement activity details.

[499] See the 2026 Cost Measures Inventory: *https://qpp.cms.gov/reporting-requirements/measures-activities/explore?tab=costMeasures&py=2026.*

[500] See the 2026 Promoting Interoperability Measure Specifications: *https://qpp-cm-prod-content.s3.amazonaws.com/uploads/3566/2026-MIPS-Promoting-Interoperability-Measure-Specifications.zip* for Promoting Interoperability measure details.

● Quality measures, improvement activities, cost measures, and Promoting Interoperability measures proposed for addition to a previously finalized MVP are identified with a plus sign (+).

● Proposed new MIPS quality measures, improvement activities, and Promoting Interoperability measures proposed for inclusion in an MVP beginning with the CY 2027 performance period/2029 MIPS payment year and future years are identified with a caret symbol (^). See Appendix 1: MIPS Quality Measures: Table Group A, Appendix 2: Improvement Activities: Table Group A, and section IV.A.4.d.(4) of this proposed rule for further information regarding new MIPS quality measures, improvement activities and Promoting Interoperability measures.

● Existing measures and improvement activities with proposed revisions are identified with a single asterisk (*). For further information regarding proposed revisions see Appendix 1: MIPS Quality Measures: Tables Group D and DD for revisions to MIPS quality measures, Appendix 2: Improvement Activities: Table Group B for revisions to improvement activities, and section IV.A.4.d.(4) for revisions to Promoting Interoperability measures. Unless changes were required to continue to meet programmatic standards for inclusion, we intend to include existing measures or activities with proposed revisions in MVPs (as applicable) regardless of whether the proposed revisions are finalized beginning with the CY 2027 performance period/2029 MIPS payment year.

● QCDR measures undergoing modifications planned by the QCDR measure stewards are identified in this appendix with a single asterisk (*). When applicable and substantive in nature, we provide a brief overview of the planned modifications within applicable MVPs. Since QCDR measures are exempt from public notice and comment, this overview allows for transparency with interested parties and an opportunity to comment on all aspects of each MVP prior to finalization. Final decisions to modify QCDR measure specifications are determined by QCDR measure stewards, separate from rulemaking, but may impact decisions as finalized in the final rule.

● Quality measures and improvement activities identified with a double asterisk (**) can only be submitted when included in an MVP.

● Improvement activities that include an advancing health and wellness component are identified with a double exclamation point (!!).

● Quality measure collection types are identified in parentheses after each quality measure title.

Foundational Layer

Each MVP contains a foundational layer, which includes the entire set of Promoting Interoperability performance category measures and two population health measures. The foundational layer is the same for all MVPs, as listed in Table 1.

Symbol Key:

Single asterisk (*): existing measures and improvement activities with proposed revisions.
Plus sign (+): measures and improvement activities proposed for addition to a previously finalized MVP.

TABLE 1: MVP Foundational Layer

Population Health Measures	Promoting Interoperability Measures
(*) Q479: Hospital-wide, 30-Day, All-cause Unplanned Readmission (HWR) Rate for the Merit-based Incentive Payment System (MIPS) Groups (Collection Type: Administrative Claims) **Q484:** Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (MCC) (Collection Type: Administrative Claims)	**PI_PPHI_2:** High Priority Practices Safety Assurance Factors for EHR Resilience (SAFER) Guide **PI_EP_1:** e-Prescribing **PI_EP_2:** Query of Prescription Drug Monitoring Program (PDMP) **PI_PEA_1:** Provide Patients Electronic Access to Their Health Information **PI_HIE_1:** Support Electronic Referral Loops By Sending Health Information AND **PI_HIE_4:** Support Electronic Referral Loops By Receiving and Reconciling Health Information OR **PI_HIE_5:** Health Information Exchange (HIE) Bi-Directional Exchange OR **PI_HIE_6:** Enabling Exchange Using the Trusted Exchange Framework and Common Agreement (TEFCA) **(+)(*) PI_HIE_7:** Electronic Prior Authorization (Optional) **PI_PHCDRR_1:** Immunization Registry Reporting **PI_PHCDRR_2:** Syndromic Surveillance Reporting (Optional) **PI_PHCDRR_3:** Electronic Case Reporting **PI_PHCDRR_4:** Public Health Registry Reporting (Optional) **PI_PHCDRR_5:** Clinical Data Registry Reporting (Optional) **PI_PHCDRR_6:** Public Health Reporting Using TEFCA (Optional) **PI_INFBLO_1:** Actions to Limit or Restrict Compatibility or Interoperability of CEHRT Attestation

Group A: New MVPs Proposed for the CY 2027 Performance Period/2029 MIPS Payment Year and Future Years
A.1 Diabetic Disease MVP

The proposed Diabetic Disease MVP assesses meaningful outcomes in diabetic disease care. This MVP would be most applicable to clinicians who provide diabetic disease patient care, including primary care, endocrinology, ophthalmology, podiatry, and nonphysician practitioners (NPPs) such as nurse practitioners, clinical nurse specialists, and physician assistants. We request public comment on this proposal.

Quality Measures

We are proposing to include 11 MIPS quality measures and 2 QCDR measures within the quality performance category of this MVP, which are relevant to the clinical topic of diabetic disease care. We reviewed the MIPS quality measure inventory and considered feedback received during the 2026 MVP candidate feedback period to determine which quality measures best represent the clinical topic of this MVP.

For the reasons stated in the introduction of this appendix[501], we are proposing the following measures as MIPS core measures for the Diabetic Disease MVP:

- **Q001**: Diabetes: Glycemic Status Assessment Greater Than 9%
- **Q128:** Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
- **Q317**: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
- **Q488**: Kidney Health Evaluation

The following quality measures provide a meaningful and comprehensive assessment of the clinical care for clinicians who specialize in diabetic disease care:

- **Q001**: Diabetes: Glycemic Status Assessment Greater Than 9%: This inverse outcome MIPS quality measure assesses patients diagnosed with diabetes mellitus for poor control of their HbA1c.
- **Q019**: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care: This MIPS quality measure focuses on the communication between the primary physician managing ongoing care and the physician performing the dilated macular or fundus exam on patients with diabetic retinopathy.
- **Q117**: Diabetes: Eye Exam: This MIPS quality measure supports eye screening for diabetic retinal disease.
- **Q126**: Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation: This MIPS quality measure ensures patients diagnosed with diabetes mellitus have a lower extremity neurological exam performed at least once every 12 months.
- **Q127**: Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear: Outcome Survey: This MIPS quality measure ensures patients diagnosed with diabetes mellitus are evaluated for proper footwear and sizing at least once every 12 months.
- **Q128:** Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan: This MIPS quality measure assesses patients for a documented BMI with a follow-up plan documented if their most recent documented BMI was outside of normal parameters
- **Q317**: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented: This MIPS quality measure ensures all adult patients are screened for

[501] See MVP Development: Quality Measure and Improvement Activity Updates

high blood pressure at each visit and have a recommended follow-up plan if blood pressure is elevated or hypertensive.

- **Q438**: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease: This MIPS quality measure identifies patients at high risk of cardiovascular events and ensures they are prescribed or currently on a statin therapy.
- **Q488**: Kidney Health Evaluation: This MIPS quality measure ensures patients with diabetes receive a kidney health evaluation including both an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR).
- **IRIS58**: Improved Visual Acuity after Vitrectomy for Complications of Diabetic Retinopathy within 120 Days: This QCDR measure assesses success of vitrectomy procedures in patients with diabetic retinopathy by reviewing patients for complications within 120 days of the procedure.
- **USWR35**: Adequate Off-loading of Diabetic Foot Ulcers performed at each visit, appropriate to location of ulcer: This QCDR measure assesses for adequate off-loading for diabetic foot ulcers during patient visits, which supports positive outcomes of Diabetic Foot Ulcer (DFU) healing.

The following broadly applicable MIPS quality measures are relevant to clinicians who specialize in diabetic disease care. The quality measures below assess for screenings and follow-up actions for select measures:

- **Q134:** Preventive Care and Screening: Screening for Depression and Follow-Up Plan: This MIPS quality measure ensures all patients are screened for depression with a follow-up plan documented for those patients who screen positive.
- **Q226**: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention: This MIPS quality measure screens patients for tobacco use. Any patients that are found to be tobacco users should receive tobacco cessation intervention.

Improvement Activities

We reviewed the improvement activities inventory and considered feedback received during the 2026 MVP candidate feedback period to determine the set of improvement activities to include in this MVP. We are proposing to include 13 improvement activities that reflect actions and processes undertaken by clinicians who specialize in diabetic disease care, as well as activities that promote advancing health and wellness, patient engagement and patient-centeredness, shared decision-making, and care coordination. These improvement activities provide opportunities for clinicians, in collaboration with patients, to drive outcomes and improve quality of care. The following improvement activities are proposed for inclusion in this MVP:

- **IA_AHW_1:** Chronic Care and Preventative Care Management for Empaneled Patients
- **IA_AHW_X:** Lifestyle Approaches to Diabetes Remediation
- **IA_BE_1:** Use of certified EHR to capture patient reported outcomes
- **IA_BE_3:** Engagement with QIN-QIO to implement self-management training programs
- **IA_BE_6:** Regularly Assess Patient Experience of Care and Follow Up on Findings
- **IA_BE_16:** Promote Self-management in Usual Care
- **IA_BE_19:** Use group visits for common chronic conditions (e.g., diabetes)
- **IA_BE_23:** Integration of patient coaching practices between visits
- **IA_CC_9:** Implementation of practices/processes for developing regular individual care plans
- **IA_MVP:** Practice-Wide Quality Improvement in MIPS Value Pathways
- **IA_PM_4:** Glycemic management services
- **IA_PM_16:** Implementation of medication management practice improvements
- **IA_PM_25:** Save a Million Hearts: Standardization of Approach to Screening and Treatment for Cardiovascular Disease Risk

Cost Measures

We are proposing to include two MIPS cost measures within the cost performance category of this MVP, which apply to the clinical topic of diabetes. We reviewed the MIPS cost measure inventory and considered feedback received during the 2026 MVP candidate feedback period to determine the set of cost measures to include in this MVP. The following cost measures provide a meaningful assessment of the clinical care for clinicians who specialize in interventional radiology and aligns with other measures and activities within this MVP:

- **COST_D_1**: Diabetes: This MIPS cost measure applies to clinicians providing diabetic care.
- **TPCC_1:** Total Per Capita Cost (TPCC): This MIPS cost measure assesses the overall cost of care delivered to a Medicare patient with a focus on the primary care the patient receives from their providers.

Symbol Key:
Single exclamation point (!): MIPS core measure within an MVP.
Caret symbol (^): proposed new measure or improvement activity.
Single asterisk (*): existing measures and improvement activities with proposed revisions.
Double asterisk (**): measures and improvement activities only available when included in an MVP.
Double exclamation point (!!): improvement activities with an advancing health and wellness component.

TABLE A.1a: Diabetic Disease MVP MIPS Core Measures

Diabetic Disease MVP MIPS Core Measures
Q001: Diabetes: Glycemic Status Assessment Greater Than 9%
Q128: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
Q317: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
Q488: Kidney Health Evaluation

TABLE A.1b: Diabetic Disease MVP Clinical Groupings

Diabetic Disease MVP		
Clinical Grouping	**Quality**	**Cost**
Ophthalmology	**Q019:** Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care (Collection Type: eCQM)	**N/A**
	Q117: Diabetes: Eye Exam (Collection Type: eCQM, MIPS CQM)	
	IRIS58: Improved Visual Acuity after Vitrectomy for Complications of Diabetic Retinopathy within 120 Days (Collection Type: QCDR)	
Podiatry	**Q126:** Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation (Collection Type: MIPS CQM)	**N/A**
	Q127: Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear (Collection Type: MIPS CQM)	
	USWR35: Adequate Off-loading of Diabetic Foot Ulcers performed at each visit, appropriate to location of ulcer (Collection Type: QCDR)	

Diabetic Disease MVP		
Clinical Grouping	**Quality**	**Cost**
Multispecialty	**(!)(*) Q001:** Diabetes: Glycemic Status Assessment Greater Than 9% (Collection Type: eCQM, MIPS CQM, Medicare Part B Claims)	**COST_D_1:** Diabetes **TPCC_1:** Total Per Capita Cost
	(*) Q438: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (Collection Type: eCQM, MIPS CQM)	
	(!) Q488: Kidney Health Evaluation (Collection Type: eCQM, MIPS CQM)	
Advancing Health and Wellness	**(!)(**) Q128:** Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (Collection Type: eCQM, MIPS CQM, Medicare Part B Claims)	**COST_D_1:** Diabetes **TPCC_1:** Total Per Capita Cost
	(*) Q134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan (Collection Type: Medicare Part B Claims, eCQM, MIPS CQM)	
	Q226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (Collection Type: eCQM, MIPS CQM, Medicare Part B Claims)	
	(!)(*) Q317: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented (Collection Type: eCQM, MIPS CQM, Medicare Part B Claims)	

Diabetic Disease Improvement Activities

- **(!!) IA_AHW_1:** Chronic Care and Preventative Care Management for Empaneled Patients
- **(^)(!!) IA_AHW_X:** Lifestyle Approaches to Diabetes Remediation
- **IA_BE_1:** Use of certified EHR to capture patient reported outcomes
- **IA_BE_3:** Engagement with QIN-QIO to implement self-management training programs
- **IA_BE_6:** Regularly Assess Patient Experience of Care and Follow Up on Findings
- **(!!) IA_BE_16:** Promote Self-management in Usual Care
- **IA_BE_19:** Use group visits for common chronic conditions (e.g., diabetes)
- **(!!) IA_BE_23:** Integration of patient coaching practices between visits
- **(*)(!!) IA_CC_9:** Implementation of practices/processes for developing regular individual care plans
- **(**) IA_MVP:** Practice-Wide Quality Improvement in MIPS Value Pathways
- **(*)(!!) IA_PM_4:** Glycemic management services
- **IA_PM_16:** Implementation of medication management practice improvements
- **(!!) IA_PM_25:** Save a Million Hearts: Standardization of Approach to Screening and Treatment for Cardiovascular Disease Risk

A.2 Hospitalist MVP

The proposed Hospitalist MVP assesses meaningful outcomes for patients receiving care provided by hospitalists. This MVP would be most applicable to hospitalists, including NPPs such as nurse practitioners, clinical nurse specialists, and physician assistants. We request public comment on this proposal.

Quality Measures

We are proposing to include four MIPS quality measures and five QCDR measures within the quality performance category of this MVP, which are relevant to care provided by hospitalists. We reviewed the MIPS quality measure inventory and considered feedback received during the 2026 MVP candidate feedback period to determine which quality measures best represent the clinical topic of this MVP.

For the reasons stated in the introduction of this appendix[502], we are proposing the following measures as MIPS core measures for the Hospitalist MVP:

- **Q005:** Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) or Angiotensin Receptor-Neprilysin Inhibitor (ARNI) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- **Q008:** Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- **Q047:** Advance Care Plan

The following quality measures provide a meaningful and comprehensive assessment of the clinical care for hospitalists:

- **Q005:** Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) or Angiotensin Receptor-Neprilysin Inhibitor (ARNI) Therapy for Left Ventricular Systolic Dysfunction (LVSD): This MIPS quality measure ensures patients diagnosed with heart failure and a left ventricular ejection fraction of less than or equal to 40% are prescribed an ACE inhibitor, ARB or ARNI therapy.
- **Q008:** Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD): This MIPS quality measure ensures patients diagnosed with heart failure and a left ventricular ejection fraction of less than or equal to 40% are prescribed beta-blocker therapy.
- **Q238:** Use of High-Risk Medications in Older Adults: This inverse MIPS quality measure supports patient safety by assessing high-risk medication utilization in the older adult population.
- **ECPR51:** Discharge Prescription of Naloxone after Opioid Poisoning or Overdose: This QCDR measure ensures patients treated for opioid poisoning in the acute care setting are prescribed naloxone and receive education on its proper use before discharge.
- **HCPR24:** Appropriate Utilization of Vancomycin for Cellulitis: This QCDR measure ensures the appropriate use of vancomycin for patients diagnosed with cellulitis in the hospital setting, whether admitted or under observation.
- **HCPR25:** Physician's Orders for Life-Sustaining Treatment (POLST) Form: This QCDR measure ensures patients with advanced illness have a completed POLST form during their hospitalization.
- **HCPR27:** Point-of-Care Ultrasound: Evaluation for Pneumothorax after Central Venous Catheter (CVC) Placement: This QCDR measure ensures patients undergoing CVC placement receive appropriate pneumothorax evaluation using point-of-care ultrasound.
- **HCPR30**: Avoidance of Sliding-Scale Insulin Monotherapy for Admitted Diabetic Patients: This QCDR measure ensures patients admitted to the hospital with a diagnosis of diabetes mellitus receive an order for basal insulin therapy.

The following broadly applicable MIPS quality measure is relevant to clinicians who specialize in hospitalist care.

- **Q047:** Advance Care Plan: This MIPS quality measure assesses for medical record documentation of an advance care plan or surrogate decisions maker.

Modifications are being considered for the following QCDR measure:

- **ECPR51:** Discharge Prescription of Naloxone after Opioid Poisoning or Overdose: This QCDR measure is undergoing modifications to expand the measure to include the treatment for opioid withdrawal in additional care settings.

Improvement Activities

[502] See MVP Development: Quality Measure and Improvement Activity Updates

We reviewed the improvement activities inventory and considered feedback received during the 2026 MVP candidate feedback period to determine the set of improvement activities to include in this MVP. We are proposing to include 12 improvement activities that reflect actions and processes undertaken by hospitalists, as well as activities that promote advancing health and wellness, patient engagement and patient-centeredness, shared decision-making, and care coordination. These improvement activities provide opportunities for clinicians, in collaboration with patients, to drive outcomes and improve quality of care. The following improvement activities are proposed for inclusion in this MVP:

- **IA_BE_6:** Regularly Assess Patient Experience of Care and Follow Up on Findings
- **IA_BMH_12:** Promoting Clinician Well-Being
- **IA_BMH_15:** Behavioral/Mental Health and Substance Use Screening & Referral for Older Adults
- **IA_CC_8:** Implementation of documentation improvements for practice/process improvements
- **IA_CC_9:** Implementation of practices/processes for developing regular individual care plans
- **IA_CC_13:** Practice improvements to align with OpenNotes principles
- **IA_MVP:** Practice-Wide Quality Improvement in MIPS Value Pathways
- **IA_PM_16:** Implementation of medication management practice improvements
- **IA_PM_21:** Advance Care Planning
- **IA_PSPA_8:** Use of patient safety tools
- **IA_PSPA_15:** Implementation of an ASP
- **IA_PSPA_21:** Implementation of fall screening and assessment programs

Cost Measures

We are proposing to include one MIPS cost measure within the cost performance category of this MVP, which applies to hospitalists. We reviewed the MIPS cost measure inventory and considered feedback received during the 2026 MVP candidate feedback period to determine the set of cost measures to include in this MVP. The following cost measure provides a meaningful assessment of the clinical care for hospitalists and aligns with other measures and activities within this MVP:

- **MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician: This MIPS cost measure applies to hospitalists.

Symbol Key:

Single exclamation point (!): MIPS core measure within an MVP.
Single asterisk (*): existing measures and improvement activities with proposed revisions.
Double asterisk (**): measures and improvement activities only available when included in an MVP.
Double exclamation point (!!): improvement activities with an advancing health and wellness component.

TABLE A.2a: Hospitalist MVP MIPS Core Measures

Hospitalist MVP MIPS Core Measures
Q005: Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) or Angiotensin Receptor-Neprilysin Inhibitor (ARNI) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
Q008: Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
Q047: Advance Care Plan

TABLE A.2b: Hospitalist MVP Clinical Groupings

Hospitalist MVP		
Clinical Grouping	**Quality**	**Cost**
Medication	**(!) Q005:** Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) or Angiotensin Receptor-Neprilysin Inhibitor (ARNI) Therapy for Left Ventricular Systolic Dysfunction (LVSD) (Collection Type: eCQM^^, MIPS CQM)	**MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
	(!) Q008: Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD) (Collection Type: eCQM^^, MIPS CQM)	
	(*) ECPR51: Discharge Prescription of Naloxone after Opioid Poisoning or Overdose (Collection Type: QCDR)	
	HCPR24: Appropriate Utilization of Vancomycin for Cellulitis (Collection Type: QCDR)	
General Clinical Care	**HCPR27:** Point-of-Care Ultrasound: Evaluation for Pneumothorax after Central Venous Catheter (CVC) Placement (Collection Type: QCDR)	**MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
	HCPR30: Avoidance of Sliding-Scale Insulin Monotherapy for Admitted Diabetic Patients (Collection Type: QCDR)	
Advancing Health and Wellness	**Q238:** Use of High-Risk Medications in Older Adults (Collection Type: eCQM, MIPS CQM)	**MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
Experience of Care	**(!) Q047:** Advance Care Plan (Collection Type: Medicare Part B Claims, MIPS CQM)	**MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
	HCPR25: Physician's Orders for Life-Sustaining Treatment (POLST) Form (Collection Type: QCDR)	

^^Please note this collection type does not include inpatient coding and may not be applicable.

Hospitalist Improvement Activities

- **IA_BE_6:** Regularly Assess Patient Experience of Care and Follow Up on Findings
- **(!!) IA_BMH_12:** Promoting Clinician Well-Being
- **(!!) IA_BMH_15:** Behavioral/Mental Health and Substance Use Screening & Referral for Older Adults
- **(*) IA_CC_8:** Implementation of documentation improvements for practice/process improvements
- **(*)(!!) IA_CC_9:** Implementation of practices/processes for developing regular individual care plans
- **IA_CC_13:** Practice improvements to align with OpenNotes principles
- **(**) IA_MVP:** Practice-Wide Quality Improvement in MIPS Value Pathways
- **IA_PM_16:** Implementation of medication management practice improvements
- **IA_PM_21:** Advance Care Planning
- **IA_PSPA_8:** Use of patient safety tools
- **(!!) IA_PSPA_15:** Implementation of an ASP
- **(!!) IA_PSPA_21:** Implementation of fall screening and assessment programs

A.3 Hypertension MVP

The proposed Hypertension MVP assesses meaningful outcomes for patients receiving care for hypertension and appropriate preventive interventions for those considered high-risk. This MVP would be most applicable to clinicians who treat patients at risk for hypertension and with a hypertension diagnosis, including cardiology, family medicine, geriatrics, internal medicine, nutrition and dietician, preventive medicine, and NPPs such as nurse practitioners, clinical nurse specialists, and physician assistants. We request public comment on this proposal.

Quality Measures

We are proposing to include 13 MIPS quality measures within the quality performance category of this MVP, which are specific to the clinical topic of hypertension. We reviewed the MIPS quality measure inventory and considered feedback received during the 2026 MVP candidate feedback period to determine which quality measures best represent the clinical topic of this MVP.

For the reasons stated in the introduction of this appendix[503], we are proposing the following measures as MIPS core measures for the Hypertension MVP:

- **Q128:** Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
- **Q226:** Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- **Q236:** Controlling High Blood Pressure

The following quality measures provide a meaningful and comprehensive assessment of the clinical care for clinicians who specialize in the treatment of hypertension:

- **Q128:** Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan: This MIPS quality measure assesses patients for a documented BMI with a follow-up plan documented if their most recent documented BMI was outside of normal parameters.
- **Q236:** Controlling High Blood Pressure: This intermediate outcome MIPS quality measure assesses patients diagnosed with hypertension for adequately controlled blood pressure.
- **Q239:** Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: This MIPS quality measure ensures that patients aged 3-17 years have a BMI recorded with appropriate nutrition and physical activity counseling.
- **Q317:** Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented: This MIPS quality measure ensures all adult patients are screened for high blood pressure at each visit and have a recommended follow-up plan if blood pressure is elevated or hypertensive.
- **Q441:** Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control): This intermediate outcome MIPS quality measure ensures optimal control of patients with IVD by assessing goals for blood pressure management, smoking cessation, antiplatelet use, and high intensity statin use.
- **Q489:** Adult Kidney Disease: Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy: This MIPS quality measure ensures patients diagnosed with chronic kidney disease and proteinuria are prescribed and ACE inhibitor or ARB therapy.
- **TBD:** Low Density Lipoprotein Cholesterol (LDL-C) Monitoring and Management: This proposed intermediate outcome MIPS quality measure ensures lipid monitoring in patients with atherosclerotic cardiovascular disease (ASCVD) and achieving the target goal of an LDL-C less than 70mg/dL.

