Patient360

Key Concepts in the CY 2026 Medicare Physician Fee Schedule Proposed Rule

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Educational Webinar Series

Meet Your Presenters!

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Disclaimer

This presentation contains Patient360's interpretation of selected topics from the proposed CY 2026 Medicare Physician Fee Schedule Proposed Rule. This information is intended to serve as a general summary and should not be considered as comprehensive nor official regulatory advice. Patient360 has made reasonable efforts to ensure accuracy, but makes no warranty or guarantee that the information is error-free and accepts no responsibility or liability for any consequences arising from reliance on this summary. The ultimate responsibility for understanding, meeting, and complying with CMS requirements resides with the relevant provider or organization.

Agenda

- Medicare Shared Savings Program (MSSP) ACOs
- Merit-based Incentive Payment System (MIPS)
  - MIPS Value Pathways (MVPs)
- New Ambulatory Specialty Model (ASM)
- How to Effectively Compose Public Comments
- Action Items

Polling Question 1

How familiar are you with the CY 2026 Physician Fee Schedule Proposed Rule?

A.I've read most or all of the entire document.

B.I've read some of the key highlights important to my organization.

C.I've read little or none of it.

Page Number References

A Proposed Rule by the Centers for Medicare & Medicaid Services on 07/16/2025

This document has a comment period that ends in 45 days. (09/12/2025) SUBMIT A PUBLIC COMMENT

150 comments received. View posted comments

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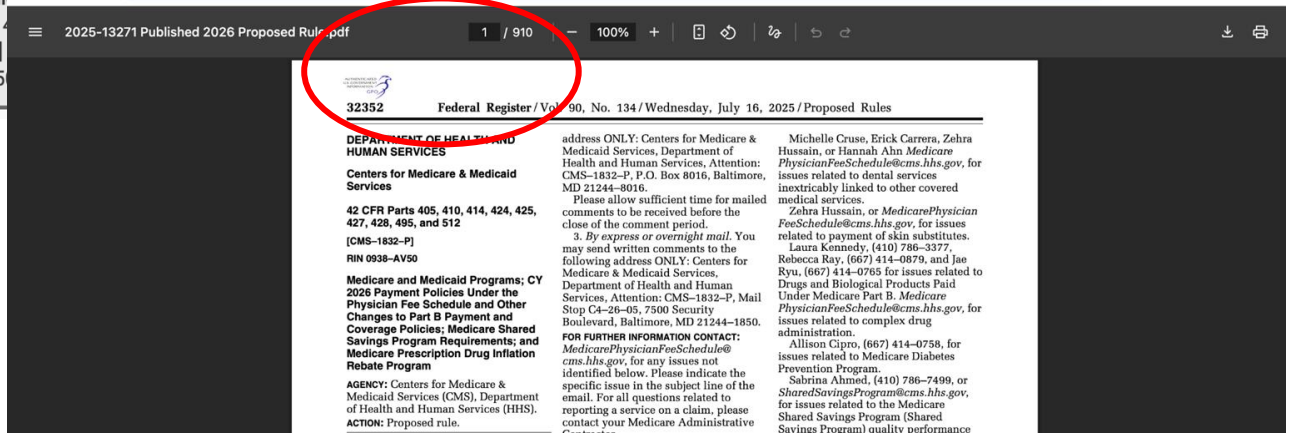
42 CFR Parts 4

[CMS-1832-P]

RIN 0938-AV5

Page numbers are directly from the published version of the 2026 Medicare Physician Fee Schedule Proposed Rule

(p.1/910 PDF OR 32352/33261)



Medicare Shared Savings Program (MSSP) **Participation**

One-Sided (BASIC Track) Risk Model participants will have a 5 year time limit beginning with agreements starting on or after January 1, 2027

p.297/910 PDF OR 32648/33261

Change of Ownership (CHOW) proposal offers a slightly more flexible timeline for ACO participant lists

p.311/910 OR 32662/33261

Medicare Shared Savings Program (MSSP)
Eligibility for Smaller ACOs

Are you on often “on the cusp” of 5,000 beneficiaries? CMS wants to encourage program participation for smaller ACOs and is proposing more flexibility with some safeguards

- Beginning with agreements starting on or after January 1, 2027 CMS will accept ACOs who have fewer than 5,000 assigned beneficiaries in Benchmark Years 1, 2, or both

p. 315/910 PDF OR 32666/3326

Medicare Shared Savings Program (MSSP)
Additional Proposals

Which patients do we report for Medicare CQMs???

