Key Concepts in the CY 2027 Medicare Physician Fee Schedule

Final Rule

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Educational Webinar Series

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Meet Your Presenter!



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This presentation contains Patient360's interpretation of selected topics from the CY 2027 Medicare Physician Fee Schedule Final Rule (CMS-1848-F). 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.

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Agenda

01 Medicare Shared Savings Program (MSSP) ACOs

02 Merit-based Incentive Payment System (MIPS)

03 MIPS Value Pathways (MVPs)

04 Ambulatory Specialty Model (ASM)

05 How CMS Responded to Public Comments

06 Action Items

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POLLING QUESTION 1

How are you actually getting through this lengthy Final Rule?

A Cover to cover (I regret nothing!)

B I search for the parts that touch my organization.

C I let sessions like this one do the heavy lifting.

D Honestly, this is my third webinar on it this month!

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Page Number References

Page numbers are from the published 2027 Medicare Physician Fee Schedule Final Rule

(91 FR 70992-72020 · PDF pages 1-1,029)

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, and 512

[CMS–1848–F]

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: Final rule.

SUMMARY: This final rule addresses: changes to the physician fee schedule 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.

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 (B1 and B2).

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

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

recommendations received and determine if they are appropriate and align with the broader vision for the MVP. Guidance on how to submit recommended changes to an MVP can be found on the Quality Payment Program website.

Comment: A commenter requested this MVP include at least one eCQM, CAHPS Survey Vendor, or Administrative Claims measure as a MIPS core measure option. As proposed, participants may be required to engage a third-party reporting vendor solely to satisfy the MIPS core measure requirements, increasing reporting complexity and expense. Providing a reporting pathway that leverages existing eCQM, CAHPS, or claims-based infrastructure would better support participation while reducing administrative burden.

Response: We thank the commenter for their suggestions. The commenter may suggest changes to the MIPS core measures through the MVP Maintenance Process and we may consider alternative MIPS core measures for this MVP through future rulemaking. We will evaluate the recommendations received and determine if they are appropriate and align with the broader vision for the MVP. Currently, the policy includes an option for self-attestation when the MIPS core measures are not appropriate or applicable to their scope of care, allowing clinicians to choose an alternate measure within the MVP that is more relevant.

After consideration of public comments, we are finalizing the *Vascular Surgery MVP* with modifications as proposed for the CY 2027 performance period/2029 MIPS payment year and future years.

[FR Doc. 2026–22743 Filed 11–4–26; 5:00 pm]

BILLING CODE 4169–69–P

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Changes to Beneficiary Assignment

Exclude non-ACO TIN primary care charges from assignment: FINALIZED, effective PY2028

Why: a patient could miss assignment only because the same ACO clinician billed through an outside TIN. Impact (PY2024 simulation): about 1% more assigned beneficiaries program-wide; average per capita savings down 3.90% ($14).

91 FR 71327, 71330-71331, 71338-71339 · PDF 336, 339-340, 347-348

Expand eligibility by Medicare enrollment status: FINALIZED, effective PY2028

Why: grow accountable care. A patient now needs only 1 month of Part A and B with no Medicare Advantage that month. Impact (PY2025 simulation): assigned beneficiaries +5.07%, per capita savings -$14.02 (-2.78%).

91 FR 71333-71334, 71338 · PDF 342-343, 347

Add primary care codes used in assignment: FINALIZED, effective PY2027

Why: keep assignment consistent with PFS billing and coding. Adds SBIRT (G2011, G0396, G0397), vaccine adverse effects (G0576), and advance care planning (G0572, G0573).

91 FR 71341-71342, 71344-71345 · PDF 350-351, 353-354

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MIPS CQMs Collection Type

FINALIZED: Extend the MIPS CQMs collection type (III.G.3.b)

Finalized as proposed: MIPS CQMs stay available for ACOs reporting APP Plus for PY2027 and subsequent PYs. All commenters supported it.