The following broadly applicable MIPS quality measures are relevant to clinicians who specialize in the treatment of hypertension. The quality measures below assess for age-specific screenings and follow-up actions for select measures:

- **Q047:** Advance Care Plan: This MIPS quality measure assesses for medical record documentation of an advance care plan or surrogate decision maker.
- **Q130:** Documentation of Current Medications in the Medical Record: This MIPS quality measure assesses for review and documentation of all current medications at each visit.

[503] See MVP Development: Quality Measure and Improvement Activity Updates

- **Q226:** Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention: This MIPS quality measure screens patients for tobacco use. Any patients that are found to be tobacco users should receive tobacco cessation intervention.
- **Q374:** Closing the Referral Loop: Receipt of Specialist Report: This MIPS quality measure is attributable to the clinician referring the patient and ensures that the referring clinician receives a report from the clinician to whom the patient was referred, therefore closing the communication loop.
- **Q431:** Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling: This MIPS quality measure screens patients for unhealthy alcohol use. Any patients that screen positive for unhealthy alcohol use should receive brief counseling.
- **Q503:** Gains in Patient Activation Measure (PAM®) Scores at 12 Months: This MIPS quality measure ensures capture of the patient voice and experience of care related to the patient's understanding and confidence in the clinician's ability to manage their health and be an active partner in the health care journey.

Improvement Activities

We reviewed the improvement activities inventory and considered feedback received during the 2026 MVP candidate feedback period to determine the set of improvement activities to include in this MVP. We are proposing to include 11 improvement activities that reflect actions and processes undertaken by clinicians who specialize in the treatment of hypertension, as well as activities that promote advancing health and wellness, engagement and patient-centeredness, shared decision-making, and care coordination. These improvement activities provide opportunities for clinicians, in collaboration with patients, to drive outcomes and improve quality of care. The following improvement activities were proposed for inclusion in this MVP:

- **IA_AHW_1:** Chronic care and preventative care management for empaneled patients
- **IA_AHW_X:** Lifestyle Approaches to Diabetes Remediation
- **IA_BE_16:** Promote Self-management in Usual Care
- **IA_BMH_2:** Tobacco use
- **IA_CC_8:** Implementation of documentation improvements for practice/process improvements
- **IA_MVP:** Practice-Wide Quality Improvement in the MIPS Value Pathways Program
- **IA_PM_4:** Glycemic management services
- **IA_PM_5:** Engagement of community for health status improvement
- **IA_PM_25:** Save a Million Hearts: Standardization of Approach to Screening and Treatment for Cardiovascular Disease Risk
- **IA_PSPA_16:** Use of decision support —ideally platform-agnostic, interoperable clinical decision support (CDS) tools —and standardized treatment protocols to manage workflow on the care team to meet patient needs
- **IA_PSPA_28:** Completion of an Accredited Safety or Quality Improvement Program

Cost Measures

We are proposing to include one MIPS cost measure within the cost performance category of this MVP, which applies to the clinical topic of hypertension. We reviewed the MIPS cost measure inventory and considered feedback received during the 2025 MVP candidate feedback period to determine the set of cost measures to include in this MVP. The following cost measure provides a meaningful assessment of the clinical care for clinicians who care for patients with hypertension:

- **TPCC_1:** Total Per Capita Cost (TPCC): This MIPS cost measure assesses the overall cost of care delivered to a Medicare patient with a focus on the primary care the patient receives from their providers.

Symbol Key:
Single exclamation point (!): MIPS core measure within an MVP.
Caret symbol (^): proposed new measure or improvement activity.
Single asterisk (*): existing measures and improvement activities with proposed revisions.
Double asterisk (**): measures and improvement activities only available when included in an MVP.
Double exclamation point (!!): improvement activities with an advancing health and wellness component.

TABLE A.3a: Hypertension MVP MIPS Core Measures

Hypertension MVP MIPS Core Measures
Q128: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
Q226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
Q236: Controlling High Blood Pressure

TABLE A.3b: Hypertension MVP Clinical Groupings

Hypertension MVP		
Clinical Grouping	**Quality**	**Cost**
Prevention	**(!)(**) Q128:** Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (Collection Type: Medicare Part B Claims, eCQM, MIPS CQM)	**TPCC_1:** Total Per Capita Cost
	Q239: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Collection Type: eCQM)	
	(*) Q317: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented (Collection Type: Medicare Part B Claims, eCQM, MIPS CQM)	
	Q489: Adult Kidney Disease: Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy (Collection Type: MIPS CQM)	
Treatment and Control	**(!)(*) Q236:** Controlling High Blood Pressure (Collection Type: Medicare Part B Claims, eCQM, MIPS CQM)	**TPCC_1:** Total Per Capita Cost
	(*) Q441: Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control) (Collection Type: MIPS CQM)	
	(^) TBD: Low Density Lipoprotein Cholesterol (LDL-C) Monitoring and Management (Collection Type: MIPS CQM)	
Advancing Health and Wellness	**(*) Q130:** Documentation of Current Medications in the Medical Record (Collection Type: eCQM, MIPS CQM)	**TPCC_1:** Total Per Capita Cost
	(!) Q226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (Collection Type: Medicare Part B Claims, eCQM, MIPS CQM)	
	Q431: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (Collection Type: MIPS CQM)	
Experience of Care	**Q047:** Advance Care Plan (Collection Type: Medicare Part B Claims, MIPS CQM)	**TPCC_1:** Total Per Capita Cost
	(*) Q374: Closing the Referral Loop: Receipt of Specialist Report (Collection Type: eCQM, MIPS CQM)	
	Q503: Gains in Patient Activation Measure (PAM®) Scores at 12 Months (Collection Type: MIPS CQM)	

Hypertension Improvement Activities

- **(!!) IA_AHW_1:** Chronic care and preventative care management for empaneled patients
- **(^)(!!) IA_AHW_X:** Lifestyle Approaches to Diabetes Remediation
- **(!!) IA_BE_16:** Promote Self-management in Usual Care
- **(!!) IA_BMH_2:** Tobacco use
- **(*) IA_CC_8:** Implementation of documentation improvements for practice/process improvements
- **(**) IA_MVP:** Practice-Wide Quality Improvement in the MIPS Value Pathways Program
- **(*)(!!) IA_PM_4:** Glycemic management services
- **(!!) IA_PM_5:** Engagement of community for health status improvement
- **(!!) IA_PM_25:** Save a Million Hearts: Standardization of Approach to Screening and Treatment for Cardiovascular Disease Risk
- **(*) IA_PSPA_16:** Use of decision support —ideally platform-agnostic, interoperable clinical decision support (CDS) tools —and standardized treatment protocols to manage workflow on the care team to meet patient needs

- **IA_PSPA_28:** Completion of an Accredited Safety or Quality Improvement Program

Group B: Modifications to Previously Finalized MVPs for the CY 2027 Performance Period/2029 MIPS Payment Year and Future Years

B.1: Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP

Table B.1a represents the proposed MIPS core measures for the Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP. The B.1b table, followed by a list of improvement activities, represents the measures and activities finalized within the Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP (90 FR 50406 through 50408) with proposed modifications for the CY 2027 performance period/2029 MIPS payment year and future years. The Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP focuses on important assessors of the care emergency clinicians provide to patients. By focusing on these specific measures and activities, emergency clinicians can reduce clinical variability, improve the quality of emergency care and potentially lower costs. This MVP would be most applicable to clinicians who treat patients within the practice of emergency medicine, including NPPs such as nurse practitioners, clinical nurse specialists, and physician assistants. We reviewed the MIPS quality measure and improvement activities inventories and considered feedback received during the 2026 MVP maintenance period to determine which measures and activities to include in this MVP. We request public comment on the proposed modifications included in this MVP.

Quality Measures

For the reasons stated in the introduction of this appendix[504], we are proposing the following measures as MIPS core measures for the Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP:

- **Q116:** Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis
- **Q331:** Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse)
- **Q416:** Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 Through 17 Years

We are proposing to add one MIPS quality measure:

- **Q066:** Appropriate Testing for Pharyngitis: This appropriate use MIPS quality measure assesses for completion of a group A streptococcus test for patients diagnosed with pharyngitis or tonsilitis who were prescribed an antibiotic.

For the reasons stated in the introduction of this appendix[505], we are proposing to remove **Q415:** Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older. We are proposing to remove one QCDR measure due to low adoption, no benchmark after 2 consecutive years in MIPS and one high performing QCDR measure:

- **ACEP52:** Appropriate Emergency Department Utilization of Lumbar Spine Imaging for Acute Atraumatic Low Back Pain (low adoption, no benchmark after 2 consecutive years in MIPS)
- **ECPR46:** Avoidance of Opiates for Low Back Pain or Migraines (high performing)

Modifications are being considered for the following QCDR measure:

- **ACEP52:** Appropriate Emergency Department Utilization of Lumbar Spine Imaging for Acute Atraumatic Low Back Pain: If the measure is not finalized for removal in the CY 2027 PFS final rule, this QCDR measure would undergo modifications to the

[504] See MVP Development: Quality Measure and Improvement Activity Updates
[505] Ibid.

denominator to exclude patients aged 65 and older, as they experience higher rates of osteoporosis-related vertebral fractures during routine activities and have higher rates of malignancies with spinal metastases compared to patients under 65 years old.

Symbol Key:
Single exclamation point (!): MIPS core measure within an MVP.
Plus sign (+): measures and improvement activities proposed for addition to a previously finalized MVP.
Double asterisk (**): measures and improvement activities only available when included in an MVP.
Double exclamation point (!!): improvement activities with an advancing health and wellness component.

TABLE B.1a: Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP MIPS Core Measures

Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP MIPS Core Measures
Q116: Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis
Q331: Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse)
Q416: Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 Through 17 Years

TABLE B.1b: Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP Clinical Groupings

Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP		
Clinical Grouping	**Quality**	**Cost**
Infectious Disease/ Antibiotic Stewardship	**Q065:** Appropriate Treatment for Upper Respiratory Infection (URI) (Collection Type: eCQM, MIPS CQM)	**COST_EDV_1:** Emergency Medicine
	(+) Q066: Appropriate Testing for Pharyngitis (Collection Type: eCQM, MIPS CQM)	
	(!) Q116: Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Collection Type: MIPS CQM)	
	(!) Q331: Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse) (Collection Type: MIPS CQM)	
	HCPR24: Appropriate Utilization of Vancomycin for Cellulitis (Collection Type: QCDR)	
Trauma	**(!) Q416:** Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 Through 17 Years (Collection Type: MIPS CQM)	**COST_EDV_1:** Emergency Medicine
Experience of Care	**Q321:** CAHPS for MIPS Clinician/Group Survey (Collection Type: CMS-approved Survey Vendor)	**COST_EDV_1:** Emergency Medicine
	ACEP50: ED Median Time from ED arrival to ED departure for all Adult Patients (Collection Type: QCDR)	

Adopting Best Practices and Promoting Patient Safety within Emergency Medicine Improvement Activities

- **IA_BE_4:** Engagement of Patients through Implementation of New Patient Portal
- **IA_BE_6:** Regularly Assess Patient Experience of Care and Follow Up on Findings
- **(!!) IA_BMH_12:** Promoting Clinician Wellbeing
- **(**) IA_MVP:** Practice-Wide Quality Improvement in the MIPS Value Pathways Program
- **IA_PSPA_1:** Participation in an AHRQ-listed patient safety organization
- **IA_PSPA_7:** Use of QCDR data for ongoing practice assessment and improvements
- **(!!) IA_PSPA_15:** Implementation of an ASP

B.2: Advancing Cancer Care MVP

Table B.2a represents the proposed MIPS core measures for the Advancing Cancer Care MVP. The B.2b table, followed by a list of improvement activities, represents the measures and activities finalized within the Advancing Cancer Care MVP (90 FR 50408 through 50411) with proposed modifications for the CY 2027 performance period/2029 MIPS payment year and future years. The Advancing Cancer Care MVP focuses on the clinical specialty of providing fundamental treatment and management of cancer care. This MVP would be most applicable to clinicians who treat patients within the practices of oncology and hematology, including NPPs such as nurse practitioners, clinical nurse specialists, and physician assistants. We reviewed the MIPS quality measure and improvement activities inventories and considered feedback received during the 2026 MVP maintenance period to determine which measures and activities to include in this MVP. We request public comment on the proposed modifications included in this MVP.

Quality Measures

For the reasons stated in the introduction of this appendix[506], we are proposing the following measures as MIPS core measures for the Advancing Cancer Care MVP:

[506] See MVP Development: Quality Measure and Improvement Activity Updates

- **Q102:** Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
- **Q144:** Oncology: Medical and Radiation - Plan of Care for Pain
- **Q451:** RAS (KRAS and NRAS) Gene Mutation Testing Performed for Patients with Metastatic Colorectal Cancer who receive Anti-epidermal Growth Factor Receptor (EGFR) Monoclonal Antibody Therapy
- **Q457:** Percentage of Patients Who Died from Cancer Admitted to Hospice for Less than 3 days (lower score – better)
- **Q495:** Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood
- **Q506:** Positive PD-L1 Biomarker Expression Test Result Prior to First-Line Immune Checkpoint Inhibitor Therapy

We are proposing to add two QCDR measures:

- **PIMSH19:** Antiemetic Therapy for Low- and Minimal-Emetic-Risk Antineoplastic Agents - Avoidance of Overuse (Lower Score - Better): This QCDR measure is an inverse measure (lower score is better) that ensures clinicians follow clinical guidelines for patients treated with low- or minimal-emetic-risk antineoplastic agents by assessing for inappropriate pre-treatment antiemetic therapy.
- **PIMSH20:** Appropriate Antiemetic Therapy for High- and Moderate-Emetic-Risk Antineoplastic Agents: This QCDR measure ensures clinicians follow clinical guidelines for patients treated with high- or moderate-emetic-risk antineoplastic agents by ensuring they receive the appropriate pre-treatment antiemetic therapy, which could result in improved control of nausea and vomiting in patients.

For the reasons stated in the introduction of this appendix[507], we are proposing to remove **Q143:** Oncology: Medical and Radiation – Pain Intensity Quantified.

Modifications are being considered for the following QCDR measure:

- **PIMSH13:** Oncology: Mutation Testing for Stage IV Lung Cancer Completed Prior to the Start of Targeted Therapy: This QCDR measure is undergoing modifications to provide additional clarification and to emphasize its focus on first-line treatment. Updates are being made to the description, denominator, denominator exclusions, and numerator, along with the addition of a numerator note.

Improvement Activities

We are proposing to add one improvement activity that is relevant to this MVP and includes an advancing health and wellness component:

- **IA_CC_9:** Implementation of practices/processes for developing regular individual care plans

For the reasons stated in the introduction of this appendix[508], we are proposing to remove **IA_BE_15:** Engagement of Patients, Family, and Caregivers in Developing a Plan of Care.

Symbol Key:

Single exclamation point (!): MIPS core measure within an MVP.

Plus sign (+): measures and improvement activities proposed for addition to a previously finalized MVP.

Single asterisk (*): existing measures and improvement activities with proposed revisions.

Double asterisk (**): measures and improvement activities only available when included in an MVP.

Double exclamation point (!!): improvement activities with an advancing health and wellness component.

---

[507] Ibid.

[508] Ibid.

TABLE B.2a: Advancing Cancer Care MVP MIPS Core Measures

Advancing Cancer Care MVP MIPS Core Measures
Q102: Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
Q144: Oncology: Medical and Radiation - Plan of Care for Pain
Q451: RAS (KRAS and NRAS) Gene Mutation Testing Performed for Patients with Metastatic Colorectal Cancer who receive Anti-epidermal Growth Factor Receptor (EGFR) Monoclonal Antibody Therapy
Q457: Percentage of Patients Who Died from Cancer Admitted to Hospice for Less than 3 days (lower score – better)
Q495: Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood
Q506: Positive PD-L1 Biomarker Expression Test Result Prior to First-Line Immune Checkpoint Inhibitor Therapy

TABLE B.2b: Advancing Cancer Care MVP Clinical Groupings

Advancing Cancer Care MVP		
Clinical Grouping	**Quality**	**Cost**
Medical Oncology	**Q450:** Appropriate Treatment for Patients with Stage I (T1c) – III HER2 Positive Breast Cancer (Collection Type: MIPS CQM)	**TPCC_1:** Total Per Capita Cost
	(!) Q451: RAS (KRAS and NRAS) Gene Mutation Testing Performed for Patients with Metastatic Colorectal Cancer who receive Anti-epidermal Growth Factor Receptor (EGFR) Monoclonal Antibody Therapy (Collection Type: MIPS CQM)	
	Q462: Bone Density Evaluation for Patients with Prostate Cancer and Receiving Androgen Deprivation Therapy (Collection Type: eCQM)	**COST_PC_1:** Prostate Cancer **TPCC_1:** Total Per Capita Cost
	Q490: Appropriate Intervention of Immune-related Diarrhea and/or Colitis in Patients Treated with Immune Checkpoint Inhibitors (Collection Type: MIPS CQM)	
	(!) Q506: Positive PD-L1 Biomarker Expression Test Result Prior to First-Line Immune Checkpoint Inhibitor Therapy (Collection Type: MIPS CQM)	**TPCC_1:** Total Per Capita Cost
	(*) Q507: Appropriate Germline Testing for Ovarian Cancer Patients (Collection Type: MIPS CQM)	
	(*) PIMSH13: Oncology: Mutation Testing for Stage IV Lung Cancer Completed Prior to the Start of Targeted Therapy (Collection Type: QCDR)	
	PIMSH17: Oncology: Utilization of Prophylactic GCSF for Cancer Patients Receiving Low-Risk Chemotherapy (inverse measure) (Collection Type: QCDR)	**TPCC_1:** Total Per Capita Cost
	(+) PIMSH19: Antiemetic Therapy for Low- and Minimal-Emetic-Risk Antineoplastic Agents - Avoidance of Overuse (Lower Score - Better) (Collection Type: QCDR)	**COST_PC_1:** Prostate Cancer **TPCC_1:** Total Per Capita Cost
	(+) PIMSH20: Appropriate Antiemetic Therapy for High- and Moderate-Emetic-Risk Antineoplastic Agents (Collection Type: QCDR)	
Radiation Oncology	**(!)(*) Q102:** Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients (Collection Type: eCQM, MIPS CQM)	**COST_PC_1:** Prostate Cancer **TPCC_1:** Total Per Capita Cost

Advancing Cancer Care MVP		
Clinical Grouping	**Quality**	**Cost**
	(!)(*) Q144: Oncology: Medical and Radiation - Plan of Care for Pain (Collection Type: MIPS CQM)	
Advancing Health and Wellness	**(*) Q134:** Preventive Care and Screening: Screening for Depression and Follow-Up Plan (Collection Type: Medicare Part B Claims, eCQM, MIPS CQM)	**COST_PC_1:** Prostate Cancer **TPCC_1:** Total Per Capita Cost
Experience of Care	**Q047:** Advance Care Plan (Collection Type: Medicare Part B Claims, MIPS CQM)	**COST_PC_1:** Prostate Cancer **TPCC_1:** Total Per Capita Cost
	Q321: CAHPS for MIPS Clinician/Group Survey (Collection Type: CMS-approved Survey Vendor)	
	(*) Q453: Percentage of Patients Who Died from Cancer Receiving Systemic Cancer-Directed Therapy in the Last 14 Days of Life (lower score – better) (Collection Type: MIPS CQM)	
	(!)(*) Q457: Percentage of Patients Who Died from Cancer Admitted to Hospice for Less than 3 days (lower score – better) (Collection Type: MIPS CQM)	
	(!) Q495: Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood (Collection Type: MIPS CQM)	
	Q503: Gains in Patient Activation Measure (PAM®) Scores at 12 Months (Collection Type: MIPS CQM)	

Advancing Cancer Care Improvement Activities

- **IA_BE_4:** Engagement of Patients through Implementation of New Patient Portal
- **IA_BE_6:** Regularly Assess Patient Experience of Care and Follow Up on Findings
- **IA_BE_24:** Financial Navigation Program
- **(!) IA_BMH_12:** Promoting Clinician Well-Being
- **(+)(*)(!!) IA_CC_9:** Implementation of practices/processes for developing regular individual care plans
- **IA_CC_13:** Practice Improvements to Align with OpenNotes Principles
- **IA_CC_17:** Patient Navigator Program
- **IA_EPA_2:** Use of telehealth services that expand practice access
- **(**) IA_MVP:** Practice-Wide Quality Improvement in the MIPS Value Pathways Program
- **IA_PM_14:** Implementation of methodologies for improvements in longitudinal care management for high-risk patients
- **IA_PM_15:** Implementation of episodic care management practice improvements
- **IA_PM_16:** Implementation of medication management practice improvements
- **IA_PM_21:** Advance Care Planning
- **IA_PSPA_13:** Participation in Joint Commission Evaluation Initiative
- **(*) IA_PSPA_16:** Use of decision support —ideally platform-agnostic, interoperable clinical decision support (CDS) tools —and standardized treatment protocols to manage workflow on the care team to meet patient needs
- **IA_PSPA_28:** Completion of an Accredited Safety or Quality Improvement Program

B.3: Advancing Care for Heart Disease MVP

Table B.3a represents the proposed MIPS core measures for the Advancing Care for Heart Disease MVP. The B.3b table, followed by a list of improvement activities, represents the measures and activities finalized within the Advancing Care for Heart Disease MVP (90 FR 50411 through 50415) with proposed modifications for the CY 2027 performance period/2029 MIPS payment year and future years. The Advancing Care for Heart Disease MVP focuses on the clinical theme of providing fundamental treatment and management of costly clinical conditions that contribute to, or may result from, heart disease. This MVP would be most

applicable to clinicians who treat patients within the practices of cardiology, internal medicine and family medicine, including NPPs such as nurse practitioners, clinical nurse specialists, and physician assistants. We reviewed the MIPS quality measure and improvement activities inventories and considered feedback received during the 2026 MVP maintenance period to determine which measures and activities to include in this MVP. We request public comment on the proposed modifications included in this MVP.

Quality Measures

For the reasons stated in the introduction of this appendix[509], we are proposing the following measures as MIPS core measures for the Advancing Care for Heart Disease MVP:

- **Q441:** Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control)
- **Q492:** Risk-standardized Acute Cardiovascular-related Hospital Admission Rates for Patients with Heart Failure under the Merit-based Incentive Payment System
- **TBD:** Low Density Lipoprotein Cholesterol (LDL-C) Monitoring and Management

We are proposing to add one MIPS quality measure:

- **TBD:** Low Density Lipoprotein Cholesterol (LDL-C) Monitoring and Management: This proposed intermediate outcome MIPS quality measure ensures lipid monitoring in patients with atherosclerotic cardiovascular disease (ASCVD) and achieving the target goal of an LDL-C less than 70mg/dL.

For the reasons stated in the introduction of this appendix[510], we are proposing to remove **Q006:** Coronary Artery Disease (CAD): Antiplatelet Therapy, **Q007:** Coronary Artery Disease (CAD): Beta-Blocker Therapy – Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%), and **Q326:** Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy.

Improvement Activities

For the reasons stated in the introduction of this appendix[511], we are proposing to remove **IA_BE_15:** Engagement of Patients, Family, and Caregivers in Developing a Plan of Care.

Symbol Key:

Exclamation point (!): MIPS core measure within an MVP.
Caret symbol (^): proposed new measure or improvement activity.
Plus sign (+): measures and improvement activities proposed for addition to a previously finalized MVP.
Single asterisk (*): existing measures and improvement activities with proposed revisions.
Double asterisk (**): measures and improvement activities only available when included in an MVP.
Double exclamation point (!!): improvement activities with an advancing health and wellness component.

TABLE B.3a: Advancing Care for Heart Disease MVP MIPS Core Measures

Advancing Care for Heart Disease MVP MIPS Core Measures
Q441: Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control)
Q492: Risk-standardized Acute Cardiovascular-related Hospital Admission Rates for Patients with Heart Failure under the Merit-based Incentive Payment System
TBD: Low Density Lipoprotein Cholesterol (LDL-C) Monitoring and Management

[509] See MVP Development: Quality Measure and Improvement Activity Updates
[510] See MVP Development: Quality Measure and Improvement Activity Updates
[511] Ibid.