Definition Revision of “beneficiary eligible for Medicare CQMs”

- Revised definition uses terms “primary care services” and “performance year,” INSTEAD OF “claims” and “measurement period”
- **Goal**: The MCQM roster will have greater overlap with the list of beneficiaries that are assignable to an ACO.

p.322/910 PDF or 32673/33261

Medicare Shared Savings Program (MSSP)
Additional Proposals

Routine updates to lists of CPT and HCPCS codes used to define "Primary Care Services" for the purpose of assigning Medicare FFS beneficiaries to an ACO and

- ADD Enhanced Care Model Management Services (HCPCS codes (GPCM1, GPCM2, and GPCM3)
- DELETE Social Determinants of Health Risk Assessment Services (HCPCS code G0136

p.320/910 PDF OR 32671/33261

Medicare Shared Savings Program (MSSP)
Additional Proposals

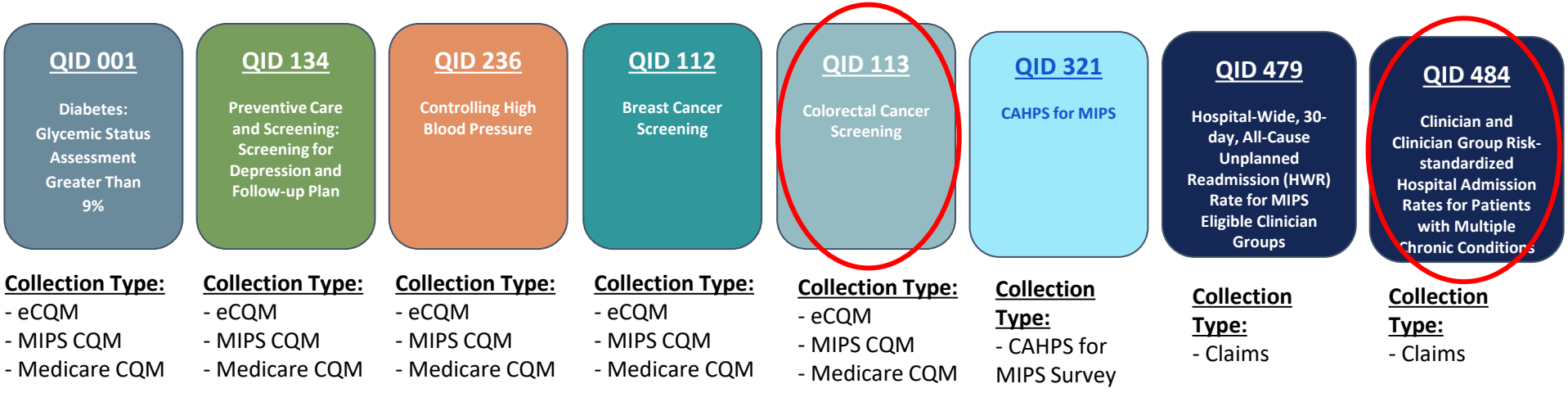
Removal of Health Equity Adjustment - to remove duplicative incentives

p.325/910 PDF OR 32676/33261

EUC Expansion - to include those impacted by cyber attacks

p.335/910 PDF OR 32686/33261

Medicare Shared Savings Program (MSSP) 2026 APP+ Quality Measure Set



Patient360 supports full CMS requirements for APP submission of both eCQM and/or CQM and MCQM collection types.

eCQM/CQM submission under APP requires data completeness on denominator eligible patients across *all payers*, for *all patients*. MCQM submissions require data completeness on all denominator eligible medicare beneficiaries.

Medicare Shared Savings Program (MSSP) **Quality Updates**

CMS previously finalized the following **Quality measures to be added** to the APP Plus quality measure set:

- Quality #305: Initiation and Engagement of Substance Use Disorder Treatment beginning with PY 2027 PY
- Quality #493: Adult Immunization Status beginning with the 2028 performance year

CMS is proposing two **changes to the CAHPS for MIPS Survey** beginning with the 2027 performance year:

- Expand administration protocol to web - mail - phone;
- CAHPS for MIPS Survey vendors must submit a range of costs for their services for public reporting

p.331/910 PDF OR 32682/33261

Removal of Quality Measure 487: Screening for Social Drivers of Health

p.329/910 PDF OR 32680/33261

Future of MSSP Reporting

- Moving towards FHIR (Fast Healthcare Interoperability Resources)
- Streamlining of Collection Types
  - Push to dQMs by 2030
  - Retirement of CQMS & Medicare CQM Collection Types
  - Report on the eCQM collection

p. 361/910 OR 32712/33261 for FHIR RFI

Medicare Shared Saving Program (MSSP)
Promoting Interoperability (PI)

- **MSSP ACOs are REQUIRED to report the MIPS PI performance category as of PY 2025**
- PI Category Requirements:
  - Use 2015 Certified Electronic Health Record Technology (CEHRT)
  - Report on all required objectives & measures in PI, including attestation statements for continuous **180-day** reporting period

For more information on the MIPS PI category: QPP MIPS Promoting Interoperability Overview.

Check out these frequently asked questions about the MSSP PI Requirement: FAQ for Shared Savings Program PI Requirement.

Excluded Special Statuses:

- Non-MIPS Eligible Clinicians
- Not exceeding the low volume threshold
- Non-patient facing clinician
- Hospital-based clinician
- Ambulatory Surgery Center (ASC)-based clinicians
- Small practices (15 or fewer clinicians)

Medicare Shared Saving Program (MSSP)
Checking Eligibility for PI

There are two ways to check clinician eligibility status:

1. Eligibility Status can be viewed and confirmed using the CMS QPP NPI Lookup Tool: https://qpp.cms.gov/participation-lookup
2. Directly from the QPP Portal: qpp.cms.gov when logged in as a security official

For more information on eligibility: https://qpp.cms.gov/mips/how-eligibility-is-determined

Medicare Shared Savings Program
ACO Action Items

- Make your voice heard through public commenting
- Upload your Medicare Beneficiary roster to Patient360 and track your Medicare CQMs
  - Benefits: Medicare CQMs have flat benchmarks
- Determine whether your member TINs will need to report on the MIPS Promoting Interoperability Category
  - Check Eligibility here: https://qpp.cms.gov/participation-lookup

Merit-based Incentive Payment System (MIPS):

General CMS priorities underlying proposals

- Reduce burden
- Advance interoperable digital quality measures (dQM/FHIR)
- Cross-cutting comparability
- Shift away from process measures to outcomes
- Implementation of MIPS Value Pathways (MVPs) to replace Traditional MIPS
- Preventative care and proactive health management
- Shift away from specific, named focus on health equity

  "...our definition of "health equity" was confusing and that health disparities are best addressed through efforts to improve overall healthcare quality for all beneficiaries."

(starts p. 345 pdf or 32696)

MIPS: General proposals

For the 2026 MIPS Performance Year (PY)

- Performance threshold: remain at 75% through PY 2028
- (no changes to data completeness 75%)
- Total Inventory of Clinical Quality Measures (CQMs) = 190 (3 only in MVPs)
- Remove Health Equity from definition of High Priority Measure

Success Tip

2024 Performance Feedback Reports are expected soon!

Watch for alerts and plan to log in to your QPP site

MIPS: Quality category proposals

Add 5 New CQMs

Patient Reported Falls and Plan of Care – process measure for a documented POC for at-risk patients – was/is a QCDR measure AAN34

Prevalent Standardized Kidney Transplant Waitlist Ratio (PSWR) – process - # of dialysis patients on the waitlist or received a transplant – builds on QM510 and QM 511

Diagnostic Delay of Venous Thromboembolism in Primary Care – eCQM – 3749e – intermediate outcome (i.e., delay in dx)

Screening for Abnormal Glucose Metabolism in Patients at Risk of Developing Diabetes – process - % screened

Hepatitus C Virus: Sustained Virological Response – outcome – achieving SVR is first step to reducing future HCV mortality and morbidity

New measures - see Table Group A p 523-533 or 32874-32884

MIPS: Quality category proposals

Remove 10 CQMs

1. **Topped Out**
    a. CQM 185 Colonoscopy Interval for Patients with h/o Adenomatous Polyps-Avoidance of Inappropriate Use
    b. CQM 290 Assessment of Mood Disorders
    c. CQM 322 Cardiac Stress Imaging
    d. CQM 419 Overuse of Imaging for Headache
    e. CQM 424 Perioperative Temperature Mngt
1. **Not aligned with current practice guidelines:** CQM 264 Sentinel Lymph Node Biopsy
1. **No longer maintained by steward:** CQM 443 Non-Recommended Cervical Cancer Screening in Adolescent Females
1. **Process measure and no longer addresses a high-priority area**
    a. CQM 487 Screening for SDoH
    b. CQM 498 Connection to Community Service Provider
    c. CQM 508 Adult COVID-19 Vaccination Status