TABLE B.3b: Advancing Care for Heart Disease MVP Clinical Groupings

Advancing Care for Heart Disease MVP		
Clinical Grouping	**Quality**	**Cost**
Congestive Heart Failure	**Q005:** Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) or Angiotensin Receptor-Neprilysin Inhibitor (ARNI) Therapy for Left Ventricular Systolic Dysfunction (LVSD) (Collection Type: eCQM, MIPS CQM)	**COST_HF_1:** Heart Failure **TPCC_1:** Total Per Capita Cost
	Q008: Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD) (Collection Type: eCQM, MIPS CQM)	
	Q377: Functional Status Assessments for Heart Failure (Collection Type: eCQM)	
	(!) Q492: Risk-standardized Acute Cardiovascular-related Hospital Admission Rates for Patients with Heart Failure under the Merit-based Incentive Payment System (Collection Type: Administrative Claims)	
General Cardiology	**Q118:** Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF ≤ 40%) (Collection Type: MIPS CQM)	**COST_HF_1:** Heart Failure **COST_EOPCI_1:** Elective Outpatient Percutaneous Coronary Intervention (PCI) **COST_STEMI_1:** Inpatient (IP) Percutaneous Coronary Intervention (PCI) **TPCC_1:** Total Per Capita Cost
	Q243: Cardiac Rehabilitation Patient Referral from an Outpatient Setting (Collection Type: MIPS CQM)	
	(!)(*) Q441: Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control) (Collection Type: MIPS CQM)	**TPCC_1:** Total Per Capita Cost
	(!)(^)(+) TBD: Low Density Lipoprotein Cholesterol (LDL-C) Monitoring and Management	
Electrophysiology	**(*) Q392:** Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation (Collection Type: MIPS CQM)	**MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
	(*) Q393: Infection within 180 Days of Cardiac Implantable Electronic Device (CIED) Implantation, Replacement, or Revision (Collection Type: MIPS CQM)	**COST_EOPCI_1:** Elective Outpatient Percutaneous Coronary Intervention (PCI) **COST_STEMI_1:** Inpatient (IP) Percutaneous Coronary Intervention (PCI) **MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
Advancing Health and Wellness	**(**) Q128:** Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (Collection Type: Medicare Part B Claims, eCQM, MIPS CQM)	**COST_HF_1:** Heart Failure **COST_EOPCI_1:** Elective Outpatient Percutaneous Coronary Intervention (PCI)

Advancing Care for Heart Disease MVP		
Clinical Grouping	**Quality**	**Cost**
	(*) Q134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan (Collection Type: Medicare Part B Claims, eCQM, MIPS CQM)	**COST_STEMI_1:** Inpatient (IP) Percutaneous Coronary Intervention (PCI) **TPCC_1:** Total Per Capita Cost **MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
	Q238: Use of High-Risk Medications in Older Adults (Collection Type: eCQM, MIPS CQM)	
Experience of Care	**Q047:** Advance Care Plan (Collection Type: Medicare Part B Claims, MIPS CQM)	**COST_HF_1:** Heart Failure **COST_EOPCI_1:** Elective Outpatient Percutaneous Coronary Intervention (PCI) **COST_STEMI_1:** Inpatient (IP) Percutaneous Coronary Intervention (PCI) **TPCC_1:** Total Per Capita Cost **MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
	Q495: Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood (Collection Type: MIPS CQM)	
	Q503: Gains in Patient Activation Measure (PAM®) Scores at 12 Months (Collection Type: MIPS CQM)	

Advancing Care for Heart Disease Improvement Activities

- **(!!) IA_AHW_1:** Chronic Care and Preventative Care Management for Empaneled Patients
- **IA_BE_6:** Regularly Assess Patient Experience of Care and Follow Up on Findings
- **(!!) IA_BE_12:** Use evidence-based decision aids to support shared decision-making
- **IA_BE_24:** Financial Navigation Program
- **IA_BE_25:** Drug Cost Transparency
- **(*)(!!) IA_CC_9:** Implementation of practices/processes for developing regular individual care plans
- **(**) IA_MVP:** Practice-Wide Quality Improvement in the MIPS Value Pathways Program
- **IA_PM_14:** Implementation of methodologies for improvements in longitudinal care management for high risk patients
- **IA_PSPA_4:** Administration of the AHRQ Survey of Patient Safety Culture
- **IA_PSPA_7:** Use of QCDR data for ongoing practice assessment and improvements

B.4: Advancing Rheumatology Patient Care MVP

Table B.4a represents the proposed MIPS core measures for the Advancing Rheumatology Patient Care MVP. The B.4b table, followed by a list of improvement activities, represents the measures and activities finalized within the Advancing Rheumatology Patient Care MVP (90 FR 50415 through 50418) with proposed modifications for the CY 2027 performance period/2029 MIPS payment year and future years. The Advancing Rheumatology Patient Care MVP focuses on the clinical theme of providing fundamental treatment and management of rheumatological conditions. This MVP would be most applicable to clinicians who treat patients within the practice of rheumatology, including NPPs such as nurse practitioners, clinical nurse specialists, and physician assistants. We reviewed the MIPS quality measure and improvement activities inventories and considered feedback received during the 2026 MVP maintenance period to determine which measures and activities to include in this MVP. We request public comment on the proposed modifications included in this MVP.

Quality Measures

For the reasons stated in the introduction of this appendix[512], we are proposing the following measures as MIPS core measures for the Advancing Rheumatology Patient Care MVP:

- **Q039:** Screening for Osteoporosis for Women Aged 65-85 Years of Age
- **Q178:** Rheumatoid Arthritis (RA): Functional Status Assessment
- **Q180:** Rheumatoid Arthritis (RA): Glucocorticoid Management

We are proposing to add one QCDR measure:

- **UREQA8:** Vitamin D level: Effective Control of Low Bone Mass/Osteopenia and Osteoporosis: Therapeutic Level Of 25 OH Vitamin D Level Achieved: This QCDR measure ensures that patients diagnosed with osteopenia or osteoporosis maintain a hydroxy-vitamin D level at or above the targeted threshold.

We are proposing to remove one process QCDR measure that does not include a quality action:

- **ACR12:** Disease Activity Measurement for Patients with PsA

Modifications are being considered for the following QCDR measures:

- **ACR10:** Hepatitis B Safety Screening: This QCDR measure is undergoing modifications to add denominator instructions that provide clearer guidance on what qualifies as a 'newly initiated' biologic.
- **ACR12:** Disease Activity Measurement for Patients with PsA: If the measure is not finalized for removal in the CY 2027 PFS final rule, this QCDR measure would undergo modifications to the denominator to add a specific age-related timeframe and clarify the required timeframe for the additional face-to-face encounter.
- **ACR14:** Gout: Serum Urate Target: This QCDR measure is undergoing modifications to the denominator to include a specific age-related timeframe. There would also be updates to the denominator exceptions to align with the American College of Rheumatology (ACR) clinical guidelines.
- **ACR15:** Safe Hydroxychloroquine Dosing: This QCDR measure is undergoing modifications to the description and numerator to add a second option for meeting numerator compliance. An alternative criterion, allowing completion and documentation of an Hydroxychloroquine (HCQ) whole blood level measurement would satisfy numerator requirements.

Improvement Activities

We are proposing to add one improvement activity that is relevant to this MVP and includes an advancing health and wellness component:

- **IA_CC_9:** Implementation of practices/processes for developing regular individual care plans

For the reasons stated in the introduction of this appendix[513], we are proposing to remove **IA_BE_15:** Engagement of Patients, Family, and Caregivers in Developing a Plan of Care.

Symbol Key:

Exclamation point (!): MIPS core measure within an MVP.
Plus sign (+): measures and improvement activities proposed for addition to a previously finalized MVP.
Single asterisk (*): existing measures and improvement activities with proposed revisions.
Double asterisk (**): measures and improvement activities only available when included in an MVP.

---

[512] See MVP Development: Quality Measure and Improvement Activity Updates
[513] Ibid.

Double exclamation point (!!): improvement activities with an advancing health and wellness component.

TABLE B.4a: Advancing Rheumatology Patient Care MVP MIPS Core Measures

Advancing Rheumatology Patient Care MVP MIPS Core Measures
Q039: Screening for Osteoporosis for Women Aged 65-85 Years of Age
Q178: Rheumatoid Arthritis (RA): Functional Status Assessment
Q180: Rheumatoid Arthritis (RA): Glucocorticoid Management

TABLE B.4b: Advancing Rheumatology Patient Care MVP Clinical Groupings

Advancing Rheumatology Patient Care MVP		
Clinical Grouping	**Quality**	**Cost**
Rheumatoid Arthritis	**Q177:** Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity (Collection Type: MIPS CQM)	**COST_RA_1:** Rheumatoid Arthritis **TPCC_1:** Total Per Capita Cost
	(!)(*) Q178: Rheumatoid Arthritis (RA): Functional Status Assessment (Collection Type: MIPS CQM)	
	(!) Q180: Rheumatoid Arthritis (RA): Glucocorticoid Management (Collection Type: MIPS CQM)	
Autoimmune/ Inflammatory Diseases	**(*) ACR14:** Gout: Serum Urate Target (Collection Type: QCDR)	**TPCC_1:** Total Per Capita Cost
	(*) ACR15: Safe Hydroxychloroquine Dosing (Collection Type: QCDR)	**COST_RA_1:** Rheumatoid Arthritis **TPCC_1:** Total Per Capita Cost
	UREQA10: Ankylosing Spondylitis: Controlled Disease Or Improved Disease Function (Collection Type: QCDR)	**TPCC_1:** Total Per Capita Cost
Advancing Health and Wellness	**(!) Q039:** Screening for Osteoporosis for Women Aged 65-85 Years of Age (Collection Type: Medicare Part B Claims, MIPS CQM)	**COST_RA_1:** Rheumatoid Arthritis **TPCC_1:** Total Per Capita Cost
	(*) Q130: Documentation of Current Medications in the Medical Record (Collection Type: eCQM, MIPS CQM)	
	(*) Q134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan (Collection Type: Medicare Part B Claims, eCQM, MIPS CQM)	
	(*) Q176: Tuberculosis Screening Prior to First Course of Biologic and/or Immune Response Modifier Therapy (Collection Type: MIPS CQM)	
	(*) ACR10: Hepatitis B Safety Screening (Collection Type: QCDR)	
	(+) UREQA8: Vitamin D level: Effective Control of Low Bone Mass/Osteopenia and Osteoporosis: Therapeutic Level Of 25 OH Vitamin D Level Achieved (Collection Type: QCDR)	
	UREQA9: Screening for Osteoporosis for Men Aged 70 Years and Older (Collection Type: QCDR)	
	Q493: Adult Immunization Status (Collection Type: MIPS CQM)	
Experience of Care	**Q503:** Gains in Patient Activation Measure (PAM®) Scores at 12 Months (Collection Type: MIPS CQM)	**COST_RA_1:** Rheumatoid Arthritis **TPCC_1:** Total Per Capita Cost

Advancing Rheumatology Improvement Activities

- **IA_BE_1:** Use of certified EHR to capture patient reported outcomes
- **IA_BE_4:** Engagement of Patients through Implementation of New Patient Portal
- **IA_BE_6:** Regularly Assess Patient Experience of Care and Follow Up on Findings
- **IA_BE_24:** Financial Navigation Program
- **IA_BE_25:** Drug Cost Transparency
- **(!!) IA_BE_26:** Promote Use of Patient-Reported Outcome Tools
- **(!!) IA_BMH_2:** Tobacco use
- **(+)(*)(!!) IA_CC_9:** Implementation of practices/processes for developing regular individual care plans

- **IA_EPA_2:** Use of telehealth services that expand practice access
- **(**) IA_MVP:** Practice-Wide Quality Improvement in the MIPS Value Pathways Program
- **IA_PM_16:** Implementation of medication management practice improvements
- **IA_PSPA_28:** Completion of an Accredited Safety or Quality Improvement Program

B.5 Complete Ophthalmologic Care MVP

Table B.5a represents the proposed MIPS core measures for the Complete Ophthalmologic Care MVP. The B.5b table, followed by a list of improvement activities, represents the measures and activities finalized within the Complete Ophthalmologic Care MVP (90 FR 50418 through 50421) with proposed modifications for the CY 2027 performance period/2029 MIPS payment year and future years. This MVP would be most applicable to clinicians who treat patients within the practices of ophthalmology and optometry, including NPPs such as nurse practitioners, clinical nurse specialists, and physician assistants. We reviewed the MIPS quality measure and improvement activities inventories and considered feedback received during the 2026 MVP maintenance period to determine which measures and activities to include in this MVP. We request public comment on the proposed modifications included in this MVP.

Quality Measures

For the reasons stated in the introduction of this appendix[514], we are proposing the following measures as MIPS core measures for the Complete Ophthalmologic Care MVP:

- **Q012:** Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation
- **Q141:** Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 20% OR Documentation of a Plan of Care
- **Q304:** Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery
- **Q385:** Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery
- **Q501:** Acute posterior vitreous detachment and acute vitreous hemorrhage appropriate examination and follow-up

Modifications are being considered for the following QCDR measure:

- **IRIS2:** Glaucoma – Intraocular Pressure Reduction: This QCDR measure is undergoing modifications to ensure compliance is based upon assessment of intraocular pressure for each eye effected.

For the reasons stated in the introduction of this appendix[515], we are proposing to remove **Q384:** Adult Primary Rhegmatogenous Retinal Detachment Surgery: No Return to the Operating Room Within 90 Days of Surgery. We are proposing to remove two high performing QCDR measures:

- **IRIS13:** Diabetic Macular Edema - Loss of Visual Acuity
- **IRIS54:** Complications After Cataract Surgery

Improvement Activities

We are proposing to add one improvement activity relevant to this MVP, which includes elements of an activity that is proposed for removal from MIPS:

- **IA_CC_8:** Implementation of documentation improvements for practice/process improvements.

For the reasons stated in the introduction of this appendix[516], we are proposing to remove **IA_CC_10:** Care transition documentation practice improvements.

Symbol Key:

---

[514] See MVP Development: Quality Measure and Improvement Activity Updates
[515] Ibid.
[516] See MVP Development: Quality Measure and Improvement Activity Updates

Exclamation point (!): MIPS core measure within an MVP.
Plus sign (+): measures and improvement activities proposed for addition to a previously finalized MVP.
Single asterisk (*): existing measures and improvement activities with proposed revisions.
Double asterisk (**): measures and improvement activities only available when included in an MVP.
Double exclamation point (!!): improvement activities with an advancing health and wellness component.

TABLE B.5a: Complete Ophthalmologic Care MVP MIPS Core Measures

Complete Ophthalmologic Care MVP MIPS Core Measures
Q012: Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation
Q141: Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 20% OR Documentation of a Plan of Care
Q304: Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery
Q385: Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery
Q501: Acute posterior vitreous detachment and acute vitreous hemorrhage appropriate examination and follow-up

TABLE B.5b: Complete Ophthalmologic Care MVP Clinical Groupings

Complete Ophthalmologic Care MVP		
Clinical Grouping	**Quality**	**Cost**
Cataract	**(*) Q191:** Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery (Collection Type: eCQM, MIPS CQM)	**COST_IOL_1** Cataract Removal with Intraocular Lens (IOL) Implantation
	Q303: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (Collection Type: MIPS CQM)	
	(!) Q304: Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery (Collection Type: MIPS CQM)	
	Q389: Cataract Surgery: Difference Between Planned and Final Refraction (Collection Type: MIPS CQM)	
	IRIS61: Visual Acuity Improvement Following Cataract Surgery and Minimally Invasive Glaucoma Surgery (Collection Type: QCDR)	
General Ophthalmology	**Q117:** Diabetes: Eye Exam (Collection Type: eCQM, MIPS CQM)	**COST_IOL_1** Cataract Removal with Intraocular Lens (IOL) Implantation
	(*) Q374: Closing the Referral Loop: Receipt of Specialist Report (Collection Type: eCQM, MIPS CQM)	
Retinal Disease	**Q019:** Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care (Collection Type: eCQM)	**N/A**
	(!) Q385: Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery (Collection Type: MIPS CQM)	

Complete Ophthalmologic Care MVP		
Clinical Grouping	**Quality**	**Cost**
	Q499: Appropriate Screening and Plan of Care for Elevated Intraocular Pressure Following Intravitreal or Periocular Steroid Therapy (Collection Type: MIPS CQM)	
	Q500: Acute Posterior Vitreous Detachment Appropriate Examination and Follow-up (Collection Type: MIPS CQM)	
	(!) Q501: Acute Posterior Vitreous Detachment and Acute Vitreous Hemorrhage Appropriate Examination and Follow-up (Collection Type: MIPS CQM)	
	IRIS58: Improved Visual Acuity after Vitrectomy for Complications of Diabetic Retinopathy within 120 Days (Collection Type: QCDR)	
Glaucoma	**(!) Q012:** Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation (Collection Type: eCQM)	**N/A**
	(!)(*) Q141: Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 20% OR Documentation of a Plan of Care (Collection Type: Medicare Part B Claims, MIPS CQM)	
	(*) IRIS2: Glaucoma – Intraocular Pressure Reduction (Collection Type: QCDR)	
	IRIS39: Intraocular Pressure Reduction Following Trabeculectomy or an Aqueous Shunt Procedure (Collection Type: QCDR)	
Advancing Health and Wellness	**(*) Q130:** Documentation of Current Medications in the Medical Record (Collection Type: eCQM, MIPS CQM)	**COST_IOL_1** Cataract Removal with Intraocular Lens (IOL) Implantation
	Q226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (Collection Type: Medicare Part B Claims, eCQM, MIPS CQM)	
Experience of Care	**Q503:** Gains in Patient Activation Measure (PAM®) Scores at 12 Months (Collection Type: MIPS CQM)	**COST_IOL_1** Cataract Removal with Intraocular Lens (IOL) Implantation

Complete Ophthalmologic Care Improvement Activities

- **(!!) IA_AHW_1:** Chronic Care and Preventative Care Management for Empaneled Patients
- **IA_BE_4:** Engagement of Patients through Implementation of New Patient Portal
- **IA_BE_6:** Regularly Assess Patient Experience of Care and Follow Up on Findings
- **IA_BE_25:** Drug Cost Transparency
- **(+)(*) IA_CC_8:** Implementation of documentation improvements for practice/process improvements
- **(*)(!!) IA_CC_9:** Implementation of practices/processes for developing regular individual care plans
- **IA_CC_13:** Practice improvements to align with OpenNotes principles
- **IA_EPA_7:** Enhance Engagement of Medicaid and Other Underserved Populations
- **(**) IA_MVP:** Practice-Wide Quality Improvement in MIPS Value Pathways
- **IA_PM_16:** Implementation of medication management practice improvements
- **IA_PSPA_7:** Use of QCDR data for ongoing practice assessment and improvements

B.6: Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes MVP

Table B.6a represents the proposed MIPS core measures for the Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes MVP. The B.6b table, followed by a list of

improvement activities, represents the measures and activities finalized within the Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes MVP (90 FR 50422 through 50424) with proposed modifications for the CY 2027 performance period/2029 MIPS payment year and future years. The Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes MVP focuses on the clinical theme of providing fundamental prevention and treatment of those patients at risk for or have had a stroke. This MVP would be most applicable to clinicians who treat patients within the practices of neurology, neurosurgical, and vascular surgery, including NPPs such as nurse practitioners, clinical nurse specialists, and physician assistants. We reviewed the MIPS quality measure and improvement activities inventories and considered feedback received during the 2026 MVP maintenance period to determine which measures and activities to include in this MVP. We request public comment on the proposed modifications included in this MVP.

Quality Measures

For the reasons stated in the introduction of this appendix[517], we are proposing the following measures as MIPS core measures for the Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes MVP:

- **Q047:** Advance Care Plan
- **Q236:** Controlling High Blood Pressure
- **Q441:** Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control).

For the reasons stated in the introduction of this appendix[518], we are proposing to remove **Q326:** Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy.

Symbol Key:

Exclamation point (!): MIPS core measures within MVP.
Single asterisk (*): existing measures and improvement activities with proposed revisions.
Double asterisk (**): measures and improvement activities only available when included in an MVP.
Double exclamation point (!!): improvement activities with an advancing health and wellness component.

TABLE B.6a: Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes MVP MIPS Core Measures

Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes MVP MIPS Core Measures
Q047: Advance Care Plan
Q236: Controlling High Blood Pressure
Q441: Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control)

[517] See MVP Development: Quality Measure and Improvement Activity Updates
[518] See MVP Development: Quality Measure and Improvement Activity Updates

TABLE B.6b: Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes MVP Clinical Groupings

Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes MVP		
Clinical Grouping	**Quality**	**Cost**
Stroke Prevention	**(!)(*) Q236:** Controlling High Blood Pressure (Collection Type: Medicare Part B Claims, eCQM, MIPS CQM)	**COST_IHCI_1:** Intracranial Hemorrhage or Cerebral Infarction
	Q344: Rate of Carotid Endarterectomy (CEA) or Carotid Artery Stenting (CAS) for Asymptomatic Patients, Without Major Complications (Discharged to Home by Post-Operative Day #2) (Collection Type: MIPS CQM)	
	(*) Q438: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (Collection Type: eCQM, MIPS CQM)	
	(!)(*) Q441: Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control) (Collection Type: MIPS CQM)	
Stroke Care	**Q187:** Stroke and Stroke Rehabilitation: Thrombolytic Therapy (Collection Type: MIPS CQM)	**COST_IHCI_1:** Intracranial Hemorrhage or Cerebral Infarction
	Q413: Door to Puncture Time for Endovascular Stroke Treatment (Collection Type: MIPS CQM)	
Experience of Care	**(!) Q047:** Advance Care Plan (Collection Type: Medicare Part B Claims, MIPS CQM)	**COST_IHCI_1:** Intracranial Hemorrhage or Cerebral Infarction
	Q495: Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood (Collection Type: MIPS CQM)	

Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes Improvement Activities

- **(!!) IA_AHW_1:** Chronic Care and Preventative Care Management for Empaneled Patients
- **IA_BE_1:** Use of certified EHR to capture patient reported outcomes
- **IA_BE_4:** Engagement of Patients through Implementation of New Patient Portal
- **IA_BE_6:** Regularly Assess Patient Experience of Care and Follow Up on Findings
- **IA_BE_24:** Financial Navigation Program
- **IA_BMH_l5:** Behavioral/Mental Health and Substance Use Screening and Referral for Older Adults
- **IA_CC_13:** Practice improvements to align with OpenNotes principles
- **IA_CC_17:** Patient Navigator Program
- **(**) IA_MVP:** Practice-Wide Quality Improvement in MIPS Value Pathways
- **IA_PM_l5:** Implementation of episodic care management practice improvements

B.7: Dermatological Care MVP

Table B.7a represents the proposed MIPS core measures for the Dermatological MVP. The B.7b table, followed by a list of improvement activities, represents the measures and activities finalized within the Dermatological MVP (90 FR 50424 through 50428) with proposed modifications for the CY 2027 performance period/2029 MIPS payment year and future years. The Dermatological Care MVP focuses on the clinical theme of providing treatment and management of dermatologic care. This MVP would be most applicable to clinicians who treat patients within the practice of dermatology, including NPPs such as nurse practitioners, clinical nurse specialists, and physician assistants. We reviewed the MIPS quality measure and improvement activities inventories and considered feedback received during the 2026 MVP maintenance period to determine which measures and activities to include in this MVP. We request public comment on the proposed modifications included in this MVP.

Quality Measures

For the reasons stated in the introduction of this appendix[519], we are proposing the following measures as MIPS core measures for the Dermatological Care MVP:

- **Q176:** Tuberculosis Screening Prior to First Course of Biologic and/or Immune Response Modifier Therapy
- **Q410:** Psoriasis: Clinical Response to Systemic Medications
- **Q486:** Dermatitis – Improvement in Patient-Reported Itch Severity

We are proposing to remove one high performing QCDR measure:

- **AAD16:** Avoidance of Post-operative Systemic Antibiotics for Office-based Closures and Reconstruction After Skin Cancer Procedures

Modifications are being considered for the following QCDR measures:

- **AAD6:** Skin Cancer: Biopsy Reporting Time - Clinician to Patient: This QCDR measure is undergoing modifications to update the description and numerator to reflect a shortened timeframe for clinician notification of final pathology findings, reducing the requirement from 8 days to 7 days.
- **AAD12:** Melanoma: - Appropriate Surgical Margins: This QCDR measure is undergoing modifications to update the title, description, denominator, and numerator to reflect a broader measure that would include additional skin cancers, specifically squamous cell carcinoma and basal cell carcinoma.

Improvement Activities

We are proposing to add one improvement activity that is relevant to this MVP and includes an advancing health and wellness component:

- **IA_CC_9:** Implementation of practices/processes for developing regular individual care plans

For the reasons stated in the introduction of this appendix[520], we are proposing to remove **IA_BE_15:** Engagement of Patients, Family, and Caregivers in Developing a Plan of Care.

Symbol Key:

Exclamation point (!): MIPS core measure within an MVP.
Plus sign (+): measures and improvement activities proposed for addition to a previously finalized MVP.
Single asterisk (*): existing measures and improvement activities with proposed revisions.
Double asterisk (**): measures and improvement activities only available when included in an MVP.
Double exclamation point (!!): improvement activities with an advancing health and wellness component.