Removals: Table Group C p.780-787.pdf or 33131-33138

MIPS: Quality category proposals

Modify (substantive changes) 32 CQMs

Tip: Be sure to notice changes (or not) specific to collection type (eCQM, CQM, claims)

Modifications to Specialty Sets

- No modifications: Electrophysiology Cardiac Specialist, Dentistry, Diagnostic Radiology, pathology
- No modifications to the set but proposed substantive changes to measures within the set: Hospitalists, Radiation Oncology, Optometry
- Multiple changes to 48 sets - mainly re: removals, additions and changes detailed on previous slides

Topped Out Measures Benchmarks List: 19 measures

- For specialty sets and MVPs impacted by limited measure choice
- to help providers with limited choice of measures avoid disadvantage of the 7 point cap

Table Group B 534-780 pdf or 32885-33131
Table Group D and DD p 787- 811 pdf or 33138- 33162
See Table 66 and p 403-404 or 32754-32757

MIPS: Cost category proposals

- 2-year informational only feedback period for **new** cost measures starting CY 2026
  - To provide clinicians more time to gain familiarity with new cost measures and better understand their impact prior to their score being affected
- Changes: Total per Capita Cost (TPCC) measure
- Routine coding updates
- No additions or removals of Cost measures
- Total 35 Cost measures (33 EBCM + 2 PBCM)

See APPENDIX 4 p907-910 pdf or 33258-33261

MIPS: Improvement Activities (IA) category proposals

"CMS is evolving the IA's inventory to emphasize activities that demonstrably improve patient outcomes while also encouraging the most efficient use of healthcare resources…. CMS' current high prioritization of measurable clinical outcomes as well as the topics of prevention, nutrition, and well being."

Add 3 new IAs:

PM_XX **Improving Detection of Cognitive Impairment in Primary Care**
PM_XX **Integrating Oral Health in Primary Care**
PSPA_XX **Patient Safety and Use of Artificial Intelligence (AI)**

Changes to 7 IAs:

BMH_1 **Behavioral and Mental Health**
Reassign other due to changes in subcategories

Subcategories

Remove Achieving Health Equity
Add Advancing Health and Wellness

Remove 8 IAs:

AHE_5 MIPS Eligible Clinician Leadership in Clinical Trials or CBPR
AHE_8 Create and Implement an Anti-Racism Plan
AHE_9 Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols
AHE_11 Create and Implement a Plan to Improve Care for Lesbian, Gay, Bisexual, Transgender, and Queer Patients
AHE_12 Practice Improvements that Engage Community Resources to Address Drivers of Health
PM_26 Vaccine Achievement for Practice Staff: COVID-19, Influenza, Hep B
PM_6 Use of Toolsets or Other Resources to Close Health and Health Care Inequities Across Communities
ERP_3 COVID-19 Clinical Data Reporting with or w/o Clinical Trial

APPENDIX 2 p 812-828 pdf or 33163-33179

MIPS: Promoting Interoperability category proposals

- Suppress the Electronic Case Reporting measure for 2025 PY due to the CDC pausing all new onboarding
- Add a second attestation required for the Security Risk Analysis measure
- Require the use of the **2025** High Priority Practices SAFER Guide
- Add a new optional bonus measure under the Public Health and Clinical Data Exchange Objective for using the Trusted Exchange Framework and Common Agreement (TEFCA) (up to 5 bonus points)
- Adopt a measure suppression policy

Starts P 346/32697 and 374/32725

MIPS Value Pathways (MVPs)

Background: MVPs are…

- Streamlined subsets requiring only 4 QMs, 1 IA, and same PI and Cost requirements
- Specific to provider specialties or patient health conditions.
- Planned to replace Traditional MIPS (date tbd)

Success Tip

Consider reporting both Traditional MIPS and MIPS Value Pathways

Why?

Minimal extra effort

CMS will award the higher score

Give you time to practice and ramp up

MVP Proposals

Add 6 new MVPs:

- Diagnostic Radiology
- Interventional Radiology
- Neuropsychology
- Pathology
- Podiatry
- Vascular Surgery

Add the PI optional **ONC-ACB Surveillance Attestation to the foundation layer of all MVPs**

See p353-910 pdf or 33258-32704

MVPs: Proposed Changes to all 21 existing

1. Adopting Best Practices & Promoting Patient Safety within Emergency Medicine
2. Advancing Cancer Care
3. Advancing Care for Heart Disease
4. Advancing Rheumatology Patient Care

5. Complete Ophthalmologic Care
6. Coordinating Stroke Care to Promote Prevention & Cultivate Positive Outcomes
7. Dermatological Care
8. Focusing on Women's Health
9. Gastroenterology Care
10. Improving Care for Lower Extremity Joint Repair
11. Optimal Care for Kidney Health
12. Optimal Care for Patients with Urologic Conditions
13. Patient Safety & Support of Positive Experiences with Anesthesia
14. Prevention & Treatment of Infectious Disorders (Hep C, HIV)
15. Pulmonology Care
16. Quality Care for Patients with Neurological Conditions
17. Quality Care for the Treatment of Ear, Nose & Throat Disorders
18. Quality Care in Mental Health & Substance Use Disorders
19. Rehabilitative Support for Musculoskeletal Care
20. Surgical Care
21. Value in Primary Care

See p353-910 pdf or 33258-32704

MVPs: Proposed Changes

Specialists and Subgroup Registration for MVPs

- Background/Previously finalized: **As of PY 2026, participants will no longer be able to register as a "multispecialty group."** Rather, multispecialty practices must divide into and register as "subgroup(s)" (or as individual).
- Proposed: Small Practices
  - A**llow small multispecialty practices to maintain the ability to register and report as a group.**

- Background: For group level registration, CMS needs to know if the group is of a single specialty (i.e., single focus of care) or multi-specialty. Using claims data will not work well enough, so attestation is the next best option.
- Proposed: **Attestation of Specialty when registering as a group.**
  - When registering for an MVP, the group will attest to being single-specialty group or a multispecialty/small practice group

MVPs: Proposed Changes

New feature: Clinical Groupings

- Added to the format of the MVP tables.
- When applicable, “Advancing Health and Wellness” and/or “Experience of Care” clinical groupings will be indicated for cross-cutting measures

Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP				
Clinical Grouping	Quality			Cost
	Measure	Outcome	High Priority	
Infectious Disease/ Antibiotic Stewardship	**Q065:** Appropriate Treatment for Upper Respiratory Infection (URI) (Collection Type: eCQM, MIPS CQM)	No	Yes	**COST_EDV_1:** Emergency Medicine
	Q116: Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Collection Type: MIPS CQM)	No	Yes	
	Q331: Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse) (Collection Type: MIPS CQM)	No	Yes	
	(*) HCPR24: Appropriate Utilization of Vancomycin for Cellulitis (Collection Type: QCDR)	No	Yes	
Trauma	**Q415:** Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older (Collection Type: MIPS CQM)	No	Yes	**COST_EDV_1:** Emergency Medicine
	Q416: Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 Through 17 Years (Collection Type: MIPS CQM)	No	Yes	
Orthopedic Emergencies	**ACEP52:** Appropriate Emergency Department Utilization of Lumbar Spine Imaging for Acute Atraumatic Low Back Pain (Collection Type: QCDR)	No	Yes	**COST_EDV_1:** Emergency Medicine
	ECPR46: Avoidance of Opiates for Low Back Pain or Migraines (Collection Type: QCDR)	No	Yes	
Experience of Care	**Q321:** CAHPS for MIPs Clinician/Group Survey (Collection Type: CAHPS Survey Vendor)	No	Yes	**COST_EDV_1:** Emergency Medicine
	ACEP50: ED Median Time from ED arrival to ED departure for all Adult Patients (Collection Type: QCDR)	Yes	Yes	

MVPs: Important Action Items

- ❑ **Determine whether there is an MVP for your speciality.** (https://qpp.cms.gov/mips/explore-mips-value-pathways)
- ❑ **Register for the MVP in the QPP Portal by Dec. 1st, 2025**: https://qpp.cms.gov/login
- ❑ If applicable to the chosen MVP, **register to report CAHPS for MIPS by June 30.**
- ❑ **In the Patient360 portal:**
  - ❑ Designate your chosen MVP.
  - ❑ You can designate Traditional MIPS too if you'd like to monitor both.
  - ❑ Continue to track all of your measure results.
- ❑ **Make sure your clinicians know where to document within the EHR/PM for your chosen measures.**