TABLE B.7a: Dermatological Care MVP MIPS Core Measures

Dermatological Care MVP MIPS Core Measures
Q176: Tuberculosis Screening Prior to First Course of Biologic and/or Immune Response Modifier Therapy
Q410: Psoriasis: Clinical Response to Systemic Medications
Q486: Dermatitis – Improvement in Patient-Reported Itch Severity

TABLE B.7b: Dermatological Care MVP Clinical Groupings

Dermatological Care MVP

[519] See MVP Development: Quality Measure and Improvement Activity Updates
[520] Ibid.

Clinical Grouping	Quality	Cost
Skin Cancer	**(*) Q397:** Melanoma Reporting (Collection Type: Medicare Part B Claims, MIPS CQM)	**COST_MR_1:** Melanoma Resection
	(*) Q440: Skin Cancer: Biopsy Reporting Time – Pathologist to Clinician (Collection Type: MIPS CQM)	
	(*) Q509: Melanoma: Tracking and Evaluation of Recurrence (Collection Type: MIPS CQM)	
	(*) **AAD12:** Melanoma: - Appropriate Surgical Margins (Collection Type: QCDR)	
	(*) AAD6: Skin Cancer: Biopsy Reporting Time – Clinician to Patient (Collection Type: QCDR)	
Inflammatory Conditions	**(!)(*) Q176:** Tuberculosis Screening Prior to First Course of Biologic and/or Immune Response Modifier Therapy (Collection Type: MIPS CQM)	**N/A**
	Q226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (Collection Type: Medicare Part B Claims, eCQM, MIPS CQM)	**COST_MR_1:** Melanoma Resection
	(!) Q410: Psoriasis: Clinical Response to Systemic Medications (Collection Type: MIPS CQM)	**N/A**
	Q485: Psoriasis – Improvement in Patient-Reported Itch Severity (Collection Type: MIPS CQM)	
	(!) Q486: Dermatitis – Improvement in Patient-Reported Itch Severity (Collection Type: MIPS CQM)	
Experience of Care	**Q047:** Advance Care Plan (Collection Type: Medicare Part B Claims, MIPS CQM)	**COST_MR_1:** Melanoma Resection
	Q503: Gains in Patient Activation Measure (PAM®) Scores at 12 Months (Collection Type: MIPS CQM)	
	AAD8: Chronic Skin Conditions: Patient Reported Quality-of-Life (Collection Type: QCDR)	
Advancing Health and Wellness	**Q238:** Use of High-Risk Medications in Older Adults (Collection Type: eCQM, MIPS CQM)	**COST_MR_1:** Melanoma Resection

Dermatological Care Improvement Activities

- **IA_BE_4:** Engagement of Patients through Implementation of New Patient Portal
- **IA_BE_6:** Regularly Assess Patient Experience of Care and Follow Up on Findings
- **(+)(*)(!) IA_CC_9:** Implementation of practices/processes for developing regular individual care plans
- **IA_EPA_2:** Use of telehealth services that expand practice access
- **IA_EPA_7:** Enhance Engagement of Medicaid and Other Underserved Populations
- **(!!) IA_EPA_8:** Provide Education Opportunities for New Clinicians
- **(**) IA_MVP:** Practice-Wide Quality Improvement in MIPS Value Pathways
- **IA_PM_16:** Implementation of medication management practice improvements
- **IA_PSPA_8:** Use of Patient Safety Tools

B.8 Diagnostic Radiology MVP

Table B.8a represents the proposed MIPS core measures for the Diagnostic Radiology MVP. The B.8b table, followed by a list of improvement activities, represents the measures and activities finalized within the Diagnostic Radiology MVP (90 FR 50376 through 50381) with proposed modifications for the CY 2027 performance period/2029 MIPS payment year and future years. The Diagnostic Radiology MVP assesses meaningful outcomes in diagnostic radiology. This MVP would be most applicable to clinicians who treat patients within the practices of diagnostic

radiology and nuclear medicine. We reviewed the MIPS quality measure and improvement activities inventories and considered feedback received during the 2026 MVP maintenance period to determine which measures and activities to include in this MVP. We request public comment on the proposed modifications included in this MVP.

Quality Measures

For the reasons stated in the introduction of this appendix[521], we are proposing the following measures as MIPS core measures for the Diagnostic Radiology MVP:

- **Q145:** Radiology: Exposure Dose Indices Reported for Procedures Using Fluoroscopy
- **Q360:** Optimizing Patient Exposure to Ionizing Radiation: Count of Potential High Dose Radiation Imaging Studies: Computed Tomography (CT) and Cardiac Nuclear Medicine Studies
- **Q405:** Appropriate Follow-up Imaging for Incidental Abdominal Lesions

We are proposing to add four MIPS quality measures to the new Nuclear Medicine clinical grouping:

- **Q282:** Dementia: Functional Status Assessment: This MIPS quality measure focuses on the importance of ensuring that patients diagnosed with dementia receive a comprehensive functional assessment annually.
- **Q286:** Dementia: Safety Concern Screening and Follow-Up for Patients with Dementia: This MIPS quality measure aims to address safety concerns in patients diagnosed with dementia by ensuring that appropriate screening and follow-up actions are conducted.
- **Q288:** Dementia: Education and Support of Caregivers for Patients with Dementia: This MIPS quality measure focuses on the importance of providing education and support to caregivers of patients with Dementia.
- **Q386:** Amyotrophic Lateral Sclerosis (ALS) Patient Care Preferences: This MIPS quality measure focuses on the importance of addressing end-of-life care preferences for patients diagnosed with ALS.

We are proposing to add one QCDR measure:

- **ACRAD34:** Multi-strata weighted average for 3 CT Exam Types: Overall Percent of CT exams for which Dose Length Product is at or below the size-specific diagnostic reference level (for CT abdomen-pelvis with contrast/single-phase scan, CT chest without contrast/single-phase scan, and CT head/brain without contrast/single-phase scan): This QCDR measure ensures that all CT scans—abdomen-pelvis with contrast, chest without contrast, and head/brain single-phase—maintain a Dose Length Product at or below the established threshold to help manage patient radiation exposure.

Improvement Activities

For the reasons stated in the introduction of this appendix[522], we are proposing to remove **IA_CC_12:** Care coordination agreements that promote improvements in patient tracking across settings and **IA_PSPA_2:** Participation in MOC Part IV.

Symbol Key:

Exclamation point (!): MIPS core measure within an MVP.
Plus sign (+): measures and improvement activities proposed for addition to a previously finalized MVP.
Single asterisk (*): existing measures and improvement activities with proposed revisions.
Double asterisk (**): measures and improvement activities only available when included in an MVP.

---

[521] See MVP Development: Quality Measure and Improvement Activity Updates
[522] See MVP Development: Quality Measure and Improvement Activity Updates

Double exclamation point (!!): improvement activities with an advancing health and wellness component.

TABLE B.8a: Diagnostic Radiology MVP MIPS Core Measures

Diagnostic Radiology MVP MIPS Core Measures
Q145: Radiology: Exposure Dose Indices Reported for Procedures Using Fluoroscopy
Q360: Optimizing Patient Exposure to Ionizing Radiation: Count of Potential High Dose Radiation Imaging Studies: Computed Tomography (CT) and Cardiac Nuclear Medicine Studies
Q405: Appropriate Follow-up Imaging for Incidental Abdominal Lesions

TABLE B.8b: Diagnostic Radiology MVP Clinical Groupings

Diagnostic Radiology MVP		
Clinical Grouping	**Quality**	**Cost**
General Diagnostic Radiology	**(!) Q145:** Radiology: Exposure Dose Indices Reported for Procedures Using Fluoroscopy (Collection Type: MIPS CQM, Medicare Part B Claims)	**MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
	(!) Q360: Optimizing Patient Exposure to Ionizing Radiation: Count of Potential High Dose Radiation Imaging Studies: Computed Tomography (CT) and Cardiac Nuclear Medicine Studies (Collection Type: MIPS CQM)	
	Q494: Excessive Radiation Dose or Inadequate Image Quality for Diagnostic CT in Adults (Clinician Level) (Collection Type: eCQM)	
	(+) ACRAD34: Multi-strata weighted average for 3 CT Exam Types: Overall Percent of CT exams for which Dose Length Product is at or below the size-specific diagnostic reference level (for CT abdomen-pelvis with contrast/single-phase scan, CT chest without contrast/single-phase scan, and CT head/brain without contrast/single-phase scan) (Collection Type: QCDR)	
Body Imaging (Thoracic/Abdominal)	**Q364:** Optimizing Patient Exposure to Ionizing Radiation: Appropriateness: Follow-up CT Imaging for Incidentally Detected Pulmonary Nodules According to Recommended Guidelines (Collection Type: MIPS CQM)	**N/A**
	(!) Q405: Appropriate Follow-up Imaging for Incidental Abdominal Lesions (Collection Type: Medicare Part B Claims, MIPS CQM)	
	Q406: Appropriate Follow-up Imaging for Incidental Thyroid Nodules (Collection Type: Medicare Part B Claims, MIPS CQM)	
	QMM17: Appropriate Follow-up Recommendations for Ovarian-Adnexal Lesions using the Ovarian-Adnexal Reporting and Data System (O-RADS) (Collection Type: QCDR)	
Nuclear Medicine	**(+) Q282:** Dementia: Functional Status Assessment (Collection Type: MIPS CQM)	**N/A**
	(+) Q286: Dementia: Safety Concern Screening and Follow-Up for Patients with Dementia (Collection Type: MIPS CQM)	
	(+)(*) Q288: Dementia: Education and Support of Caregivers for Patients with Dementia (Collection Type: MIPS CQM)	

Diagnostic Radiology MVP		
Clinical Grouping	**Quality**	**Cost**
	(+) Q386: Amyotrophic Lateral Sclerosis (ALS) Patient Care Preferences (Collection Type: MIPS CQM)	
Advancing Health and Wellness	**QMM18:** Use of Breast Cancer Risk Score on Mammography (Collection Type: QCDR)	**MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
	QMM26: Screening Abdominal Aortic Aneurysm Reporting with Recommendations (Collection Type: QCDR)	

Diagnostic Radiology Improvement Activities

- **IA_BE_6**: Regularly Assess Patient Experience of Care and Follow Up on Findings
- **(!!) IA_BMH_12**: Promoting Clinician Well-Being
- **IA_CC_7**: Regular training in care coordination
- **(*) IA_CC_8**: Implementation of documentation improvements for practice/process improvements
- **IA_CC_19**: Tracking of clinician's relationship to and responsibility for a patient by reporting MACRA patient relationship codes
- **(**) IA_MVP**: Practice-Wide Quality Improvement in MIPS Value Pathways
- **IA_PSPA_1**: Participation in an AHRQ-listed patient safety organization
- **IA_PSPA_7**: Use of QCDR data for ongoing practice assessment and improvements
- **IA_PSPA_12**: Participation in private payer CPIA

B.9: Focusing on Women's Health MVP

Table B.9a represents the proposed MIPS core measures for the Focusing on Women's Health MVP. The B.9b table, followed by a list of improvement activities, represents the measures and activities finalized within the Women's Health MVP (90 FR 50428 through 50430) with modifications for the CY 2027 performance period/2029 MIPS payment year and future years. The Focusing on Women's Health MVP focuses on the clinical specialty of providing treatment and management of women's health. This MVP would be most applicable to clinicians who treat patients within the practices of gynecology, obstetrics, and urogynecology, including NPPs such as certified nurse-midwives, nurse practitioners, clinical nurse specialists, and physician assistants. We reviewed the MIPS quality measure and improvement activities inventories and considered feedback received during the 2026 MVP maintenance period to determine which measures and activities to include in this MVP. We request public comment on the proposed modifications included in this MVP.

Quality Measures

For the reasons stated in the introduction of this appendix[523], we are proposing the following measures as MIPS core measures for the Focusing on Women's Health MVP:

- **Q039:** Screening for Osteoporosis for Women Aged 65-85 Years of Age
- **Q112:** Breast Cancer Screening
- **Q432:** Proportion of Patients Sustaining a Bladder or Bowel Injury at the Time of any Pelvic Organ Prolapse Repair

Symbol Key:

Exclamation point (!): MIPS core measure within an MVP.
Single asterisk (*): existing measures and improvement activities with proposed revisions.
Double asterisk (**): measures and improvement activities only available when included in an MVP.

[523]See MVP Development: Quality Measure and Improvement Activity Updates

Double exclamation point (!!): improvement activities with an advancing health and wellness component.

TABLE B.9a: Focusing on Women's Health MVP MIPS Core Measures

Focusing on Women's Health MVP MIPS Core Measures
Q039: Screening for Osteoporosis for Women Aged 65-85 Years of Age
Q112: Breast Cancer Screening
Q432: Proportion of Patients Sustaining a Bladder or Bowel Injury at the Time of any Pelvic Organ Prolapse Repair

TABLE B.9b: Focusing on Women's Health MVP Clinical Groupings

Focusing on Women's Health MVP		
Clinical Grouping	**Quality**	**Cost**
Obstetrics	**Q335:** Maternity Care: Elective Delivery (Without Medical Indication) at < 39 Weeks (Overuse) (Collection Type: MIPS CQM)	**MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
	(*) Q336: Maternity Care: Postpartum Follow-up and Care Coordination (Collection Type: MIPS CQM)	**MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician **TPCC_1:** Total Per Capita Cost
	Q496: Cardiovascular Disease (CVD) Risk Assessment Measure - Proportion of Pregnant/Postpartum Patients that Receive CVD Risk Assessment with a Standardized Instrument (Collection Type: MIPS CQM)	**TPCC_1:** Total Per Capita Cost
Gynecology	**Q422:** Performing Cystoscopy at the Time of Hysterectomy for Pelvic Organ Prolapse to Detect Lower Urinary Tract Injury (Collection Type: Medicare Part B Claims, MIPS CQM)	**MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
	(!) Q432: Proportion of Patients Sustaining a Bladder or Bowel Injury at the Time of any Pelvic Organ Prolapse Repair (Collection Type: MIPS CQM)	
	Q448: Appropriate Workup Prior to Endometrial Ablation (Collection Type: MIPS CQM)	
Advancing Health and Wellness	**(!) Q039:** Screening for Osteoporosis for Women Aged 65-85 Years of Age (Collection Type: Medicare Part B Claims, MIPS CQM)	**MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician **TPCC_1:** Total Per Capita Cost
	Q048: Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older (Collection Type: MIPS CQM)	
	(!)(**) Q112: Breast Cancer Screening (Collection Type: Medicare Part B Claims, eCQM, MIPS CQM)	
	(*) Q134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan (Collection Type: Medicare Part B Claims, eCQM, MIPS CQM)	
	Q226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	

Focusing on Women's Health MVP		
Clinical Grouping	**Quality**	**Cost**
	(Collection Type: Medicare Part B Claims, eCQM, MIPS CQM)	
	Q309: Cervical Cancer Screening (Collection Type: eCQM)	
	Q310: Chlamydia Screening in Women (Collection Type: eCQM)	
	Q400: One-Time Screening for Hepatitis C Virus (HCV) and Treatment Initiation (Collection Type: MIPS CQM)	
	Q431: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (Collection Type: MIPS CQM)	
	(*) Q475: HIV Screening (Collection Type: eCQM)	
	Q493: Adult Immunization Status (Collection Type: MIPS CQM)	
	UREQA8: Vitamin D level: Effective Control of Low Bone Mass/Osteopenia and Osteoporosis: Therapeutic Level Of 25 OH Vitamin D Level Achieved (Collection Type: QCDR)	

Focusing on Women's Health Improvement Activities

- **IA_BE_4:** Engagement of Patients through Implementation of New Patient Portal
- **(!!) IA_BE_16:** Promote Self-management in Usual Care
- **(!!) IA_BE_26:** Promote Use of Patient-Reported Outcome Tools
- **IA_BMH_11:** Implementation of a Trauma-Informed Care (TIC) Approach to Clinical Practice
- **(!!) IA_BMH_14:** Behavioral/Mental Health and Substance Use Screening and Referral for Pregnant and Postpartum Women
- **(*)(!!) IA_CC_9:** Implementation of practices/processes for developing regular individual care plans
- **IA_EPA_2:** Use of telehealth services that expand practice access
- **IA_EPA_7:** Enhance Engagement of Medicaid and Other Underserved Populations
- **(**) IA_MVP:** Practice-Wide Quality Improvement in the MIPS Value Pathways Program
- **(!!) IA_PM_23:** Use of Computable Guidelines and Clinical Decision Support to Improve Adherence for Cervical Cancer Screening and Management Guidelines

B.10: Gastroenterology Care MVP

Table B.10a represents the proposed MIPS core measures for the Gastroenterology Care MVP. The B.10b table, followed by a list of improvement activities, represents the measures and activities finalized within the Gastroenterology Care MVP (90 FR 50430 through 50434) with modifications for the CY 2027 performance period/2029 MIPS payment year and future years. The Gastroenterology Care MVP focuses on the clinical theme of providing treatment and management of the digestive system and the liver. This MVP would be most applicable to clinicians who treat patients within the practice of gastroenterology, including NPPs such as nurse practitioners, clinical nurse specialists, and physician assistants. We reviewed the MIPS quality and cost measure and improvement activities inventories and considered feedback received during the 2026 MVP maintenance period to determine which measures and activities to include in this MVP. We request public comment on the proposed modifications included in this MVP.

Quality Measures

For the reasons stated in the introduction of this appendix[524], we are proposing the following

[524] See MVP Development: Quality Measure and Improvement Activity Updates

measures as MIPS core measures for the Gastroenterology Care MVP:

- **Q226:** Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- **Q275:** Inflammatory Bowel Disease (IBD): Assessment of Hepatitis B Virus (HBV) Status Before Initiating Anti-TNF (Tumor Necrosis Factor) Therapy
- **Q516:** Hepatitis C Virus (HCV): Sustained Virological Response (SVR)

For the reasons stated in the introduction of this appendix[525], we are proposing to remove **Q320:** Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients. We are proposing to remove one high performing QCDR measure:

- **NHCR4:** Repeat screening or surveillance colonoscopy recommended within one year due to inadequate bowel preparation.

Modifications are being considered for the following QCDR measures:

- **GIQIC23:** Appropriate follow-up interval based on pathology findings in screening colonoscopy: This QCDR measure is undergoing modifications to ensure patients are receiving appropriate follow up within the recommended timeframe.

Improvement Activities

We are proposing to add one improvement activity relevant to this MVP:

- **IA_CC_8:** Implementation of documentation improvements for practice/process improvements.

For the reasons stated in the introduction of this appendix[526], we are proposing to remove **IA_CC_10:** Care transition documentation practice improvements.

Symbol Key:

Exclamation point (!): MIPS core measure within an MVP.
Plus sign (+): measures and improvement activities proposed for addition to a previously finalized MVP.
Single asterisk (*): existing measures and improvement activities with proposed revisions.
Double asterisk (**): measures and improvement activities only available when included in an MVP.
Double exclamation point (!!): improvement activities with an advancing health and wellness component.

TABLE B.10a: Gastroenterology Care MVP MIPS Core Measures

Gastroenterology Care MVP MIPS Core Measures
Q226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
Q275: Inflammatory Bowel Disease (IBD): Assessment of Hepatitis B Virus (HBV) Status Before Initiating Anti-TNF (Tumor Necrosis Factor) Therapy
Q516: Hepatitis C Virus (HCV): Sustained Virological Response (SVR)

TABLE B.10b: Gastroenterology Care MVP Clinical Groupings

Gastroenterology Care MVP		
Clinical Grouping	**Quality**	**Cost**
Interventional/ Endoscopy	**GIQIC26:** Screening Colonoscopy Adenoma Detection Rate (Collection Type: QCDR)	**COST_SSC_1:** Screening/Surveillance Colonoscopy

[525] Ibid.
[526] Ibid.

Gastroenterology Care MVP		
Clinical Grouping	**Quality**	**Cost**
	N/A	**COST_LGH_1:** Lower Gastrointestinal Hemorrhage
Hepatobiliary	**Q400:** One-Time Screening for Hepatitis C Virus (HCV) and Treatment Initiation (Collection Type: MIPS CQM)	**TPCC_1:** Total Per Capita Cost
	Q401: Hepatitis C: Screening for Hepatocellular Carcinoma (HCC) in Patients with Cirrhosis (Collection Type: MIPS CQM)	
	(!) Q516: Hepatitis C Virus (HCV): Sustained Virological Response (SVR) (Collection Type: MIPS CQM)	
Inflammatory	**(!) Q275**: Inflammatory Bowel Disease (IBD): Assessment of Hepatitis B Virus (HBV) Status Before Initiating Anti-TNF (Tumor Necrosis Factor) Therapy (Collection Type: MIPS CQM)	**TPCC_1:** Total Per Capita Cost
General Gastroenterology	**(*) Q374:** Closing the Referral Loop: Receipt of Specialist Report (Collection Type: eCQM, MIPS CQM)	**COST_SSC_1:** Screening/Surveillance Colonoscopy **TPCC_1:** Total Per Capita Cost **COST_LGH_1:** Lower Gastrointestinal Hemorrhage
Advancing Health and Wellness	**(**) Q113:** Colorectal Cancer Screening (Collection Type: Medicare Part B Claims, eCQM, MIPS CQM)	**COST_SSC_1:** Screening/Surveillance Colonoscopy **TPCC_1:** Total Per Capita Cost **COST_LGH_1:** Lower Gastrointestinal Hemorrhage
	(*) Q130: Documentation of Current Medications in the Medical Record (Collection Type: eCQM, MIPS CQM)	
	(!) Q226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (Collection Type: Medicare Part B Claims, eCQM, MIPS CQM)	
	(*) GIQIC23: Appropriate follow-up interval based on pathology findings in screening colonoscopy (Collection Type: QCDR)	
Experience of Care	**Q503:** Gains in Patient Activation Measure (PAM®) Scores at 12 Months (Collection Type: MIPS CQM)	**COST_SSC_1:** Screening/Surveillance Colonoscopy **TPCC_1:** Total Per Capita Cost **COST_LGH_1:** Lower Gastrointestinal Hemorrhage

Gastroenterology Care Improvement Activities

- **IA_BE_4:** Engagement of Patients through Implementation of New Patient Portal
- **(!!) IA_BE_26:** Promote Use of Patient-Reported Outcome Tools
- **IA_CC_7:** Regular training in care coordination
- **(+)(*) IA_CC_8:** Implementation of documentation improvements for practice/process improvements
- **(*)(!!) IA_CC_9:** Implementation of practices/processes for developing regular individual care plans
- **IA_CC_13:** Practice improvements to align with OpenNotes principles
- **(!!) IA_EPA_8:** Provide Education Opportunities for New Clinicians

- **(**) IA_MVP:** Practice-Wide Quality Improvement in MIPS Value Pathways

B.11: Improving Care for Lower Extremity Joint Repair MVP

Table B.11a represents the proposed MIPS core measures for the Improving Care for Lower Extremity Joint Repair MVP. The B.11b table, followed by a list of improvement activities, represents the measures and activities finalized within the Improving Care for Lower Extremity Joint Repair MVP (90 FR 50434 through 50435) with modifications for the CY 2027 performance period/2029 MIPS payment year and future years. The Improving Care for Lower Extremity Joint Repair MVP focuses on the clinical theme of providing fundamental treatment and management of patients with osteoarthritis and lower extremity surgical repair, such as fracture and total joint replacement, to ensure appropriate care and reduce costs. This MVP would be most applicable to clinicians who treat patients within the practice of orthopedic surgery, including NPPs such as nurse practitioners, clinical nurse specialists, and physician assistants. We reviewed the MIPS quality measure and improvement activities inventories and considered feedback received during the 2026 MVP maintenance period to determine which measures and activities to include in this MVP. We request public comment on the proposed modifications included in this MVP.

Quality Measures

For the reasons stated in the introduction of this appendix[527], we are proposing the following measures as MIPS core measures for the Improving Care for Lower Extremity Joint Repair MVP:

- **Q351:** Total Knee or Hip Replacement: Venous Thromboembolic and Cardiovascular Risk Evaluation
- **Q470:** Functional Status After Primary Total Knee Replacement
- **Q480:** Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) for Merit-based Incentive Payment System (MIPS)

For the reasons stated in the introduction of this appendix[528], we are proposing to remove **Q350:** Total Knee or Hip Replacement: Shared Decision-Making: Trial of Conservative (Non-surgical) Therapy.

Symbol Key:

Exclamation point (!): MIPS core measure within an MVP.
Single asterisk (*): existing measures and improvement activities with proposed revisions.
Double asterisk (**): measures and improvement activities only available when included in an MVP.
Double exclamation point (!!): improvement activities with an advancing health and wellness component.