New! Ambulatory Specialty Model (ASM)

CMS INNOVATION CENTER

WHO: ASM Cohorts: Heart Failure and Low Back Pain

WHAT: Mandatory Ambulatory Specialty Model (ASM)

WHY: Improve quality of care and keep patient costs low

TIMEFRAME: 2027- 2031

p. 207/910 or 32558/33261

Check out these ASM resources: CMS Innovation Center: ASM & ASM Fact Sheet

Ambulatory Specialty Model (ASM)
Eligibility

- Determined at INDIVIDUAL level - NO GROUP REPORTING!!!
- Clinicians with the following specialities:
  - Heart Failure cohort: Cardiology
  - Low Back Pain cohort: Anesthesiology, Interventional Pain Management, Neurosurgery, Orthopedic Surgery, Pain Management, or Physical Medicine and Rehabilitation
- Clinicians who bill claims under the Medicare Physician Fee Schedule
- Clinicians who meet the Episode Based Cost Measure (EBCM) episode volume threshold of 20 attributed episodes for:
  - Heart Failure cohort: COST_HF_1: Heart Failure
  - Low Back Pain cohort: COST_LBP_1: Low Back Pain
- Clinicians who are located in one of the selected mandatory geographic areas

p. 213/910 or 32564/33261

ASM Participants would be exempt from MIPS reporting when they are required to report on the new ASM

P. 211/910 or 32562/33261

ASM: Heart Failure **Quality & Cost Measure Set**

ID	Measure	Collection Type
492	Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates for Patients with HF	Claims
008	HF: Beta-Blocker Therapy for LVSD	eCQM/CQM
005	HF: ACE Inhibitor or ARB or ARNI Therapy for LVSD	eCQM/CQM
236	Controlling High Blood Pressure	eCQM/CQM
377	Functional Status Assessments for Heart Failure	eCQM
COST_HF_1	The Heart Failure EBCM	Claims

Required reporting of ALL measures

Reporting Period: Full calendar year

Quality: see p 213/910 or 32564/33261; Cost: p. 235/910 or 32586/33261

ASM: Low Back Pain **Quality & Cost Measure Set**

ID	Measure	Collection Type
TBD	MRI Lumbar Spine for LBP	Claims
238	Use of High Risk Medications in Older Adults	eCQM/CQM
134	Preventive Care and Screening: Screening for Depression and Follow- Up Plan	eCQM/CQM
128	Preventive Care and Screening: BMI Screening and Follow- Up Plan	eCQM
220	Functional Status Change for Patients with Low Back Impairments	CQM
COST_ LBP_1	Low Back Pain Episode Based Cost Measure	Claims

Required reporting of ALL measures

Reporting Period: Full calendar year

Quality: see p 213/910 or 32564/33261; Cost: p. 236/910 or 32587/33261

Ambulatory Specialty Model (ASM)

Improvement Activities and Promoting Interoperability

Improvement Activities

- Reporting period: 90 Days
- 2 Required IAs:
  - IA-1: Connecting to Primary Care and Ensuring Completion of Health-Related Social Needs Screening
  - IA-2: Establishing Communication and Collaboration Expectations with Primary Care using Collaborative Care Arrangements
- Attestation Only

p. 238/910 or 32597/33261

Promoting Interoperability (PI)

- Reporting period: 180 days
- 2015 CEHRT Required
- All PI Objectives, Attestations, & Measures Require

Note: No PI Hardship Exceptions available!

p. 238/910 or 32597/33261

Ambulatory Specialty Model (ASM)
Category Weights and Scoring Adjustments

ASM Performance Category	Weight or Scoring Adjustments
Quality	50%
Cost	50%
Improvement Activities	Scoring adjustment of 0, -10, or -20 points
Promoting Interoperability	Scoring adjustment of 0 to -10 points

Additional Points to Final Score for:

- Up to 10 points for complex patient care based on HCC risk scores or dual-eligible populations
- 10 points will be awarded to participants who are in a small practice (fewer than 15 clinicians)
- 15 points will be awarded for participants who are solo practitioners

p.247/910 or 32598/33261

Ambulatory Specialty Model (ASM)
Final Scores

Meets Quality Data Submission Requirements	Receives ASM Quality Score	Receives ASM Cost Score	Final Score	Payment Adjustment
Yes	Yes	Yes	Between 0 - 100	Positive, neutral, or negative adjustment
Yes	No	Yes	No Final Score	Neutral
Yes	Yes	No	No Final Score	Neutral
Yes	No	Yes	No Final Score	Neutral
No	No	Yes	0	Maximum negative adjustment based on ASM Risk Level
No	No	No	0	Maximum negative adjustment based on ASM Risk Level

p.247/910 or 32598/33261

Ambulatory Specialty Model (ASM)
Risk Level and Redistribution Percentage

Risk Level: the magnitude of the maximum positive or negative net payment adjustment percentage that can be applied during the applicable payment year

p.258/910 or 32609/33261

ASM Performance Year	ASM Payment Year	ASM Risk Level
2027	2029	9%
2028	2030	9%
2029	2031	10%
2030	2031	11%

ASM Redistribution Percentage: a percentage of Medicare Part B payments that CMS will distribute in the form of payment adjustments

- CMS is proposing the ASM Redistribution Percentage at 85%. This means that 85% of the ASM incentive pool would be redistributed as positive payment adjustments and 15% would be retained in the Medicare Trust Fund

p.258/910 or 32609/33261

Ambulatory Specialty Model (ASM)
Incentive Pool and Scoring Overview

ASM Incentive Pool: the total amount of Medicare Part B claims paid to ASM participants that would be used to distribute the ASM scaled payment adjustments

ASM Incentive Pool = risk level × redistribution % × ∑ participant Medicare Part B payments

Example: 9% * 85% * $1 Billion = $76.5 million

p.258/910 or 32609/33261

Scoring Overview

CMS will calculate the following:

1. The ASM Incentive Pool
2. The ASM Adjustment Factor
3. The Payment Multiplier
4. The overall Payment Adjustment

p.258/910 or 32609/33261

Main Takeaways

- Different than the budget neutrality payment adjustments under MIPS, CMS proposes to calculate separate ASM incentive pools for each cohort
- ASM participants will be notified of their payment adjustment information through the ASM performance report

Requests For Information

CMS is requesting feedback on the following RFIs:

- **Core Elements in an MVP** - A Core Elements reporting requirement for MVPs would identify a subset of quality measures in each MVP to make up the MVPs "Core Elements"
- **Procedural Codes for MVP Assignment** - The use of procedural billing codes to assign clinicians to an MVP
- **Well-Being and Nutrition Measures** - These can provide a more comprehensive approach to disease prevention and health promotion
- **Transition Toward Digital Quality Measures** - Continuing advancements to digital quality measurement and the use of HL7 FHIR standard for CMS programs, including the Shared Savings Program
- **Query of Prescription Drug Monitoring Program (PDMP) Measure** - How effective is the current Query of PDMP measure is at evaluating performance
- **Performance-Based Measures in the Public Health and Clinical Data Exchange Objective** - Can alternatives to the current attestation-based measures drive further improvements in the quality and consistency of reporting to PHA's
- **Data Quality** - The current data environment, including the quality of the data being collected and exchanged

p.345/910 PDF OR 32696/33261

Polling Question 2

In the past, how many times have you submitted commentary on this proposed rule?

A.Never

B.Once or twice

C.Annually

2026 Proposed Rule Resources

Access the CMS 2026 Proposed Rule and Fact Sheets:

- 2026 Proposed Rule (published version)
- QPP Resource Library
  - 2026 Proposed Rule Fact Sheet
  - 2026 Proposed and Modified MVPs Guide
- 2026 Medicare Shared Savings Fact sheet
- 2026 ASM Fact Sheet

How to Effectively Compose Public Comments

This is an example of the CMS suggested format for Proposed Rule comments

You must submit your comments electronically by September 12, 2025

- Submit public comments electronically

August 30th, 2025

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1832-P
P.O. Box 8016,
Baltimore, MD 21244-8016

Submitted
ONLINE

Dear Administrator,

"Your Organization" comments are in direct response to the following:

42 CFR Parts 405, 410, 414, 424, 425, 427, 428, 495, and 512
CMS-1832-P
RIN 0938-AV50

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

https://www.federalregister.gov/documents/2025/07/16/2025-13271/medicare-and-medicaid-programs-cy-2026-payment-policies-under-the-physician-fee-schedule-and-other