TABLE B.11a: Improving Care for Lower Extremity Joint Repair MVP MIPS Core Measures

Improving Care for Lower Extremity Joint Repair MVP MIPS Core Measures
Q351: Total Knee or Hip Replacement: Venous Thromboembolic and Cardiovascular Risk Evaluation
Q470: Functional Status After Primary Total Knee Replacement
Q480: Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) for Merit-based Incentive Payment System (MIPS)

[527] See MVP Development: Quality Measure and Improvement Activity Updates
[528] See MVP Development: Quality Measure and Improvement Activity Updates

TABLE B.11b: Improving Care for Lower Extremity Joint Repair MVP Clinical Groupings

Improving Care for Lower Extremity Joint Repair MVP		
Clinical Grouping	**Quality**	**Cost**
Non-Surgical	**Q024:** Communication with the Physician or Other Clinician Managing On-Going Care Post-Fracture for Men and Women Aged 50 Years and Older (Collection Type: Medicare Part B Claims, MIPS CQM)	**N/A**
Surgical	**(!) Q351:** Total Knee or Hip Replacement: Venous Thromboembolic and Cardiovascular Risk Evaluation (Collection Type: MIPS CQM)	**COST_PHA_1:** Elective Primary Hip Arthroplasty **COST_KA_1:** Knee Arthroplasty
	Q376: Functional Status Assessments for Total Hip Replacement (Collection Type: eCQM)	**COST_PHA_1:** Elective Primary Hip Arthroplasty
	(!) Q470: Functional Status After Primary Total Knee Replacement (Collection Type: MIPS CQM)	**COST_KA_1:** Knee Arthroplasty
	(!) Q480: Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) for Merit-based Incentive Payment System (MIPS) (Collection Type: Administrative Claims)	**COST_PHA_1:** Elective Primary Hip Arthroplasty **COST_KA_1:** Knee Arthroplasty
Advancing Health and Wellness	**(**) Q128:** Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (Collection Type: Medicare Part B Claims, eCQM, MIPS CQM)	**COST_PHA_1:** Elective Primary Hip Arthroplasty **COST_KA_1:** Knee Arthroplasty

Improving Care for Lower Extremity Joint Repair Improvement Activities

- **IA_BE_6:** Regularly Assess Patient Experience of Care and Follow Up on Findings
- **IA_BE_12:** Use evidence-based decision aids to support shared decision-making
- **(!!) IA_BE_26:** Promote Use of Patient-Reported Outcome Tools
- **IA_CC_7:** Regular training in care coordination
- **(*)(!!) IA_CC_9:** Implementation of practices/processes for developing regular individual care plans
- **IA_CC_13:** Practice Improvements to Align with OpenNotes Principles
- **IA_CC_15:** PSH Care Coordination
- **(**) IA_MVP:** Practice-Wide Quality Improvement in MIPS Value Pathways
- **IA_PSPA_7:** Use of QCDR data for ongoing practice assessment and improvements
- **IA_PSPA_18:** Measurement and improvement at the practice and panel level

B.12 Interventional Radiology MVP

Table B.12a represents the proposed MIPS core measures for the Interventional Radiology MVP. The B.12b table, followed by a list of improvement activities, represents the measures and activities finalized within the Interventional Radiology MVP (90 FR 50381 through 50386) with proposed modifications for the CY 2027 performance period/2029 MIPS payment year and future years. The Interventional Radiology MVP assesses meaningful outcomes in interventional radiology. This MVP would be most applicable to clinicians who treat patients within the practice of interventional radiology, including NPPs such as nurse practitioners, clinical nurse specialists, and physician assistants. We reviewed the MIPS quality measure and improvement activities inventories and considered feedback received during the 2026 MVP maintenance period to determine which measures and activities to include in this MVP. We request public comment on the proposed modifications included in this MVP.

Quality Measures

For the reasons stated in the introduction of this appendix[529], we are proposing the following measures as MIPS core measures for the Interventional Radiology MVP:

- **Q145:** Radiology: Exposure Dose Indices Reported for Procedures Using Fluoroscopy
- **Q413:** Door to Puncture Time for Endovascular Stroke Treatment
- **Q420:** Varicose Vein Treatment with Saphenous Ablation: Outcome Survey

Improvement Activities

We are proposing to remove one improvement activity as the activity is more relevant to general surgery and surgical subspecialties:

- **IA_CC_15:** PSH Care Coordination

Symbol Key:

Exclamation point (!): MIPS core measure within an MVP.
Single asterisk (*): existing measures and improvement activities with proposed revisions.
Double asterisk (**): measures and improvement activities only available when included in an MVP.
Double exclamation point (!!): improvement activities with an advancing health and wellness component.

TABLE B.12a: Interventional Radiology MVP MIPS Core Measures

Interventional Radiology MVP MIPS Core Measures
Q145: Radiology: Exposure Dose Indices Reported for Procedures Using Fluoroscopy
Q413: Door to Puncture Time for Endovascular Stroke Treatment
Q420: Varicose Vein Treatment with Saphenous Ablation: Outcome Survey

[529] See MVP Development: Quality Measure and Improvement Activity Updates

TABLE B.12b: Interventional Radiology MVP Clinical Groupings

Interventional Radiology MVP		
Clinical Grouping	**Quality**	**Cost**
Vascular	**(!) Q420:** Varicose Vein Treatment with Saphenous Ablation: Outcome Survey (Collection Type: MIPS CQM)	**MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
	Q421: Appropriate Assessment of Retrievable Inferior Vena Cava (IVC) Filters for Removal (Collection Type: MIPS CQM)	
	Q465: Uterine Artery Embolization Technique: Documentation of Angiographic Endpoints and Interrogation of Ovarian Arteries (Collection Type: MIPS CQM)	
Dialysis-Related	**RCOIR12:** Tunneled Hemodialysis Catheter Clinical Success Rate (Collection Type: QCDR)	**MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician **COST_HAC_1:** Hemodialysis Access Creation
	RCOIR13: Percutaneous Arteriovenous Fistula for Dialysis - Clinical Success Rate (Collection Type: QCDR)	
	RPAQIR14: Arteriovenous Graft Thrombectomy Clinical Success Rate (Collection Type: QCDR)	
	RPAQIR15: Arteriovenous Fistulae Thrombectomy Clinical Success Rate (Collection Type: QCDR)	
Neurological Intervention	**(!) Q413:** Door to Puncture Time for Endovascular Stroke Treatment (Collection Type: MIPS CQM)	**MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician **COST_IHCI_1:** Intracranial Hemorrhage or Cerebral Infarction
General Interventional Radiology	**(!) Q145:** Radiology: Exposure Dose Indices Reported for Procedures Using Fluoroscopy (Collection Type: Medicare Part B Claims, MIPS CQM)	**MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician **COST_HAC_1:** Hemodialysis Access Creation
	(*) Q374: Closing the Referral Loop: Receipt of Specialist Report (Collection Type: eCQM, MIPS CQM)	

Interventional Radiology Improvement Activities

- **IA_BE_1:** Use of certified EHR to capture patient reported outcomes
- **IA_BE_4:** Engagement of Patients through Implementation of New Patient Portal
- **IA_BE_12:** Use evidence-based decision aids to support shared decision-making
- **(!!) IA_BE_26:** Promote Use of Patient-Reported Outcome Tools
- **(!!) IA_BMH_12:** Promoting Clinician Well-Being
- **IA_CC_7:** Regular training in care coordination
- **(*) IA_CC_8:** Implementation of documentation improvements for practice/process improvements
- **(*)(!!) IA_CC_9:** Implementation of practices/processes for developing regular individual care plans
- **IA_CC_17:** Patient Navigator Program
- **IA_CC_19:** Tracking of clinician's relationship to and responsibility for a patient by reporting MACRA patient relationship codes
- **IA_EPA_2:** Use of telehealth services that expand practice access
- **IA_EPA_3:** Collection and use of patient experience and satisfaction data on access
- **(!!) IA_EPA_8:** Provide Education Opportunities for New Clinicians
- **(**) IA_MVP**: Practice-Wide Quality Improvement in MIPS Value Pathways
- **IA_PM_17:** Participation in Population Health Research
- **IA_PSPA_1:** Participation in an AHRQ-listed patient safety organization.
- **IA_PSPA_18:** Measurement and improvement at the practice and panel level
- **IA_PSPA_25:** Cost Display for Laboratory and Radiographic Orders

B.13 Neuropsychology MVP

Table B.13a represents the proposed MIPS core measures for the Neuropsychology MVP. The B.13b table, followed by a list of improvement activities, represents the measures and activities finalized within the Neuropsychology MVP (90 FR 50386 through 50390) with modifications for the CY 2027 performance period/2029 MIPS payment year and future years. The Neuropsychology MVP focuses on the clinical specialty of providing treatment and management of neuropsychological care. This MVP would be most applicable to clinicians who treat patients within the practice of neuropsychology, including NPPs such as nurse practitioners, clinical nurse specialists, and physician assistants. We reviewed the MIPS quality measure and improvement activities inventories and considered feedback received during the 2026 MVP maintenance period to determine which measures and activities to include in this MVP. We request public comment on the proposed modifications included in this MVP.

Quality Measures

For the reasons stated in the introduction of this appendix[530], we are proposing the following measures as MIPS core measures for the Neuropsychology MVP:

- **Q134:** Preventive Care and Screening: Screening for Depression and Follow-Up Plan
- **Q181:** Elder Maltreatment Screen and Follow-up Plan
- **Q282:** Dementia: Functional Status Assessment

Improvement Activities

For the reasons stated in the introduction of this appendix[531], we are proposing to remove **IA_BE_15:** Engagement of Patients, Family and Caregivers in Developing a Plan of Care.

Symbol Key:

Exclamation point (!): MIPS core measure within an MVP.
Single asterisk (*): existing measures and improvement activities with proposed revisions.
Double asterisk (**): measures and improvement activities only available when included in an MVP.
Double exclamation point (!!): improvement activities with an advancing health and wellness component.

TABLE B.13a: Neuropsychology MVP MIPS Core Measures

Neuropsychology MVP MIPS Core Measures
Q134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan
Q181: Elder Maltreatment Screen and Follow-up Plan
Q282: Dementia: Functional Status Assessment

TABLE B.13b: Neuropsychology MVP Clinical Groupings

Neuropsychology MVP		
Clinical Grouping	**Quality**	**Cost**
Neurodegenerative Disorders	**(!) Q282:** Dementia: Functional Status Assessment (Collection Type: MIPS CQM)	

[530] See MVP Development: Quality Measure and Improvement Activity Updates
[531] Ibid.

Neuropsychology MVP		
Clinical Grouping	**Quality**	**Cost**
	Q286: Dementia: Safety Concern Screening and Follow-Up for Patients with Dementia (Collection Type: MIPS CQM)	**MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician **TPCC_1:** Total Per Capita Cost
	(*) Q288: Dementia: Education and Support of Caregivers for Patients with Dementia (Collection Type: MIPS CQM)	
Advancing Health and Wellness	**(*) Q130:** Documentation of Current Medications in the Medical Record (Collection Type: eCQM, MIPS CQM)	**MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician **TPCC_1:** Total Per Capita Cost
	(!)(*) Q134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan (Collection Type: Medicare Part B Claims, eCQM, MIPS CQM)	
	(!) Q181: Elder Maltreatment Screen and Follow-up Plan (Collection Type: Medicare Part B Claims, MIPS CQM	

Neuropsychology Improvement Activities

- **IA_BE_4:** Engagement of Patients through Implementation of New Patient Portal
- **(!!) IA_BE_14:** Engage Patients and Families to Guide Improvement in the System of Care
- **(!!) IA_BE_16:** Promote Self-management in Usual Care
- **IA_BE_22:** Improved Practices that Engage Patients Pre-Visit
- **IA_BMH_7:** Implementation of Integrated Patient Centered Behavioral Health Model
- **(*)(!!) IA_CC_9:** Implementation of practices/processes for developing regular individual care plans
- **(*) IA_EPA_7:** Enhance Engagement of Medicaid and Other Underserved Populations
- **(**) IA_MVP:** Practice-Wide Quality Improvement in MIPS Value Pathways
- **IA_PM_21:** Advance Care Planning

B.14: Optimal Care for Kidney Health MVP

Table B.14a represents the proposed MIPS core measures for the Optimal Care for Kidney Health MVP. The B.14b table, followed by a list of improvement activities, represents the measures and activities finalized within the Optimal Care for Kidney Health MVP (90 FR 50435 through 50438) with modifications for the CY 2027 performance period/2029 MIPS payment year and future years. The Optimal Care for Kidney Health MVP focuses on the clinical specialty of providing fundamental treatment and management of costly clinical conditions that contribute to, or may result from, kidney disease. This MVP would be most applicable to clinicians who treat patients within the practice of nephrology, including NPPs such as nurse practitioners, clinical nurse specialists, and physician assistants. We reviewed the MIPS quality measure and improvement activities inventories and considered feedback received during the 2026 MVP maintenance period to determine which measures and activities to include in this MVP. We request public comment on the proposed modifications included in this MVP.

Quality Measures

For the reasons stated in the introduction of this appendix[532], we are proposing the following measures as MIPS core measures for the Optimal Care for Kidney Health MVP:

- **Q236:** Controlling High Blood Pressure
- **Q482:** Hemodialysis Vascular Access: Practitioner Level Long-term Catheter Rate
- **Q489:** Adult Kidney Disease: Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy

Improvement Activities

[532] See MVP Development: Quality Measure and Improvement Activity Updates

We are proposing to add one improvement activity that is relevant to this MVP and includes an advancing health and wellness component:

- **IA_CC_9:** Implementation of practices/processes for developing regular individual care plans

For the reasons stated in the introduction of this appendix[533], we are proposing to remove **IA_BE_15:** Engagement of Patients, Family, and Caregivers in Developing a Plan of Care.

Symbol Key:
Exclamation point (!): MIPS core measure within an MVP.
Plus sign (+): measures and improvement activities proposed for addition to a previously finalized MVP.
Single asterisk (*): existing measures and improvement activities with proposed revisions.
Double asterisk (**): measures and improvement activities only available when included in an MVP.
Double exclamation point (!!): improvement activities with an advancing health and wellness component.

TABLE B.14a: Optimal Care for Kidney Health MVP MIPS Core Measures

Optimal Care for Kidney Health MVP MIPS Core Measures
Q236: Controlling High Blood Pressure
Q482: Hemodialysis Vascular Access: Practitioner Level Long-term Catheter Rate
Q489: Adult Kidney Disease: Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy

TABLE B.14b: Optimal Care for Kidney Health MVP Clinical Groupings

Optimal Care for Kidney Health MVP		
Clinical Grouping	**Quality**	**Cost**
General Nephrology	**(*) Q001:** Diabetes: Glycemic Status Assessment Greater Than 9% (Collection Type: Medicare Part B Claims, eCQM, MIPS CQM)	**COST_AKID_1:** Acute Kidney Injury Requiring New Inpatient Dialysis **COST_CKD_1:** Chronic Kidney Disease (CKD) **COST_ESRD_1:** End-Stage Renal Disease **COST_KTM_1:** Kidney Transplant Management **TPCC_1:** Total Per Capita Cost
	(!)(*) Q236: Controlling High Blood Pressure (Collection Type: Medicare Part B Claims, eCQM, MIPS CQM)	
	Q488: Kidney Health Evaluation (Collection Type: eCQM, MIPS CQM)	**TPCC_1:** Total Per Capita Cost
	(!) Q489: Adult Kidney Disease: Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy (Collection Type: MIPS CQM)	**COST_CKD_1:** Chronic Kidney Disease (CKD) **COST_ESRD_1:**

[533] Ibid.

Optimal Care for Kidney Health MVP		
Clinical Grouping	**Quality**	**Cost**
		End-Stage Renal Disease **TPCC_1:** Total Per Capita Cost
Dialysis/Transplant	**(!) Q482:** Hemodialysis Vascular Access: Practitioner Level Long-term Catheter Rate (Collection Type: MIPS CQM)	**COST_CKD_1:** Chronic Kidney Disease (CKD) **COST_ESRD_1:** End-Stage Renal Disease **TPCC_1:** Total Per Capita Cost
	Q510: First Year Standardized Waitlist Ratio (FYSWR) (Collection Type: MIPS CQM)	**COST_ESRD_1:** End-Stage Renal Disease **TPCC_1:** Total Per Capita Cost
	Q511: Percentage of Prevalent Patients Waitlisted for Kidney Transplant (PPPW) and Percentage of Prevalent Patients Waitlisted for Kidney Transplant in Active Status (aPPPW) (Collection Type: MIPS CQM)	
	Q512: Prevalent Standardized Kidney Transplant Waitlist Ratio (PSWR) (Collection Type: MIPS CQM)	
Advancing Health and Wellness	**(*) Q130:** Documentation of Current Medications in the Medical Record (Collection Type: eCQM, MIPS CQM)	**COST_AKID_1:** Acute Kidney Injury Requiring New Inpatient Dialysis **COST_CKD_1:** Chronic Kidney Disease (CKD) **COST_ESRD_1:** End-Stage Renal Disease **COST_KTM_1:** Kidney Transplant Management **TPCC_1:** Total Per Capita Cost
	Q493: Adult Immunization Status (Collection Type: MIPS CQM)	
Experience of care	**Q047:** Advance Care Plan (Collection Type: Medicare Part B Claims, MIPS CQM)	**COST_AKID_1:** Acute Kidney Injury Requiring New Inpatient Dialysis **COST_CKD_1:** Chronic Kidney Disease (CKD) **COST_ESRD_1:** End-Stage Renal Disease **COST_KTM_1:** Kidney Transplant Management **TPCC_1:** Total Per Capita Cost
	Q495: Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood (Collection Type: MIPS CQM)	
	Q503: Gains in Patient Activation Measure (PAM®) Scores at 12 Months (Collection Type: MIPS CQM)	

Optimal Care for Kidney Health Improvement Activities

- **(!!) IA_AHW_1:** Chronic Care and Preventative Care Management for Empaneled Patients

- **IA_BE_4:** Engagement of Patients through Implementation of New Patient Portal
- **IA_BE_6:** Regularly Assess Patient Experience of Care and Follow Up on Findings
- **IA_BE_14:** Engage Patients and Families to Guide Improvement in the System of Care
- **(!!) IA_BE_16**: Promote Self-management in Usual Care
- **(!!) IA_BE_26:** Promote Use of Patient-Reported Outcome Tools
- **(+)(*)(!!) IA_CC_9:** Implementation of practices/processes for developing regular individual care plans
- **IA_CC_13**: Practice Improvements to Align with OpenNotes Principles
- **(**) IA_MVP:** Practice-Wide Quality Improvement in MIPS Value Pathways
- **IA_PM_11:** Regular Review Practices in Place on Targeted Patient Population Needs
- **IA_PM_16:** Implementation of medication management practice improvements
- **(*) IA_PSPA_16:** Use of decision support —ideally platform-agnostic, interoperable clinical decision support (CDS) tools —and standardized treatment protocols to manage workflow on the care team to meet patient needs

B.15: Optimal Care for Patients with Urologic Conditions MVP

Table B.15a represents the proposed MIPS core measures for the Optimal Care for Patients with Urologic Conditions MVP. The B.15b table, followed by a list of improvement activities, represents the measures and activities finalized within the Optimal Care for Patients with Urologic Conditions MVP (90 FR 50438 through 50441) with modifications for the CY 2027 performance period/2029 MIPS payment year and future years. The Optimal Care for Patients with Urologic Conditions MVP focuses on assessing optimal care for patients treated for a broad range of urologic conditions, including kidney stones, urinary incontinence, bladder cancer, and prostate cancer. This MVP would be most applicable to clinicians who treat patients within the practices of urology, general urologists, urology oncologists, and urogynecology, including NPPs such as nurse practitioners, clinical nurse specialists, and physician assistants. We reviewed the MIPS quality measure and improvement activities inventories and considered feedback received during the 2026 MVP maintenance period to determine which measures and activities to include in this MVP. We request public comment on the proposed modifications included in this MVP.

Quality Measures

For the reasons stated in the introduction of this appendix[534], we are proposing the following measures as MIPS core measures for the Optimal Care for Patients with Urologic Conditions MVP:

- **Q050:** Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older
- **Q358:** Patient-Centered Surgical Risk Assessment and Communication
- **Q462:** Bone Density Evaluation for Patients with Prostate Cancer and Receiving Androgen Deprivation Therapy

We are proposing to remove two high performance QCDR measures, one process QCDR measure, and one QCDR measure due to low adoption, no benchmark after 2 consecutive years in MIPS:

- **AQUA8:** Hospital Admissions or Infectious Complications Within 30 days of Prostate Biopsy (high performing)
- **AQUA14:** Stones: Repeat Shock Wave Lithotripsy (SWL) Within 6 Months of Initial Treatment (high performing)
- **AQUA15:** Stones: Urinalysis or Urine Culture Performed Before Surgical Stone Procedures (process measure)
- **AQUA16:** Non-Muscle Invasive Bladder Cancer: Repeat Transurethral Resection of Bladder Tumor (TURBT) for T1 Disease (low adoption, no benchmark after 2 consecutive years in MIPS)

Modifications are being considered for the following QCDR measures:

[534] See MVP Development: Quality Measure and Improvement Activity Updates

- **AQUA14:** Stones: Repeat Shock Wave Lithotripsy (SWL) Within 6 Months of Initial Treatment: If the measure is not finalized for removal in the CY 2027 PFS final rule, this QCDR measure would undergo modifications to the title, description, and numerator to align with the American Urological Association (AUA) updated clinical guidelines, which recommend a second SWL or ureteroscopy (URS) when the initial SWL does not achieve complete clearance.
- **AQUA15:** Stones: Urinalysis or Urine Culture Performed Before Surgical Stone Procedures: If the measure is not finalized for removal in the CY 2027 PFS final rule, this QCDR measure would undergo modifications to add a quality action to the numerator to ensure abnormal results are appropriately addressed.
- **MUSIC4:** Prostate Cancer: Active Surveillance/Watchful Waiting for Newly Diagnosed Low Risk Prostate Cancer Patients: This QCDR measure is undergoing modifications to ensure patients newly diagnosed with low-risk prostate cancer on active surveillance undergo a confirmation biopsy within 24 months of their diagnosis.

Improvement Activities

We are proposing to add two improvement activities relevant to this MVP, both of which include an advancing health and wellness component:

- **IA_BE_16:** Promote Self-management in Usual Care
- **IA_CC_9:** Implementation of practices/processes for developing regular individual care plans

For the reasons stated in the introduction of this appendix[535], we are proposing to remove **IA_BE_15:** Engagement of Patients, Family, and Caregivers in Developing a Plan of Care.

Symbol Key:

Exclamation point (!): MIPS core measure within an MVP.
Single asterisk (*): existing measures and improvement activities with proposed revisions.
Double asterisk (**): measures and improvement activities only available when included in an MVP.
Double exclamation point (!!): improvement activities with an advancing health and wellness component.