How to Effectively Compose Public Comments

Each Comment should be structured as follows according to CMS recommendations:

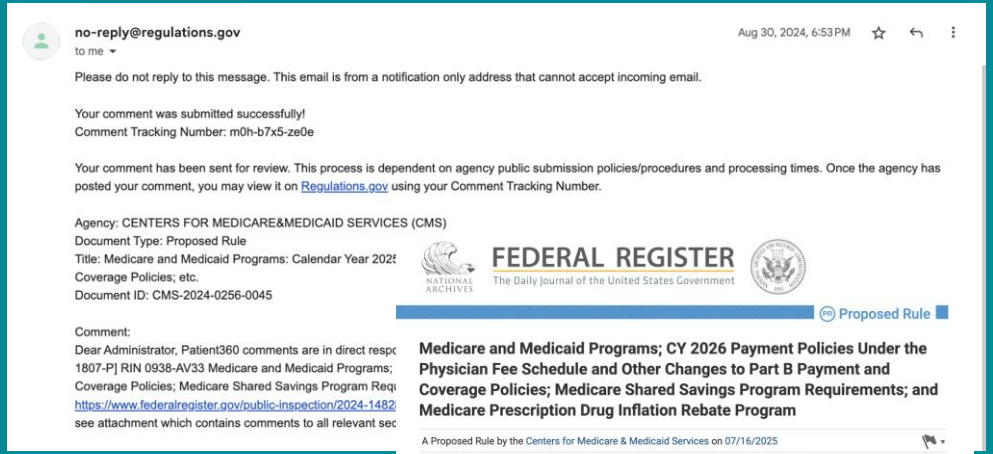
- Always include the section being referenced, page number, and what CMS is stating that you are commenting about
- Include the issues your organization foresees as result of the proposal being finalized, who it will impact, and your organization's potential alternate solution

Sample Public Comment for current 2026 Proposed Rule:

Topic: Payment Adjustments under the ASM model: Page 479/1803
CMS States: "We seek comments on the following …"
Issues: The issue with this proposal is…
Direct Impact: This will impact the following stakeholders and here is why….
Alternate Solution: Instead, we propose to ….

After Submitting Your Comments

- Confirm your comment was received
- Track your comment
- Review other comments: https://www.regulations.gov/document/CMS-2025-0304-0009/comment



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Agency: CENTERS FOR MEDICARE&MEDICAID SERVICES (CMS)
Document Type: Proposed Rule
Title: Medicare and Medicaid Programs: Calendar Year 202
Coverage Policies; etc.
Document ID: CMS-2024-0256-0045

Comment:
Dear Administrator, Patient360 comments are in direct respo
1807-P] RIN 0938-AV33 Medicare and Medicaid Programs;
Coverage Policies; Medicare Shared Savings Program Req
https://www.federalregister.gov/public-inspection/2024-1482
see attachment which contains comments to all relevant sec

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Proposed Rule

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

A Proposed Rule by the Centers for Medicare & Medicaid Services on 07/16/2025

This document has a comment period that ends in 45 days. (09/12/2025)

SUBMIT A PUBLIC COMMENT

150 comments received. View posted comments

PUBLISHED DOCUMENT: 2025-13271 (90 FR 32352)

PDF
Document Details
Document Dates

DOCUMENT HEADINGS

Department of Health and Human Services
Centers for Medicare & Medicaid Services
42 CFR Parts 405, 410, 414, 424, 425, 427, 428, 495, and 512
[CMS-1832-P]
RIN 0938-AV50

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Your comment on Medicare and Medicaid Programs; CY 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments (comment tracking number: m0h-b7x5-ze0e) has been publicly posted on Regulations.gov by the Centers For Medicare & Medicaid Services.

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Final Recommended Action Items

- Login to the Quality Payment Program Portal (QPP) at least once per quarter
  - Look out for 2024 MIPS Feedback Report and Payment Adjustment
  - Register for a MIPS Value Pathway in QPP by Dec. 1st, 2025
  - Download full eligibility status
- Medicare Shared Savings Program ACOs should consider reporting on Medicare CQMs in addition to all-payer data
- Comment on the 2026 Proposed Rule

Stop by our VBCExhibitHall.com Virtual Booth

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Please reach out to

john@patient360.com to learn more!

Thank you