TABLE B.15a: Optimal Care for Patients with Urologic Conditions MVP MIPS Core Measures

Optimal Care for Patients with Urologic Conditions MVP MIPS Core Measures
Q050: Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older
Q358: Patient-Centered Surgical Risk Assessment and Communication
Q462: Bone Density Evaluation for Patients with Prostate Cancer and Receiving Androgen Deprivation Therapy

[535] See MVP Development: Quality Measure and Improvement Activity Updates

TABLE B.15b: Optimal Care for Patients with Urologic Conditions MVP Clinical Groupings

Optimal Care for Patients with Urologic Conditions MVP		
Clinical Grouping	**Quality**	**Cost**
Urological Cancer	**(!) Q462:** Bone Density Evaluation for Patients with Prostate Cancer and Receiving Androgen Deprivation Therapy (Collection Type: eCQM)	**COST_PC_1:** Prostate Cancer **MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
	(*) Q476: Urinary Symptom Score Change 6-12 Months After Diagnosis of Benign Prostatic Hyperplasia (Collection Type: eCQM)	
	(*) Q481: Intravesical Bacillus-Calmette Guerin for Non-muscle Invasive Bladder Cancer (Collection Type: eCQM)	**MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
	(*) MUSIC4: Prostate Cancer: Active Surveillance/Watchful Waiting for Newly Diagnosed Low Risk Prostate Cancer Patients (Collection Type: QCDR)	**COST_PC_1:** Prostate Cancer **MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
General Urology	**(!) Q050:** Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older (Collection Type: MIPS CQM)	**COST_RUSST_1:** Renal or Ureteral Stone Surgical Treatment **MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
Advancing Health and Wellness	**Q318:** Falls: Screening for Future Fall Risk (Collection Type: eCQM)	**COST_PC_1:** Prostate Cancer **COST_RUSST_1:** Renal or Ureteral Stone Surgical Treatment **MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
Experience of Care	**Q321:** CAHPS for MIPS Clinician/Group Survey (Collection Type: CMS-approved Survey Vendor)	**COST_PC_1:** Prostate Cancer **COST_RUSST_1:** Renal or Ureteral Stone Surgical Treatment **MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
	(!) Q358: Patient-Centered Surgical Risk Assessment and Communication (Collection Type: MIPS CQM)	
	Q503: Gains in Patient Activation Measure (PAM®) Scores at 12 Months (Collection Type: MIPS CQM)	

Optimal Care for Patients with Urologic Conditions Improvement Activities

- **IA_BE_6:** Regularly Assess Patient Experience of Care and Follow Up on Findings
- **(+)(!!) IA_BE_16:** Promote Self-management in Usual Care
- **(!!) IA_BE_26:** Promote Use of Patient-Reported Outcome Tools
- **IA_CC_7**: Regular training in care coordination
- **(+)(*)(!!) IA_CC_9:** Implementation of practices/processes for developing regular individual care plans
- **IA_CC_13:** Practice improvements to align with OpenNotes principles
- **IA_CC_17:** Patient Navigator Program
- **IA_EPA_2:** Use of telehealth services that expand practice access
- **(**) IA_MVP:** Practice-Wide Quality Improvement in MIPS Value Pathways
- **IA_PM_17:** Participation in Population Health Research
- **IA_PM_21:** Advance Care Planning
- **IA_PSPA_7:** Use of QCDR data for ongoing practice assessment and improvements
- **IA_PSPA_12:** Participation in private payer CPIA
- **IA_PSPA_21:** Implementation of fall screening and assessment programs

B.16 Pathology MVP

Table B.16a represents the proposed MIPS core measures for the Pathology MVP. The B.16b table, followed by a list of improvement activities, represents the measures and activities finalized within the Pathology MVP (90 FR 50390 through 50395) with modifications for the CY 2027 performance period/2029 MIPS payment year and future years. The Pathology MVP focuses on assessing meaningful outcomes in pathology. This MVP would be most applicable to pathology clinicians. We reviewed the MIPS quality measure and improvement activities inventories and considered feedback received during the 2026 MVP maintenance period to determine which measures and activities to include in this MVP. We request public comment on the proposed modifications included in this MVP.

Quality Measures

For the reasons stated in the introduction of this appendix[536], we are proposing the following measures as MIPS core measures for the Pathology MVP:

- **Q396:** Lung Cancer Reporting (Resection Specimens)
- **Q440:** Skin Cancer: Biopsy Reporting Time – Pathologist to Clinician
- **Q491:** Mismatch Repair (MMR) or Microsatellite Instability (MSI) Biomarker Testing Status

We are proposing to add one QCDR measure that is relevant to this MVP:

- **QMM33:** Immunohistochemistry (IHC) and/or Molecular BRAF Testing Status in Metastatic Melanoma: This QCDR measure ensures that pathologists include a recommendation for BRAF testing, documentation of current or prior BRAF test results, or confirmation that BRAF testing is pending in all final immunohistochemical staining reports for patients with an initial diagnosis of metastatic melanoma.

We are proposing to remove one QCDR measure due to low adoption, no benchmark after 2 consecutive years in MIPS:

- **QMM25:** Use of Structured Reporting for Urine Cytology Specimens

Modifications are being considered for the following QCDR measures:

- **CAP30:** Urinary Bladder Cancer: Complete Analysis and Timely Reporting: This QCDR measure is undergoing modifications to the title and description to clarify the quality action in relation to patient outcomes and the overarching goal of supporting informed treatment decisions.

Improvement Activities

We are proposing to add four additional improvement activities relevant to this MVP, all of which include an advancing health and wellness component:

- **IA_CC_8:** Implementation of documentation improvements for practice/process improvements
- **IA_CC_XX:** Use of Data to Improve Practice Workflows
- **IA_CC_XX:** Understand and Improve Diagnostic Performance
- **IA_ EPA_8:** Provide Education Opportunities for New Clinicians

For the reasons stated in the introduction of this appendix[537], we are proposing to remove **IA_BE_15:** Engagement of Patients, Family, and Caregivers in Developing a Plan of Care, **IA_CC_12:** Care coordination agreements that promote improvements in patient tracking across settings and **IA_PSPA_2:** Participation in MOC Part IV.

---

[536] See MVP Development: Quality Measure and Improvement Activity Updates

[537] See MVP Development: Quality Measure and Improvement Activity Updates

Symbol Key:
Exclamation point (!): MIPS core measure within an MVP.
Caret symbol (^): proposed new measure or improvement activity.
Plus sign (+): measures and improvement activities proposed for addition to a previously finalized MVP.
Single asterisk (*): existing measures and improvement activities with proposed revisions.
Double asterisk (**): measures and improvement activities only available when included in an MVP.
Double exclamation point (!!): improvement activities with an advancing health and wellness component.

TABLE B.16a: Pathology MVP MIPS Core Measures

Pathology MVP MIPS Core Measures
Q396: Lung Cancer Reporting (Resection Specimens)
Q440: Skin Cancer: Biopsy Reporting Time – Pathologist to Clinician
Q491: Mismatch Repair (MMR) or Microsatellite Instability (MSI) Biomarker Testing Status

TABLE B.16b: Pathology MVP Clinical Groupings

Pathology MVP		
Clinical Grouping	**Quality**	**Cost**
Pathology	**Q249:** Barrett's Esophagus (Collection Type: Medicare Part B Claims, MIPS CQM)	**N/A**
	(*) Q250: Radical Prostatectomy Pathology Reporting (Collection Type: Medicare Part B Claims, MIPS CQM)	**MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
	(*) Q395: Lung Cancer Reporting (Biopsy/Cytology Specimens) (Collection Type: Medicare Part B Claims, MIPS CQM)	**N/A**
	(!)(*) Q396: Lung Cancer Reporting (Resection Specimens) (Collection Type: Medicare Part B Claims, MIPS CQM)	**MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
	(*) Q397: Melanoma Reporting (Collection Type: Medicare Part B Claims, MIPS CQM)	**N/A**
	(!)(*) Q440: Skin Cancer: Biopsy Reporting Time – Pathologist to Clinician (Collection Type: MIPS CQM)	
	(!)(*) Q491: Mismatch Repair (MMR) or Microsatellite Instability (MSI) Biomarker Testing Status (Collection Type: MIPS CQM)	
	(*) CAP30: Urinary Bladder Cancer: Complete Analysis and Timely Reporting (Collection Type: QCDR)	
	CAP34: Molecular Assessment: Biomarkers in Non-Small Cell Lung Cancer (Collection Type: QCDR)	
	CAP40: Squamous Cell Skin Cancer: Complete Reporting (Collection Type: QCDR)	
	QMM21: Incorporating results of concurrent studies into Final Reports for Bone Marrow Aspirate of patients with Leukemia, Myelodysplastic syndrome, or Chronic Anemia (Collection Type: QCDR)	
	QMM29: Use of Appropriate Classification System for Lymphoma Specimen (Collection Type: QCDR)	
	QMM30: Appropriate Use of Bethesda System for Reporting Thyroid Cytopathology on Fine Needle Aspirations (FNA) of Thyroid Nodule(s) (Collection Type: QCDR)	
	(+) QMM33: Immunohistochemistry (IHC) and/or Molecular BRAF Testing Status in Metastatic Melanoma (Collection Type: QCDR)	

Pathology Improvement Activities

- **IA_BE_6:** Regularly Assess Patient Experience of Care and Follow Up on Findings
- **(!!) IA_BE_26:** Promote Use of Patient-Reported Outcome Tools
- **(!!) IA_BMH_12:** Promoting Clinician Well-Being
- **(+)(*)(!!) IA_CC_8:** Implementation of documentation improvements for practice/process improvements
- **(*)(!!) IA_CC_9:** Implementation of practices/processes for developing regular individual care plans
- **IA_CC_19:** Tracking of clinician's relationship to and responsibility for a patient by reporting MACRA patient relationship codes
- **(^)(+) IA_CC_XX:** Use of Data to Improve Practice Workflows
- **(^)(+) IA_CC_XX:** Understand and Improve Diagnostic Performance
- **(+) IA_ EPA_8:** Provide Education Opportunities for New Clinicians

- **(**) IA_MVP:** Practice-Wide Quality Improvement in MIPS Value Pathways
- **IA_PSPA_1:** Participation in an AHRQ-listed patient safety organization
- **IA_PSPA_12:** Participation in private payer CPIA
- **IA_PSPA_13:** Participation in Joint Commission Evaluation Initiative
- **IA_PSPA_35:** Adopt Certified Health Information Technology for Security Tags for Electronic Health Record Data

B.17: Patient Safety and Support of Positive Experiences with Anesthesia MVP

Table B.17a represents the proposed MIPS core measures for the Patient Safety and Support of Positive Experiences with Anesthesia MVP. The B.17b table, followed by a list of improvement activities, represents the measures and activities finalized within the Patient Safety and Support of Positive Experiences with Anesthesia MVP (90 FR 50441 through 50444) with modifications for the CY 2027 performance period/2029 MIPS payment year and future years. The Patient Safety and Support of Positive Experiences with Anesthesia MVP focuses on increasing the quality of anesthesia care, improving postoperative outcomes, promoting patient safety, and enhancing satisfaction for patients receiving anesthesia. The measures are used for a variety of surgical procedures that anesthesiologists deliver care for, and are broadly applicable to anesthesiologists practicing within ambulatory, outpatient, and inpatient hospital settings, including NPPs such as certified registered nurse anesthetists (CRNAs), nurse practitioners, clinical nurse specialists, and physician assistants. We reviewed the MIPS quality measure and improvement activities inventories and considered feedback received during the 2026 MVP maintenance period to determine which measures and activities to include in this MVP. We request public comment on the proposed modifications included in this MVP.

Quality Measures

For the reasons stated in the introduction of this appendix[538], we are proposing the following measures as MIPS core measures for the Patient Safety and Support of Positive Experiences with Anesthesia MVP:

- **Q404:** Anesthesiology Smoking Abstinence
- **Q477:** Multimodal Pain Management
- **TBD:** Intraoperative Hypotension (IOH) among Non-Emergent Noncardiac Surgical Cases

We are proposing to add two new MIPS quality measures and two QCDR measures:

- **TBD:** Intraoperative Hypotension (IOH) among Non-Emergent Noncardiac Surgical Cases: This proposed MIPS quality measure assesses the mean arterial pressure (MAP) of patients undergoing noncardiac, non-emergency surgery that requires general anesthesia or monitored anesthesia.
- **TBD:** Patient-Reported Experience with Anesthesia: This proposed MIPS quality measure assesses patient experience and satisfaction with anesthesia care.
- **AQI65:** Avoidance of Cerebral Hyperthermia for Procedures Involving Cardiopulmonary Bypass: This QCDR measure ensures patients receive appropriate intraoperative temperature monitoring during cardiopulmonary bypass, with documentation that pulmonary artery, oropharyngeal, or nasopharyngeal temperatures are maintained at or above 37.0 degrees Celsius.
- **AQI71:** Ambulatory Glucose Management: This QCDR measure ensures patients with diabetes undergoing office-based or ambulatory surgery receive appropriate blood glucose monitoring and intervention throughout the entire anesthesia care episode.

[538] See MVP Development: Quality Measure and Improvement Activity Updates

For the reasons stated in the introduction of this appendix[539], we are proposing to remove **Q430:** Prevention of Post-Operative Nausea and Vomiting (PONV) – Combination Therapy and **Q463:** Prevention of Post-Operative Vomiting (POV) – Combination Therapy (Pediatrics). We are proposing to remove one high performing QCDR measure and two QCDR measures proposed to transition to MIPS measures:

- **ABG44:** Low Flow Inhalational General Anesthesia (high performing)
- **AQI48:** Patient-Reported Experience with Anesthesia (proposed as a MIPS measure)
- **EPREOP31:** Intraoperative Hypotension (IOH) among Non-Emergent Noncardiac Surgical Cases (proposed as a MIPS measure)

Symbol Key:
Exclamation point (!): MIPS core measure within an MVP.
Single asterisk (*): existing measures and improvement activities with proposed revisions.
Double asterisk (**): measures and improvement activities only available when included in an MVP.
Double exclamation point (!!): improvement activities with an advancing health and wellness component.

TABLE B.17a: Patient Safety and Support of Positive Experiences with Anesthesia MVP MIPS Core Measures

Patient Safety and Support of Positive Experiences with Anesthesia MVP MIPS Core Measures
Q404: Anesthesiology Smoking Abstinence
Q477: Multimodal Pain Management
TBD: Intraoperative Hypotension (IOH) among Non-Emergent Noncardiac Surgical Cases

[539] See MVP Development: Quality Measure and Improvement Activity Updates

TABLE B.17b: Patient Safety and Support of Positive Experiences with Anesthesia MVP Clinical Groupings

Patient Safety and Support of Positive Experiences with Anesthesia MVP		
Clinical Grouping	**Quality**	**Cost**
Sedation/General Anesthesia	**(!) Q404:** Anesthesiology Smoking Abstinence (Collection Type: MIPS CQM)	**MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
	(!)(^)(+) TBD: Intraoperative Hypotension (IOH) among Non-Emergent Noncardiac Surgical Cases (Collection Type: MIPS CQM)	
	(+) AQI65: Avoidance of Cerebral Hyperthermia for Procedures Involving Cardiopulmonary Bypass (Collection Type: QCDR)	
	(+) AQI71: Ambulatory Glucose Management (Collection Type: QCDR)	
Pain Management	**(!) Q477**: Multimodal Pain Management (Collection Type: MIPS CQM)	**MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
Experience of Care	**(^)(+) TBD:** Patient-Reported Experience with Anesthesia (Collection Type: MIPS CQM)	**MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician

Patient Safety and Support of Positive Experiences with Anesthesia Improvement Activities

- **IA_BE_6:** Regularly Assess Patient Experience of Care and Follow Up on Findings
- **IA_BE_22:** Improved practices that engage patients pre-visit
- **(!!) IA_BMH_2:** Tobacco use
- **IA_CC_15:** PSH Care Coordination
- **IA_CC_19:** Tracking of clinician's relationship to and responsibility for a patient by reporting MACRA patient relationship codes
- **(**) IA_MVP:** Practice-Wide Quality Improvement in MIPS Value Pathways
- **IA_PSPA_1:** Participation in an AHRQ-listed patient safety organization
- **IA_PSPA_7:** Use of QCDR data for ongoing practice assessment and improvements
- **(*) IA_PSPA_16:** Use decision support—ideally platform-agnostic, interoperable clinical decision support (CDS) tools —and standardized treatment protocols to manage workflow on the care team to meet patient needs

B.18 Podiatry MVP

Table B.18a represents the proposed MIPS core measures for the Podiatry MVP. The B.18b table, followed by a list of improvement activities, represents the measures and activities finalized within the Podiatry MVP (90 FR 50395 through 50400) with modifications for the CY 2027 performance period/2029 MIPS payment year and future years. The Podiatry MVP focuses on assessing meaningful outcomes in foot and ankle care for patients with chronic conditions, wound/ulcers, and general care for the podiatry patient. This MVP would be most applicable to podiatry clinicians, including NPPs such as nurse practitioners, clinical nurse specialists, and physician assistants. We reviewed the MIPS quality measure and improvement activities inventories and considered feedback received during the 2026 MVP maintenance period to determine which measures and activities to include in this MVP. We request public comment on the proposed modifications included in this MVP.

Quality Measures

For the reasons stated in the introduction of this appendix[540], we are proposing the following measures as MIPS core measures for the Podiatry MVP:

- **Q126:** Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation

[540] See MVP Development: Quality Measure and Improvement Activity Updates

- **Q155:** Falls: Plan of Care
- **Q358:** Patient-Centered Surgical Risk Assessment and Communication

We are proposing to remove two QCDR measures due to low adoption, no benchmark after 2 consecutive years in MIPS:

- **REGCLR5:** Offloading with Remote Monitoring
- **REGCLR8:** Monitor and Improve Treatment Outcomes in Chronic Wound Healing

Symbol Key:
Exclamation point (!): MIPS core measure within an MVP.
Single asterisk (*): existing measures and improvement activities with proposed revisions.
Double asterisk (**): measures and improvement activities only available when included in an MVP.
Double exclamation point (!!): improvement activities with an advancing health and wellness component.

TABLE B.18a: Podiatry MVP MIPS Core Measures

Podiatry MVP MIPS Core Measures
Q126: Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation
Q155: Falls: Plan of Care
Q358: Patient-Centered Surgical Risk Assessment and Communication

TABLE B.18b: Podiatry MVP Clinical Groupings

Podiatry MVP		
Clinical Grouping	**Quality**	**Cost**
Chronic Conditions	**(!) Q126:** Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation (Collection Type: MIPS CQM)	**MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
	Q127: Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear (Collection Type: MIPS CQM)	
Wound/Ulcer	**USWR32:** Adequate Compression at each visit for Patients with Venous Leg Ulcers (VLUs) appropriate to arterial supply (Collection Type: QCDR)	**N/A**
	USWR33: Diabetic Foot Ulcer (DFU) Healing or Closure (Collection Type: QCDR)	
	USWR34: Venous Leg Ulcer (VLU) Healing or Closure (Collection Type: QCDR)	
	USWR35: Adequate Off-loading of Diabetic Foot Ulcers performed at each visit, appropriate to location of ulcer (Collection Type: QCDR)	
General Podiatry	**(*) Q374:** Closing the Referral Loop: Receipt of Specialist Report (Collection Type: eCQM, MIPS CQM,)	**MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
Advancing Health and Wellness	**(!) Q155:** Falls: Plan of Care (Collection Type: MIPS CQM)	**MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
	Q226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (Collection Type: Medicare Part B Claims, eCQM, MIPS CQM)	
	(*) Q317: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented (Collection Type: Medicare Part B Claims, eCQM, MIPS CQM)	
	(!) Q358: Patient-Centered Surgical Risk Assessment and Communication (Collection Type: MIPS CQM)	
	MEX5: Hammer Toe Outcome (Collection Type: QCDR)	**N/A**
	REGCLR1: Heel Pain Treatment Outcomes for Adults (Collection Type: QCDR)	
	REGCLR3: Bunion Outcome - Adult and Adolescent (Collection Type: QCDR)	

Podiatry Improvement Activities

- **IA_BE_6:** Regularly Assess Patient Experience of Care and Follow Up on Findings
- **(!!) IA_BMH_12:** Promoting Clinician Well-Being
- **IA_CC_19:** Tracking of clinician's relationship to and responsibility for a patient by reporting MACRA patient relationship codes
- **IA_EPA_7:** Enhance Engagement of Medicaid and Other Underserved Populations
- **(**) IA_MVP:** Practice-Wide Quality Improvement in MIPS Value Pathways
- **IA_PM_14:** Implementation of methodologies for improvements in longitudinal care management for high risk patients
- **IA_PSPA_7:** Use of QCDR data for ongoing practice assessment and improvements
- **IA_PSPA_18:** Measurement and improvement at the practice and panel level
- **IA_PSPA_22:** CDC Training on CDC's Guideline for Prescribing Opioids for Chronic Pain
- **IA_PSPA_23:** Completion of CDC Training on Antibiotic Stewardship

B.19: Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV MVP

Table B.18a represents the proposed MIPS core measures for the Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV MVP. The B.18b table, followed by a list of improvement activities, represents the measures and activities finalized within the Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV MVP (90 FR 50444 through 50447) with modifications for the CY 2027 performance period/2029 MIPS payment year and future years. The Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV MVP focuses on promoting quality care for patients suffering from infectious disorders. This MVP would be most applicable to clinicians who treat patients within the practices of infectious disease and immunology, including NPPs such as nurse practitioners, clinical nurse specialists, and physician assistants. We reviewed the MIPS quality and cost measure and improvement activities inventories and considered feedback received during the 2026 MVP maintenance period to determine which measures and activities to include in this MVP. We request public comment on the proposed modifications included in this MVP.

Quality Measures

For the reasons stated in the introduction of this appendix[541], we are proposing the following measures as MIPS core measures for the Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV MVP:

- **Q205:** Sexually Transmitted Infection (STI) Testing for People with HIV
- **Q338:** HIV Viral Suppression
- **Q516:** Hepatitis C Virus (HCV): Sustained Virological Response (SVR)

Improvement Activities

We are proposing to add one improvement activity that is relevant to this MVP and includes an advancing health and wellness component:

- **IA_CC_9:** Implementation of practices/processes for developing regular individual care plans

For the reasons stated in the introduction of this appendix[542], we are proposing to remove **IA_BE_15:** Engagement of Patients, Family, and Caregivers in Developing a Plan of Care.

Symbol Key:

Exclamation point (!): MIPS core measure within an MVP.
Plus sign (+): measures and improvement activities proposed for addition to a previously finalized MVP.
Single asterisk (*): existing measures and improvement activities with proposed revisions.
Double asterisk (**): measures and improvement activities only available when included in an MVP.
Double exclamation point (!!): improvement activities with an advancing health and wellness component.

TABLE B.19a: Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV MVP MIPS Core Measures

[541] See MVP Development: Quality Measure and Improvement Activity Updates
[542] Ibid.

Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV MVP MIPS Core Measures
Q205: Sexually Transmitted Infection (STI) Testing for People with HIV
Q338: HIV Viral Suppression
Q516: Hepatitis C Virus (HCV): Sustained Virological Response (SVR)

TABLE B.19b: Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV MVP Clinical Groupings

Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV MVP		
Clinical Grouping	**Quality**	**Cost**
Chronic: Hep C, HIV/AIDS	**(!) Q205:** Sexually Transmitted Infection (STI) Testing for People with HIV (Collection Type: eCQM, MIPS CQM)	**TPCC_1:** Total Per Capita Cost
	(!) Q338: HIV Viral Suppression (Collection Type: eCQM, MIPS CQM)	
	Q340: HIV Annual Retention in Care (Collection Type: eCQM, MIPS CQM)	
	Q387: Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users (Collection Type: MIPS CQM)	
	Q401: Hepatitis C: Screening for Hepatocellular Carcinoma (HCC) in Patients with Cirrhosis (Collection Type: MIPS CQM)	
	(!) Q516: Hepatitis C Virus (HCV): Sustained Virological Response (SVR) (Collection Type: MIPS CQM)	
Acute Infection	**Q065:** Appropriate Treatment for Upper Respiratory Infection (URI) (Collection Type: eCQM, MIPS CQM)	**N/A**
	N/A	**COST_RIH_1:** Respiratory Infection Hospitalization **COST_S_1:** Sepsis **MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
Advancing Health and Wellness	**(*) Q130:** Documentation of Current Medications in the Medical Record (Collection Type: eCQM, MIPS CQM)	**COST_RIH_1:** Respiratory Infection Hospitalization **COST_S_1:** Sepsis **MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician **TPCC_1:** Total Per Capita Cost
	(*) Q134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan (Collection Type: Medicare Part B Claims, eCQM, MIPS CQM)	
	Q240: Childhood Immunization Status (Collection Type: eCQM)	
	Q310: Chlamydia Screening in Women (Collection Type: eCQM)	
	Q400: One-Time Screening for Hepatitis C Virus (HCV) and Treatment Initiation (Collection Type: MIPS CQM)	
	(*) Q475: HIV Screening (Collection Type: eCQM)	
	Q493: Adult Immunization Status (Collection Type: MIPS CQM)	

Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV Improvement Activities

- **IA_BE_4:** Engagement of Patients through Implementation of New Patient Portal
- **(+)(*)(!!) IA_CC_9:** Implementation of practices/processes for developing regular individual care plans
- **IA_EPA_7:** Enhance Engagement of Medicaid and Other Underserved Populations
- **(**) IA_MVP:** Practice-Wide Quality Improvement in MIPS Value Pathways
- **IA_PM_11:** Regular review practices in place on targeted patient population needs

- **IA_PM_14:** Implementation of methodologies for improvements in longitudinal care management for high risk patients
- **(!!) IA_PM_22:** Improving Practice Capacity for Human Immunodeficiency Virus (HIV) Prevention Services
- **IA_PSPA_23:** Completion of CDC Training on Antibiotic Stewardship
- **(!!) IA_PSPA_32:** Use of CDC Guideline for Clinical Decision Support to Prescribe Opioids for Chronic Pain via Clinical Decision Support

B.20: Pulmonology Care MVP

Table B.20a represents the proposed MIPS core measures for the Pulmonology Care MVP. The B.20b table, followed by a list of improvement activities, represents the measures and activities finalized within the Pulmonology Care MVP (90 FR 50447 through 50449) with modifications for the CY 2027 performance period/2029 MIPS payment year and future years. The Pulmonology Care MVP focuses on assessing optimal care for patients treated for a broad range of pulmonology conditions including COPD, asthma, sleep apnea, and general pulmonology. This MVP would be most applicable to clinicians who specialize in pulmonology and sleep medicine, including NPPs such as nurse practitioners, clinical nurse specialists, and physician assistants. We reviewed the improvement activities inventory and considered feedback received during the 2026 MVP maintenance period to determine which measures and activities to include in this MVP. We request public comment on the proposed modifications included in this MVP.

Quality Measures

For the reasons stated in the introduction of this appendix[543], we are proposing the following measures as MIPS core measures for the Pulmonology Care MVP:

- **Q052:** Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation and Long-Acting Inhaled Bronchodilator Therapy
- **Q279:** Sleep Apnea: Assessment of Adherence to Obstructive Sleep Apnea (OSA) Therapy
- **Q398:** Optimal Asthma Control

Symbol Key:

Exclamation point (!): MIPS core measure within an MVP.
Single asterisk (*): existing measures and improvement activities with proposed revisions.
Double asterisk (**): measures and improvement activities only available when included in an MVP.
Double exclamation point (!!): improvement activities with an advancing health and wellness component.

TABLE B.20a: Pulmonology Care MVP MIPS Core Measures

Pulmonology Care MVP MIPS Core Measures
Q052: Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation and Long-Acting Inhaled Bronchodilator Therapy
Q279: Sleep Apnea: Assessment of Adherence to Obstructive Sleep Apnea (OSA) Therapy
Q398: Optimal Asthma Control

TABLE B.20b: Pulmonology Care MVP Clinical Groupings

Pulmonology Care MVP		
Clinical Grouping	**Quality**	**Cost**

[543] See MVP Development: Quality Measure and Improvement Activity Updates

Pulmonology Care MVP		
Clinical Grouping	**Quality**	**Cost**
Asthma	**(!)(*) Q398:** Optimal Asthma Control (Collection Type: MIPS CQM)	**COST_ACOPD_1:** Asthma/ Chronic Obstructive Pulmonary Disease (COPD)
COPD	**(!) Q052:** Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation and Long-Acting Inhaled Bronchodilator Therapy (Collection Type: MIPS CQM)	**COST_ACOPD_1:** Asthma/ Chronic Obstructive Pulmonary Disease (COPD) **COST_COPDE_1:** Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation
	ACEP25: Tobacco Use: Screening and Cessation Intervention for Patients with Asthma and COPD (Collection Type: QCDR)	
Sleep Medicine	**Q277:** Sleep Apnea: Severity Assessment at Initial Diagnosis (Collection Type: MIPS CQM)	**N/A**
	(!) Q279: Sleep Apnea: Assessment of Adherence to Obstructive Sleep Apnea (OSA) Therapy (Collection Type: MIPS CQM)	
Advancing Health and Wellness	**(**) Q128:** Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (Collection Type: Medicare Part B Claims, eCQM, MIPS CQM)	**COST_ACOPD_1:** Asthma/ Chronic Obstructive Pulmonary Disease (COPD) **COST_COPDE_1:** Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation
	Q226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (Collection Type: Medicare Part B Claims, eCQM, MIPS CQM)	
Experience of Care	**Q047:** Advance Care Plan (Collection Type: Medicare Part B Claims, MIPS CQM)	**COST_ACOPD_1:** Asthma/ Chronic Obstructive Pulmonary Disease (COPD) **COST_COPDE_1:** Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation
	Q503: Gains in Patient Activation Measure (PAM®) Scores at 12 Months (Collection Type: MIPS CQM)	

Pulmonology Care Improvement Activities

- **(!!) IA_AHW_1:** Chronic Care and Preventative Care Management for Empaneled Patients
- **(!!) IA_BE_23:** Integration of patient coaching practices between visits
- **(!!) IA_BE_26:** Promote Use of Patient-Reported Outcome Tools
- **(*)(!!) IA_CC_9:** Implementation of practices/processes for developing regular individual care plans
- **IA_EPA_2:** Use of telehealth services that expand practice access
- **(**) IA_MVP:** Practice-Wide Quality Improvement in MIPS Value Pathways
- **IA_PM_16:** Implementation of medication management practice improvements

B.21: Quality Care for Patients with Neurological Conditions MVP

Table B.21a represents the proposed MIPS core measures for the Quality Care for Patients with Neurological Conditions MVP. The B.21b table, followed by a list of improvement activities, represents the measures and activities finalized within the Quality Care for Patients with Neurological Conditions MVP (90 FR 50449 through 50451) with modifications for the CY 2027 performance period/2029 MIPS payment year and future years. The Quality Care for Patients with Neurological Conditions MVP focuses on the clinical theme of promoting quality care for patients suffering from neurological conditions. This MVP would be most applicable to clinicians who specialize in neurology care, including NPPs such as nurse practitioners, clinical nurse specialists, and physician assistants. We reviewed the improvement activities inventory and considered feedback received during the 2026 MVP maintenance period to determine which measures and activities to include in this MVP. We request public comment on the proposed modifications included in this MVP.

Quality Measures

For the reasons stated in the introduction of this appendix[544], we are proposing the following measures as MIPS core measures for the Quality Care for Patients with Neurological Conditions MVP:

- **Q238:** Use of High-Risk Medications in Older Adults
- **Q282:** Dementia: Functional Status Assessment
- **Q495:** Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood

Symbol Key:

Exclamation point (!): MIPS core measure within an MVP.
Single asterisk (*): existing measures and improvement activities with proposed revisions.
Double asterisk (**): measures and improvement activities only available when included in an MVP.
Double exclamation point (!!): improvement activities with an advancing health and wellness component.

TABLE B.21a: Quality Care for Patients with Neurological Conditions MVP MIPS Core Measures

Quality Care for Patients with Neurological Conditions MVP MIPS Core Measures
Q238: Use of High-Risk Medications in Older Adults
Q282: Dementia: Functional Status Assessment
Q495: Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood

TABLE B.21b: Quality Care for Patients with Neurological Conditions MVP Clinical Groupings

[544] See MVP Development: Quality Measure and Improvement Activity Updates

Quality Care for Patients with Neurological Conditions MVP		
Clinical Grouping	**Quality**	**Cost**
Brain Conditions	**Q268:** Epilepsy: Counseling for Women of Childbearing Potential with Epilepsy (Collection Type: MIPS CQM)	**MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
Dementia	**Q281:** Dementia: Cognitive Assessment (Collection Type: eCQM)	**MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
	(!) Q282: Dementia: Functional Status Assessment (Collection Type: MIPS CQM)	
	Q286: Dementia: Safety Concern Screening and Follow-Up for Patients with Dementia (Collection Type: MIPS CQM)	
	(*) Q288: Dementia: Education and Support of Caregivers for Patients with Dementia (Collection Type: MIPS CQM)	
Neurodegenerative Disorders	**(*) Q291:** Assessment of Cognitive Impairment or Dysfunction for Patients with Parkinson's Disease (Collection Type: MIPS CQM)	**MSPB_1**: Medicare Spending Per Beneficiary (MSPB) Clinician
	Q293: Rehabilitative Therapy Referral for Patients with Parkinson's Disease (Collection Type: MIPS CQM)	
	Q386: Amyotrophic Lateral Sclerosis (ALS) Patient Care Preferences (Collection Type: MIPS CQM)	
Advancing Health and Wellness	**(*) Q130:** Documentation of Current Medications in the Medical Record (Collection Type: eCQM, MIPS CQM)	**MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
	(!) Q238: Use of High-Risk Medications in Older Adults (Collection Type: eCQM, MIPS CQM)	
	(*) Q513: Patient reported falls and plan of care (Collection Type: MIPS CQM)	
Experience of Care	**Q047:** Advance Care Plan (Collection Type: Medicare Part B Claims, MIPS CQM)	**MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
	(!) Q495: Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood (Collection Type: MIPS CQM)	
	Q503: Gains in Patient Activation Measure (PAM®) Scores at 12 Months (Collection Type: MIPS CQM)	

Quality Care for Patients with Neurological Conditions Improvement Activities

- **IA_BE_4:** Engagement of Patients through Implementation of New Patient Portal
- **IA_BE_6:** Regularly Assess Patient Experience of Care and Follow Up on Findings
- **(!!) IA_BE_16:** Promote Self-management in Usual Care
- **IA_BE_24:** Financial Navigation Program
- **(!!) IA_BE_26:** Promote Use of Patient-Reported Outcome Tools
- **(*)(!!) IA_BMH_4:** Depression screening
- **IA_EPA_2:** Use of telehealth services that expand practice access
- **(**) IA_MVP:** Practice-Wide Quality Improvement in MIPS Value Pathways
- **IA_PM_11:** Regular review practices in place on targeted patient population needs
- **IA_ PM_16:** Implementation of medication management practice improvements
- **IA_PM_21:** Advance Care Planning
- **(!!) IA_PSPA_21:** Implementation of fall screening and assessment programs

B.22: Quality Care for the Treatment of Ear, Nose, and Throat Disorders MVP

Table B.22a represents the proposed MIPS core measures for the Quality Care for the Treatment of Ear, Nose, and Throat Disorders MVP. The B.22b table, followed by a list of improvement activities, represents the measures and activities finalized within the Quality Care for the Treatment of Ear, Nose, and Throat Disorders MVP (90 FR 50451 through 50453) with modifications for the CY 2027 performance period/2029 MIPS payment year and future years. The Quality Care for the Treatment of Ear, Nose, and Throat Disorders MVP focuses on providing care for patients experiencing some of the most common otolaryngology conditions such as, but not limited to: otologic conditions, chronic rhinosinusitis (CRS), age-related hearing loss (ARHL), and otitis media. This MVP would be most applicable to clinicians who treat patients within the practice of otolaryngology, including NPPs such as audiologists, nurse practitioners, clinical nurse specialists, and physician assistants. We reviewed the improvement activities inventory and considered feedback received during the 2026 MVP maintenance period to determine which measures and activities to include in this MVP. We request public comment on the proposed modifications included in this MVP.

Quality Measures

For the reasons stated in the introduction of this appendix[545], we are proposing the following measures as MIPS core measures for the Quality Care for the Treatment of Ear, Nose, and Throat Disorders MVP:

- **Q331:** Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse)
- **Q357:** Surgical Site Infection (SSI)
- **TBD:** Age-Related Hearing Loss: Comprehensive Audiometric Evaluation

We are proposing to add one new MIPS quality measure that is relevant to this MVP:

- **TBD:** Age-Related Hearing Loss: Comprehensive Audiometric Evaluation: This proposed MIPS quality measure assesses patients with hearing loss or tinnitus for completion of a comprehensive audiometric evaluation.

For the reasons stated in the introduction of this appendix[546], we are proposing to remove **Q332:** Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use). We are proposing to remove one duplicative QCDR measure and one QCDR measure proposed to transition to a MIPS measure:

- **AAO16:** Age-Related Hearing Loss: Audiometric Evaluation (proposed as a MIPS measure)
- **AAO21:** Otitis Media with Effusion (OME): Comprehensive Audiometric Evaluation for Chronic OME > or = 3 months (duplicative measure)

Modifications are being considered for the following QCDR measures:

- **AAO16:** Age-Related Hearing Loss: Audiometric Evaluation: If the measure is not finalized for removal in the CY 2027 PFS final rule, this QCDR measure would undergo modifications to update the description, denominator, and numerator to reflect the addition of a tinnitus diagnosis and clarifying that a hearing screening does not meet the measure's intent. Expanding the measure to include patients diagnosed with tinnitus will help capture a broader group of individuals who may have underlying or undiagnosed hearing loss.
- **AAO20:** Tympanostomy Tubes: Comprehensive Audiometric Evaluation: This QCDR measure is undergoing modifications to update the description, denominator, and instructions to remove the otitis media with effusion (OME) diagnosis and expand the eligible population to include all patients undergoing tympanostomy tube insertion. This would increase the measure's applicability and case volume. This change reflects that

[545] See MVP Development: Quality Measure and Improvement Activity Updates
[546] Ibid.

preoperative hearing evaluation is an important component of care for any patient receiving tubes, not just those with OME.

Improvement Activities

We are proposing to add eight improvement activities relevant to this MVP, several of which include an advancing health and wellness component:

- **IA_BE_6:** Regularly Assess Patient Experience of Care and Follow Up on Findings
- **IA_CC_7:** Regular training in care coordination
- **IA_CC_8:** Implementation of documentation improvements for practice/process improvements
- **IA_CC_9:** Implementation of practices/processes for developing regular individual care plans
- **IA_CC_17:** Patient Navigator Program
- **IA_PM_14:** Implementation of methodologies for improvements in longitudinal care management for high risk patients
- **IA_PM_17:** Participation in Population Health Research
- **IA_PSPA_12:** Participation in private payer CPIA

For the reasons stated in the introduction of this appendix[547], we are proposing to remove **IA_BE_15:** Engagement of Patients, Family, and Caregivers in Developing a Plan of Care.

Symbol Key:

Exclamation point (!): MIPS core measure within an MVP.
Caret symbol (^): proposed new measure or improvement activity.
Plus sign (+): measures and improvement activities proposed for addition to a previously finalized MVP.
Single asterisk (*): existing measures and improvement activities with proposed revisions.
Double asterisk (**): measures and improvement activities only available when included in an MVP.
Double exclamation point (!!): improvement activities with an advancing health and wellness component.

TABLE B.22a: Quality Care for the Treatment of Ear, Nose, and Throat Disorders MVP MIPS Core Measures

Quality Care for the Treatment of Ear, Nose, and Throat Disorders MVP MIPS Core Measures
Q331: Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse)
Q357: Surgical Site Infection (SSI)
TBD: Age-Related Hearing Loss: Comprehensive Audiometric Evaluation

TABLE B.22b: Quality Care for the Treatment of Ear, Nose, and Throat Disorders MVP Clinical Groupings

Quality Care for the Treatment of Ear, Nose, and Throat Disorders MVP		
Clinical Grouping	**Quality**	**Cost**
Otology	**(*) AAO20:** Tympanostomy Tubes: Comprehensive Audiometric Evaluation (Collection Type: QCDR)	**N/A**

[547] See MVP Development: Quality Measure and Improvement Activity Updates

Quality Care for the Treatment of Ear, Nose, and Throat Disorders MVP		
Clinical Grouping	**Quality**	**Cost**
Sleep Disorders	**Q277:** Sleep Apnea: Severity Assessment at Initial Diagnosis (Collection Type: MIPS CQM)	**N/A**
General Otolaryngology	**(!) Q331:** Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse) (Collection Type: MIPS CQM)	**N/A**
	(!)(^)(+) TBD: Age-Related Hearing Loss: Comprehensive Audiometric Evaluation (Collection Type: MIPS CQM)	
Surgical	**Q355:** Unplanned Reoperation within the 30-Day Postoperative Period (Collection Type: MIPS CQM)	**MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
	(!) Q357: Surgical Site Infection (SSI) (Collection Type: MIPS CQM)	
Advancing Health and Wellness	**(**) Q128:** Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (Collection Type: Medicare Part B Claims, eCQM, MIPS CQM)	**MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
	Q226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (Collection Type: Medicare Part B Claims, eCQM, MIPS CQM)	

Quality Care for the Treatment of Ear, Nose, and Throat Disorders Improvement Activities

- **IA_BE_4:** Engagement of Patients through Implementation of New Patient Portal
- **(+) IA_BE_6:** Regularly Assess Patient Experience of Care and Follow Up on Findings
- **(!!) IA_BE_26:** Promote Use of Patient-Reported Outcome Tools
- **(+) IA_CC_7:** Regular training in care coordination
- **(+)(*) IA_CC_8:** Implementation of documentation improvements for practice/process improvements
- **(+)(*)(!!) IA_CC_9:** Implementation of practices/processes for developing regular individual care plans
- **IA_CC_13:** Practice improvements to align with OpenNotes principles
- **(+) IA_CC_17:** Patient Navigator Program
- **(**) IA_MVP:** Practice-Wide Quality Improvement in MIPS Value Pathways
- **(+) IA_PM_14:** Implementation of methodologies for improvements in longitudinal care management for high risk patients
- **IA_PM_16:** Implementation of medication management practice improvements
- **(+) IA_PM_17:** Participation in Population Health Research
- **IA_PSPA_7:** Use of QCDR data for ongoing practice assessment and improvements
- **(+) IA_PSPA_12:** Participation in private payer CPIA

B.23: Quality Care in Mental Health and Substance Use Disorders MVP

Table B.23a represents the proposed MIPS core measures for the Quality Care in Mental Health and Substance Use Disorders MVP. The B.23b table, followed by a list of improvement activities, represents the measures and activities finalized within the Quality Care in Mental Health and Substance Use Disorders MVP (90 FR 50453 through 50456) with modifications for the CY 2027 performance period/2029 MIPS payment year and future years. The Quality Care in Mental Health and Substance Use Disorders MVP focuses on clinical actions promoting prevention of and quality care in behavioral health, including mental health and substance use disorders (SUD). This MVP would be most applicable to clinicians who treat patients with mental health and substance use disorders within the practices of mental/behavioral health and psychiatry, including NPPs such as clinical social workers, nurse practitioners, clinical nurse specialists, and physician assistants. We reviewed the improvement activities inventory and considered feedback received during the 2026 MVP maintenance period to determine which

measures and activities to include in this MVP. We request public comment on the proposed modifications included in this MVP.

Quality Measures

For the reasons stated in the introduction of this appendix[548], we are proposing the following measures as MIPS core measures for the Quality Care in Mental Health and Substance Use Disorders MVP:

- **Q305:** Initiation and Engagement of Substance Use Disorder Treatment
- **Q370:** Depression Remission at Twelve Months
- **Q383:** Adherence to Antipsychotic Medications For Individuals with Schizophrenia

Improvement Activities

We are proposing to add one improvement activity that is relevant to this MVP and includes an advancing health and wellness component:

- **IA_BMH_4:** Depression screening, treatment, and prevention.

For the reasons stated in the introduction of this appendix[549], we are proposing to remove **IA_BMH_5:** MDD prevention and treatment interventions.

Symbol Key:

Exclamation point (!): MIPS core measure within an MVP.
Plus sign (+): measures and improvement activities proposed for addition to a previously finalized MVP.
Single asterisk (*): existing measures and improvement activities with proposed revisions.
Double asterisk (**): measures and improvement activities only available when included in an MVP.
Double exclamation point (!!): improvement activities with an advancing health and wellness component.

TABLE B.23a: Quality Care in Mental Health and Substance Use Disorders MVP MIPS Core Measures

Quality Care in Mental Health and Substance Use Disorders MVP MIPS Core Measures
Q305: Initiation and Engagement of Substance Use Disorder Treatment
Q370: Depression Remission at Twelve Months
Q383: Adherence to Antipsychotic Medications For Individuals with Schizophrenia

TABLE B.23b: Quality Care in Mental Health and Substance Use Disorders MVP Clinical Groupings

Quality Care in Mental Health and Substance Use Disorders MVP		
Clinical Grouping	**Quality**	**Cost**
Mental Health—General	**Q009:** Anti-Depressant Medication Management (Collection Type: eCQM)	**COST_DEP_1**: Depression
	(*) Q134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan (Collection Type: Medicare Part B Claims, eCQM, MIPS CQM)	**COST_DEP_1:** Depression **COST_PRC_1:** Psychoses/Related Conditions

[548] See MVP Development: Quality Measure and Improvement Activity Updates
[549] Ibid.

Quality Care in Mental Health and Substance Use Disorders MVP		
Clinical Grouping	**Quality**	**Cost**
		MSPB_1: Medicare Spending Per Beneficiary (MSPB) Clinician
	Q366: Follow-Up Care for Children Prescribed ADHD Medication (Collection Type: eCQM)	**N/A**
	(!) Q370: Depression Remission at Twelve Months (Collection Type: eCQM, MIPS CQM)	**COST_DEP_1:** Depression **COST_PRC_1:** Psychoses/Related Conditions
	(!)(*) Q383: Adherence to Antipsychotic Medications For Individuals with Schizophrenia (Collection Type: MIPS CQM)	**COST_PRC_1:** Psychoses/Related Conditions
	MBHR2: Anxiety Response at 6-months (Collection Type: QCDR)	**COST_DEP_1:** Depression **COST_PRC_1:** Psychoses/Related Conditions
	MBHR7: Posttraumatic Stress Disorder (PTSD) Outcome Assessment for Adults and Children (Collection Type: QCDR)	**N/A**
Mental Health—Suicide	**Q382:** Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (Collection Type: eCQM)	**COST_DEP_1:** Depression **COST_PRC_1:** Psychoses/Related Conditions
	Q504: Initiation, Review, and/or Update to Suicide Safety Plan for Individuals with Suicidal Thoughts, Behavior, or Suicide Risk (Collection Type: MIPS CQM)	
	(*) Q505: Reduction in Suicidal Ideation or Behavior Symptoms (Collection Type: MIPS CQM)	
Substance Use Disorder	**(!) Q305:** Initiation and Engagement of Substance Use Disorder Treatment (Collection Type: eCQM)	**N/A**
	Q468: Continuity of Pharmacotherapy for Opioid Use Disorder (OUD) (Collection Type: MIPS CQM)	
Experience of Care	**Q502:** Improvement or Maintenance of Functioning for Individuals with a Mental and/or Substance Use Disorder (Collection Type: MIPS CQM)	**COST_DEP_1:** Depression **COST_PRC_1:** Psychoses/Related Conditions **MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician

Mental Health and Substance Use Disorders Improvement Activities

- **(!!) IA_BE_12:** Use evidence-based decision aids to support shared decision-making
- **(!!) IA_BE_16:** Promote Self-management in Usual Care
- **(!!) IA_BE_23:** Integration of patient coaching practices between visits
- **(!!) IA_BE_26:** Promote Use of Patient-Reported Outcome Tools
- **(!!) IA_BMH_2:** Tobacco use
- **(+)(*)(!!) IA_BMH_4:** Depression screening and follow-up plan
- **IA_BMH_7:** Implementation of Integrated Patient Centered Behavioral Health Model
- **(!!) IA_BMH_14:** Behavioral/Mental Health and Substance Use Screening and Referral for Pregnant and Postpartum Women
- **(!!) IA_BMH_15:** Behavioral/Mental Health and Substance Use Screening and Referral for Older Adults
- **IA_EPA_2:** Use of telehealth services that expand practice access

- **IA_EPA_7:** Enhance Engagement of Medicaid and Other Underserved Populations
- **(**) IA_MVP:** Practice-Wide Quality Improvement in MIPS Value Pathways
- **(!!) IA_PSPA_32:** Use of CDC Guideline for Clinical Decision Support to Prescribe Opioids for Chronic Pain via Clinical Decision Support

B.24: Rehabilitative Support MVP

Table B.24a represents the proposed MIPS core measures for the Rehabilitative Support MVP. The B.24b table, followed by a list of improvement activities, represents the measures and activities finalized within the Rehabilitative Support for Musculoskeletal Care MVP (90 FR 50457 through 50461) with modifications for the CY 2027 performance period/2029 MIPS payment year and future years, including an MVP title update to Rehabilitative Support MVP to more closely reflect the measures and activities included in the MVP. The Rehabilitative Support MVP focuses on clinical actions promoting quality rehabilitative care for patients. This MVP would be most applicable to clinicians who specialize in providing rehabilitative support such as chiropractic, physiatry, physical therapy and occupational therapy, including NPPs such as nurse practitioners, clinical nurse specialists, and physician assistants. We reviewed the improvement activities inventory and considered feedback received during the 2026 MVP maintenance period to determine which measures and activities to include in this MVP. We request public comment on the proposed modifications included in this MVP.

Quality Measures

For the reasons stated in the introduction of this appendix[550], we are proposing the following measures as MIPS core measures for the Rehabilitative Support MVP:

- **Q050:** Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older
- **Q155:** Falls: Plan of Care
- **TBD:** Functional Improvement for Patients with Back Impairments

We are proposing to add five new MIPS quality measures relevant to this MVP:

- **TBD:** Functional Improvement for Patients with Neck Impairments: This proposed MIPS quality measure assesses functional improvement for patients with neck impairments after completing an episode of care, excluding surgical interventions. This measure is proposed to replace Q478: Functional Status Change for Patients with Neck Impairments.
- **TBD:** Functional Improvement for Patients with Upper Extremity Impairments: This proposed MIPS quality measure assesses functional improvement for patients with upper extremity impairments after completing an episode of care, excluding surgical interventions. This measure is proposed to replace Q222: Functional Status Change for Patients with Elbow, Wrist or Hand Impairments.
- **TBD:** Functional Improvement for Patients with Lower Extremity Impairments: This MIPS quality measure assesses functional improvement for patients with lower extremity impairments after completing an episode of care, excluding surgical interventions. This measure is proposed to replace Q218 Functional Status Change for Patients with Hip Impairments and Q219: Functional Status Change for Patients with Lower Leg, Foot or Ankle Impairments.
- **TBD:** Functional Improvement for Patients with Knee Impairments: This proposed MIPS quality measure assesses functional improvement for patients with knee impairments after completing an episode of care, excluding surgical interventions. This measure is proposed to replace Q217: Functional Status Change for Patients with Knee Impairments.
- **TBD:** Functional Improvement for Patients with Back Impairments: This proposed MIPS quality measure assesses functional improvement for patients with back impairments

[550] See MVP Development: Quality Measure and Improvement Activity Updates

after completing an episode of care, excluding surgical interventions. This measure is proposed to replace Q220: Functional Status Change for Patients with Low Back Impairments.

For the reasons stated in the introduction of this appendix[551], we are proposing to remove **Q217:** Functional Status Change for Patients with Knee Impairments, **Q218:** Functional Status Change for Patients with Hip Impairments, **Q219:** Functional Status Change with Lower Leg, Foot or Ankle Impairments, **Q220:** Functional Status Change for Patients with Low Back Impairments, **Q221:** Functional Status Change for Patients with Shoulder Impairments, **Q222:** Functional Status Change for Patients with Elbow, Wrist or Hand Impairments, and **Q478:** Functional Status Change for Patients with Neck Impairments.

Improvement Activities

We are proposing to add one improvement activity that is relevant to this MVP and includes an advancing health and wellness component:

- **IA_CC_9:** Implementation of practices/processes for developing regular individual care plans

For the reasons stated in the introduction of this appendix[552], we are proposing to remove **IA_BE_15:** Engagement of Patients, Family and Caregivers in Developing a Plan of Care and **IA_CC_12:** Care coordination agreements that promote improvements in patient tracking across settings.

Symbol Key:

Exclamation point (!): MIPS core measure within an MVP.
Caret symbol (^): proposed new measure or improvement activity.
Plus sign (+): measures and improvement activities proposed for addition to a previously finalized MVP.
Single asterisk (*): existing measures and improvement activities with proposed revisions.
Double asterisk (**): measures and improvement activities only available when included in an MVP.
Double exclamation point (!!): improvement activities with an advancing health and wellness component.

TABLE B.24a: Rehabilitative Support MVP MIPS Core Measures

Rehabilitative Support MVP MIPS Core Measures
Q050: Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older
Q155: Falls: Plan of Care
TBD: Functional Improvement for Patients with Back Impairments

[551] Ibid.
[552] See MVP Development: Quality Measure and Improvement Activity Updates

TABLE B.24b: Rehabilitative Support MVP Clinical Groupings

Rehabilitative Support MVP		
Clinical Grouping	**Quality**	**Cost**
Orthopedic	**Q182:** Functional Outcome Assessment (Collection Type: MIPS CQM)	**COST_LBP_1:** Low Back Pain
	(^)(+) TBD: Functional Improvement for Patients with Neck Impairments (Collection Type: MIPS CQM)	**N/A**
	(^)(+) TBD: Functional Improvement for Patients with Upper Extremity Impairments (Collection Type: MIPS CQM)	
	(^)(+) TBD: Functional Improvement for Patients with Lower Extremity Impairments (Collection Type: MIPS CQM)	
	(^)(+) TBD: Functional Improvement for Patients with Knee Impairments (Collection Type: MIPS CQM)	
	(!)(^)(+) TBD: Functional Improvement for Patients with Back Impairments (Collection Type: MIPS CQM)	**COST_LBP_1:** Low Back Pain
	MSK6: Patients Suffering From a Neck Injury who Improve Pain (Collection Type: QCDR)	**N/A**
	MSK7: Patients Suffering From an Upper Extremity Injury who Improve Pain (Collection Type: QCDR)	
	MSK8: Patients Suffering From a Back Injury who Improve Pain (Collection Type: QCDR)	**COST_LBP_1:** Low Back Pain
	MSK9: Patients Suffering From a Lower Extremity Injury who Improve Pain (Collection Type: QCDR)	**N/A**
Geriatric	**(!) Q050:** Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older (Collection Type: MIPS CQM)	**N/A**
Advancing Health and Wellness	**(**) Q128:** Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (Collection Type: Medicare Part B Claims, eCQM, MIPS CQM)	**COST_LBP_1:** Low Back Pain
	(*) Q134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan (Collection Type: Medicare Part B Claims, eCQM, MIPS CQM)	
	(!) Q155: Falls: Plan of Care (Collection Type: MIPS CQM)	

Rehabilitative Support Improvement Activities

- **(!!) IA_AHW_1:** Chronic Care and Preventative Care Management for Empaneled Patients
- **IA_BE_6:** Regularly Assess Patient Experience of Care and Follow Up on Findings
- **(!!) IA_BE_16:** Promote Self-management in Usual Care
- **(!!) IA_BE_26:** Promote Use of Patient-Reported Outcome Tools
- **(!!) IA_BMH_12:** Promoting Clinician Well-Being
- **(!!) IA_BMH_15:** Behavioral/Mental Health and Substance Use Screening and Referral for Older Adults
- **(*) IA_CC_8**: Implementation of documentation improvements for practice/process improvements
- **(+)(*)(!!) IA_CC_9:** Implementation of practices/processes for developing regular individual care plans
- **IA_EPA_2:** Use of telehealth services that expand practice access
- **IA_EPA_3:** Collection and use of patient experience and satisfaction data on access
- **(!) IA_EPA_8:** Provide Education Opportunities for New Clinicians

- **(**) IA_MVP:** Practice-Wide Quality Improvement in MIPS Value Pathways
- **(*) IA_PSPA_16:** Use decision support—ideally platform-agnostic, interoperable clinical decision support (CDS) tools —and standardized treatment protocols to manage workflow on the care team to meet patient needs
- **(!!) IA_PSPA_21:** Implementation of fall screening and assessment programs

B.25: Surgical Care MVP

Table B.25a represents the proposed MIPS core measures for the Surgical Care MVP. The B.25b table, followed by a list of improvement activities, represents the measures and activities finalized within the Surgical Care MVP (90 FR 50461 through 50464) with modifications for the CY 2027 performance period/2029 MIPS payment year and future years. The Surgical Care MVP focuses on the clinical theme of surgery. This MVP would be most applicable to clinicians who specialize in general surgery, neurosurgery, and cardiothoracic surgery, including NPPs such as nurse practitioners, clinical nurse specialists, and physician assistants. We reviewed the improvement activities inventory and considered feedback received during the 2026 MVP maintenance period to determine which measures and activities to include in this MVP. We request public comment on the proposed modifications included in this MVP.

Quality Measures

For the reasons stated in the introduction of this appendix[553], we are proposing the following measures as MIPS core measures for the Surgical Care MVP:

- **Q047:** Advance Care Plan
- **Q164:** Coronary Artery Bypass Graft (CABG): Prolonged Intubation
- **Q354:** Anastomotic Leak Intervention
- **Q357:** Surgical Site Infection (SSI)
- **Q358:** Patient-Centered Surgical Risk Assessment and Communication
- **Q459:** Back Pain After Lumbar Surgery

Symbol Key:

Exclamation point (!): MIPS core measure within an MVP.
Single asterisk (*): existing measures and improvement activities with proposed revisions.
Double asterisk (**): measures and improvement activities only available when included in an MVP.
Double exclamation point (!!): improvement activities with an advancing health and wellness component.

TABLE B.25a: Surgical Care MVP MIPS Core Measures

Surgical Care MVP MIPS Core Measures
Q047: Advance Care Plan
Q164: Coronary Artery Bypass Graft (CABG): Prolonged Intubation
Q354: Anastomotic Leak Intervention
Q357: Surgical Site Infection (SSI)
Q358: Patient-Centered Surgical Risk Assessment and Communication
Q459: Back Pain After Lumbar Surgery

TABLE B.25b: Surgical Care MVP Clinical Groupings

[553] See MVP Development: Quality Measure and Improvement Activity Updates

Surgical Care MVP		
Clinical Grouping	**Quality**	**Cost**
Cardiothoracic Surgery	**(!) Q164:** Coronary Artery Bypass Graft (CABG): Prolonged Intubation (Collection Type: MIPS CQM)	**COST_NECABG_1:** Non-Emergent Coronary Artery Bypass Graft (CABG) **MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
	(*) Q167: Coronary Artery Bypass Graft (CABG): Postoperative Renal Failure (Collection Type: MIPS CQM)	
	(*) Q168: Coronary Artery Bypass Graft (CABG): Surgical Re-Exploration (Collection Type: MIPS CQM)	
	Q445: Risk-Adjusted Operative Mortality for Coronary Artery Bypass Graft (CABG) (Collection Type: MIPS CQM)	
General Surgery	**(!) Q354:** Anastomotic Leak Intervention (Collection Type: MIPS CQM)	**MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
	Q355: Unplanned Reoperation within the 30-Day Postoperative Period (Collection Type: MIPS CQM)	**COST_LPMSM_1:** Lumpectomy, Partial Mastectomy, Simple Mastectomy **COST_CRR_1:** Colon and Rectal Resection **COST_FIHR_1:** Femoral or Inguinal Hernia Repair **MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
	(!) Q357: Surgical Site Infection (SSI) (Collection Type: MIPS CQM)	**COST_LSFDD_1:** Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels **COST_LPMSM_1:** Lumpectomy, Partial Mastectomy, Simple Mastectomy **COST_CRR_1:** Colon and Rectal Resection **COST_FIHR_1**: Femoral or Inguinal Hernia Repair **MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
Neurosurgical	**(!) Q459:** Back Pain After Lumbar Surgery (Collection Type: MIPS CQM)	**COST_LSFDD_1:** Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels **MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
	Q461: Leg Pain After Lumbar Surgery (Collection Type: MIPS CQM)	
	Q471: Functional Status After Lumbar Surgery (Collection Type: MIPS CQM)	
Advancing Health and Wellness	**Q226:** Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (Collection Type: Medicare Part B Claims, eCQM, MIPS CQM)	**COST_NECABG_1:** Non-Emergent Coronary Artery Bypass Graft (CABG) **COST_LSFDD_1:** Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels **COST_LPMSM_1:** Lumpectomy, Partial Mastectomy, Simple

Surgical Care MVP		
Clinical Grouping	**Quality**	**Cost**
		Mastectomy **COST_CRR_1:** Colon and Rectal Resection **COST_FIHR_1:** Femoral or Inguinal Hernia Repair **MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
Experience of Care	**(!) Q047:** Advance Care Plan (Collection Type: Medicare Part B Claims, MIPS CQM)	**COST_NECABG_1:** Non-Emergent Coronary Artery Bypass Graft (CABG) **COST_LSFDD_1:** Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels **COST_LPMSM_1:** Lumpectomy, Partial Mastectomy, Simple Mastectomy **COST_CRR_1:** Colon and Rectal Resection **COST_FIHR_1:** Femoral or Inguinal Hernia Repair **MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
	(!) Q358: Patient-Centered Surgical Risk Assessment and Communication (Collection Type: MIPS CQM)	

Surgical Care Improvement Activities

- **(!!) IA_BE_12:** Use evidence-based decision aids to support shared decision-making
- **(!!) IA_BE_26:** Promote Use of Patient-Reported Outcome Tools
- **IA_CC_15:** PSH Care Coordination
- **IA_CC_17:** Patient Navigator Program
- **(!!) IA_CC_18:** Relationship-Centered Communication
- **(**) IA_MVP:** Practice-Wide Quality Improvement in MIPS Value Pathways
- **IA_PM_11:** Regular review practices in place on targeted patient population needs
- **IA_PSPA_7:** Use of QCDR data for ongoing practice assessment and improvements
- **IA_PSPA_8:** Use of Patient Safety Tools

B.26: Value in Primary Care MVP

Table B.26a represents the proposed MIPS core measures for the Value in Primary Care MVP. The B.26b table, followed by a list of improvement activities, represents the measures and activities finalized within the Value in Primary Care MVP (90 FR 50465 through 50467) with modifications for the CY 2027 performance period/2029 MIPS payment year and future years. The Value in Primary Care MVP focuses on the clinical theme of promoting quality care for patients to reduce the risk of diseases, disabilities, and death. This MVP would be most applicable to clinicians who specialize in preventive medicine, internal medicine, family medicine, and geriatrics, including NPPs such as nurse practitioners, clinical nurse specialists, and physician assistants. We reviewed the MIPS quality measure and improvement activities inventories and considered feedback received during the 2026 MVP maintenance period to

determine which measures and activities to include in this MVP. We request public comment on the proposed modifications included in this MVP.

Quality Measures

For the reasons stated in the introduction of this appendix[554], we are proposing the following measures as MIPS core measures for the Value in Primary Care MVP:

- **Q001:** Diabetes: Glycemic Status Assessment Greater Than 9%
- **Q134:** Preventive Care and Screening: Screening for Depression and Follow-up Plan
- **Q236:** Controlling High Blood Pressure

We are proposing to add one new MIPS quality measure:

- **TBD:** Low Density Lipoprotein Cholesterol (LDL-C) Monitoring and Management: This proposed intermediate outcome MIPS quality measure ensures lipid monitoring in patients with atherosclerotic cardiovascular disease (ASCVD) and assesses target goal achievement of an LDL-C less than 70mg/dl.

For the reasons stated in the introduction of this appendix[555], we are proposing to remove **Q483:** Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM).

Symbol Key:

Exclamation point (!): MIPS core measure within an MVP.
Caret symbol (^): proposed new measure or improvement activity.
Plus sign (+): measures and improvement activities proposed for addition to a previously finalized MVP.
Single asterisk (*): existing measures and improvement activities with proposed revisions.
Double asterisk (**): measures and improvement activities only available when included in an MVP.
Double exclamation point (!!): improvement activities with an advancing health and wellness component.

TABLE B.26a: Value in Primary Care MVP MIPS Core Measures

Value in Primary Care MVP MIPS Core Measures
Q001: Diabetes: Glycemic Status Assessment Greater Than 9%
Q134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan
Q236: Controlling High Blood Pressure

TABLE B.26b: Value in Primary Care MVP Clinical Groupings

[554] See MVP Development: Quality Measure and Improvement Activity Updates
[555] Ibid.

Value in Primary Care MVP		
Clinical Grouping	**Quality**	**Cost**
Chronic Conditions	**(!)(*) Q001:** Diabetes: Glycemic Status Assessment Greater Than 9% (Collection Type: Medicare Part B Claims, eCQM, MIPS CQM)	**COST_D_1:** Diabetes **TPCC_1:** Total Per Capita Cost
	(!)(*) Q236: Controlling High Blood Pressure (Collection Type: Medicare Part B Claims, eCQM, MIPS CQM)	**COST_ACOPD_1:** Asthma/ Chronic Obstructive Pulmonary Disease (COPD) **COST_D_1:** Diabetes **COST_DEP_1:** Depression **COST_HF_1:** Heart Failure **TPCC_1:** Total Per Capita Cost
	Q305: Initiation and Engagement of Substance Use Disorder Treatment (Collection Type: eCQM)	**N/A**
	(*) Q438: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (Collection Type: eCQM, MIPS CQM)	**TPCC_1:** Total Per Capita Cost
	Q504: Initiation, Review, and/or Update to Suicide Safety Plan for Individuals with Suicidal Thoughts, Behavior, or Suicide Risk (Collection Type: MIPS CQM)	**COST_DEP_1:** Depression **TPCC_1:** Total Per Capita Cost
	(^)(+) TBD: Low Density Lipoprotein Cholesterol (LDL-C) Monitoring and Management (Collection Type: MIPS CQM)	**TPCC_1:** Total Per Capita Cost
Advancing Health and Wellness	**(!)(*) Q134:** Preventive Care and Screening: Screening for Depression and Follow-Up Plan (Collection Type: Medicare Part B Claims, eCQM, MIPS CQM)	**COST_ACOPD_1:** Asthma/ Chronic Obstructive Pulmonary Disease (COPD) **COST_D_1:** Diabetes **COST_DEP_1:** Depression **COST_HF_1:** Heart Failure **TPCC_1:** Total Per Capita Cost
	(*) Q475: HIV Screening (Collection Type: eCQM)	
	Q493: Adult Immunization Status (Collection Type: MIPS CQM)	
	(*) Q497: Preventive Care and Wellness (composite) (Collection Type: MIPS CQM)	
Experience of Care	**Q047:** Advance Care Plan (Collection Type: Medicare Part B Claims, MIPS CQM)	**COST_ACOPD_1:** Asthma/ Chronic Obstructive Pulmonary Disease (COPD) **COST_D_1:** Diabetes **COST_DEP_1:** Depression **COST_HF_1:** Heart Failure **TPCC_1:** Total Per Capita Cost
	Q321: CAHPS for MIPS Clinician/Group Survey (Collection Type: CMS-approved Survey Vendor)	

Value in Primary Care Improvement Activities

- **(!!) IA_AHW_1:** Chronic Care and Preventative Care Management for Empaneled Patients
- **IA_BE_4:** Engagement of Patients through Implementation of New Patient Portal
- **IA_BE_6:** Regularly Assess Patient Experience of Care and Follow Up on Findings
- **IA_BE_12:** Use evidence-based decision aids to support shared decision-making
- **(!!) IA_BE_26:** Promote Use of Patient-Reported Outcome Tools
- **IA_CC_13:** Practice improvements to align with OpenNotes principles

- **(**) IA_MVP:** Practice-Wide Quality Improvement in MIPS Value Pathways
- **IA_PM_11:** Regular review practices in place on targeted patient population needs
- **IA_PM_16:** Implementation of medication management practice improvements
- **(!!) IA_PM_22:** Improving Practice Capacity for Human Immunodeficiency Virus (HIV) Prevention Services
- **(!!) IA_PM_23:** Use of Computable Guidelines and Clinical Decision Support to Improve Adherence for Cervical Cancer Screening and Management Guidelines
- **(!!) IA_PM_25:** Save a Million Hearts: Standardization of Approach to Screening and Treatment for Cardiovascular Disease Risk

B.27 Vascular Surgery MVP

Table B.27a represents the proposed MIPS core measures for the Vascular Surgery MVP. The B.27b table, followed by a list of improvement activities, represents the measures and activities finalized within the Vascular Surgery MVP (90 FR 50400 through 50405) with proposed modifications for the CY 2027 performance period/2029 MIPS payment year and future years. The Vascular Surgery MVP focuses on the clinical theme of providing high quality care for patients treated under vascular surgery. This MVP would be most applicable to clinicians who treat patients within the surgical setting of vascular surgery, including NPPs such as nurse practitioners, clinical nurse specialists, and physician assistants. We reviewed the MIPS quality measure and improvement activities inventories and considered feedback received during the 2026 MVP maintenance period to determine which measures and activities to include in this MVP. We request public comment on the proposed modifications included in this MVP.

Quality Measures

For the reasons stated in the introduction of this appendix[556], we are proposing the following measures as MIPS core measures for the Vascular Surgery MVP:

- **Q344:** Rate of Carotid Endarterectomy (CEA) or Carotid Artery Stenting (CAS) for Asymptomatic Patients, Without Major Complications (Discharged to Home by Post-Operative Day #2)
- **Q356:** Unplanned Hospital Readmission within 30 Days of Principal Procedure
- **Q358:** Patient-Centered Surgical Risk Assessment and Communication

Improvement Activities

For the reasons stated in the introduction of this appendix[557], we are proposing to remove **IA_PM_2:** Anticoagulant Management Improvements.

Symbol Key:

Exclamation point (!): MIPS core measure within an MVP.
Single asterisk (*): existing measures and improvement activities with proposed revisions.
Double asterisk (**): measures and improvement activities only available when included in an MVP.
Double exclamation point (!!): improvement activities with an advancing health and wellness component.

TABLE B.27a: Vascular Surgery MVP MIPS Core Measures

Vascular Surgery MVP MIPS Core Measures
Q344: Rate of Carotid Endarterectomy (CEA) or Carotid Artery Stenting (CAS) for Asymptomatic Patients, Without Major Complications (Discharged to Home by Post-Operative Day #2)
Q356: Unplanned Hospital Readmission within 30 Days of Principal Procedure

[556] See MVP Development: Quality Measure and Improvement Activity Updates
[557] Ibid.

Q358: Patient-Centered Surgical Risk Assessment and Communication

TABLE B.27b: Vascular Surgery MVP Clinical Groupings

Vascular Surgery MVP		
Clinical Grouping	**Quality**	**Cost**
Interventional	**Q259:** Rate of Endovascular Aneurysm Repair (EVAR) of Small or Moderate Non-Ruptured Infrarenal Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post-Operative Day #2) (Collection Type: MIPS CQM)	**MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
	(!) Q344: Rate of Carotid Endarterectomy (CEA) or Carotid Artery Stenting (CAS) for Asymptomatic Patients, Without Major Complications (Discharged to Home by Post-Operative Day #2) (Collection Type: MIPS CQM)	
Surgical	**Q355:** Unplanned Reoperation within the 30-Day Postoperative Period (Collection Type: MIPS CQM)	**COST_HAC_1:** Hemodialysis Access Creation **MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
	(!) Q356: Unplanned Hospital Readmission within 30 Days of Principal Procedure (Collection Type: MIPS CQM)	**MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
	Q357: Surgical Site Infection (SSI) (Collection Type: MIPS CQM)	**COST_HAC_1:** Hemodialysis Access Creation **MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
Dialysis-Related	**RCOIR12:** Tunneled Hemodialysis Catheter Clinical Success Rate (Collection Type: QCDR)	**MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician **COST_HAC_1:** Hemodialysis Access Creation
	RCOIR13: Percutaneous Arteriovenous Fistula for Dialysis - Clinical Success Rate (Collection Type: QCDR)	
	RPAQIR14: Arteriovenous Graft Thrombectomy Clinical Success Rate (Collection Type: QCDR)	
	RPAQIR15: Arteriovenous Fistulae Thrombectomy Clinical Success Rate (Collection Type: QCDR)	
General Vascular Surgery	**(*) Q374:** Closing the Referral Loop: Receipt of Specialist Report (Collection Type: eCQM, MIPS CQM)	**COST_CCLI_1:** Revascularization For Lower Extremity Chronic Critical Limb Ischemia **COST_HAC_1:** Hemodialysis Access Creation **MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
	(*) Q001: Diabetes: Glycemic Status Assessment Greater Than 9%	**COST_CCLI_1:** Revascularization For

Vascular Surgery MVP		
Clinical Grouping	**Quality**	**Cost**
Advancing Health and Wellness	(Collection Type: Medicare Part B Claims, eCQM, MIPS CQM)	Lower Extremity Chronic Critical Limb Ischemia **COST_HAC_1:** Hemodialysis Access Creation **MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
	(*) Q130: Documentation of Current Medications in the Medical Record (Collection Type: eCQM, MIPS CQM)	
	Q226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (Collection Type: Medicare Part B Claims, eCQM, MIPS CQM)	
	(*) Q438: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (Collection Type: eCQM, MIPS CQM)	
Experience of Care	**Q047:** Advance Care Plan (Collection Type: Medicare Part B Claims, MIPS CQM)	**COST_CCLI_1:** Revascularization For Lower Extremity Chronic Critical Limb Ischemia **COST_HAC_1:** Hemodialysis Access Creation **MSPB_1:** Medicare Spending Per Beneficiary (MSPB) Clinician
	Q321: CAHPS for MIPS Clinician/Group Survey (Collection Type: CMS-approved Survey Vendor)	
	(!) Q358: Patient-Centered Surgical Risk Assessment and Communication (Collection Type: MIPS CQM)	

Vascular Surgery Improvement Activities

- **IA_BE_1:** Use of certified EHR to capture patient reported outcomes
- **IA_BE_4:** Engagement of Patients through Implementation of New Patient Portal
- **(!!) IA_BE_12:** Use evidence-based decision aids to support shared decision-making
- **(!!) IA_BE_26:** Promote Use of Patient-Reported Outcome Tools
- **IA_CC_15:** PSH Care Coordination
- **IA_EPA_2:** Use of telehealth services that expand practice access
- **IA_EPA_3:** Collection and use of patient experience and satisfaction data on access
- **IA_EPA_8:** Provide Education Opportunities for New Clinicians
- **(**) IA_MVP:** Practice-Wide Quality Improvement in MIPS Value Pathways
- **(!!) IA_PM_5:** Engagement of community for health status improvement
- **IA_PM_11:** Regular Review Practices in Place on Targeted Patient Population Needs
- **IA_PM_15:** Implementation of episodic care management practice improvements
- **IA_PM_16:** Implementation of medication management practice improvements
- **IA_PM_21:** Advance Care Planning
- **IA_PSPA_1:** Participation in an AHRQ-listed patient safety organization

[FR Doc. 2026-14327 Filed: 7/14/2026 4:15 pm; Publication Date: 7/16/2026]