"…the removal of the MIPS CQMs collection type for ACOs during this transition would be disruptive…" (91 FR 71347 / PDF 356)

91 FR 71345-71349 · PDF 354-358

Why CMS finalized it, and what is still open

MIPS CQM use jumped to 140 of 472 reconciled ACOs in PY2025 (from 36 in PY2024). No sunset was finalized; CMS anticipates PY2030, subject to rulemaking.

91 FR 71347-71349 · PDF 356-358

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MIPS CQM Reporting Incentive

FINALIZED: Extend the MIPS CQM reporting incentive (III.G.3.b)

Finalized as proposed. For PY2027+, an ACO meets the quality performance standard, qualifying it for its track's maximum sharing rate and avoiding the maximum loss rate, if it:

- Reports all eCQMs/MIPS CQMs in the APP Plus set, meeting data completeness (§ 414.1340);
- Scores at or above the 10th percentile on at least one outcome measure; and
- Scores at or above the 40th percentile on at least one of the remaining measures.

91 FR 71347-71349 · PDF 356-358

Why it matters, and what's next

In PY2024, 26 ACOs met the standard only through this incentive. Still not available for Medicare CQMs or the new Medicare eCQMs (not all-payer reporting).

"…we anticipate sunsetting the MIPS CQM reporting incentive when the 2-year FHIR-based reporting transition period begins in PY 2028…" (91 FR 71348 / PDF 357)

91 FR 71348, 71370-71371 · PDF 357, 379-380

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Flat Benchmarks for Medicare CQMs

FINALIZED: Extend flat benchmarks for Medicare CQMs (III.G.3.c)

Finalized as proposed: flat benchmarks for all Medicare CQMs for PY2027 and beyond, and retroactively for Quality IDs 001, 134, and 236 in PY2026.

"…ACOs with high quality performance on a measure are not penalized as low performers." (91 FR 71349-71350 / PDF 358-359)

91 FR 71349-71356 · PDF 358-365

Why CMS finalized it

All commenters supported flat benchmarks; one opposed the PY2026 retroactive piece. A PY2024 simulation showed an 11-point gain in average quality scores.

91 FR 71353-71355 · PDF 362-364

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Meeting Data Completeness

FINALIZED: Revise quality reporting requirements, beginning PY2026 (III.G.3.d.(2))

- Finalized as proposed: exclude whole TINs (e.g., practice closure, specialty EHR) if the rest cover 95% of assigned beneficiaries on the Q4 aggregate report.

91 FR 71357-71358, 71365-71366 · PDF 366-367, 374-375

FINALIZED: Establish a Medicare eCQMs collection type, PY2027+ (III.G.3.d.(3))

- Assigned beneficiaries only; 75% data completeness; quarterly eligible list from Q1 PY2027. Built for multi-TIN ACOs.
- Flat benchmarks (separate from Medicare CQMs); not eligible for the reporting incentive or Complex Organization Adjustment.

91 FR 71366-71372, 71540 · PDF 375-381, 549

75% data completeness applies to every collection type; CMS expects eCQMs submitted via CEHRT to reach 100% in most cases. Source: CMS MIPS Quality Data Completeness Quick Guide.

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Reporting Population: Assigned vs. All-Patient

FINALIZED: Medicare CQMs and Medicare eCQMs are reported on assigned beneficiaries only (PY2027+)

For PY2027+, a beneficiary eligible for Medicare CQMs is “a beneficiary that is assigned to the ACO.” Medicare eCQMs are also reported on only the ACO’s assigned beneficiaries.

“A Medicare eCQM is essentially an eCQM that is reported by a Shared Savings Program ACO on only the ACO’s assigned beneficiaries…” (91 FR 71370-71371 / PDF 379-380)

91 FR 71370-71371, 71375 · PDF 379-380, 384

Why CMS narrowed the Medicare CQM population (III.G.3.d.(4))

CMS: the current definition, aligned with assignable beneficiaries, “includes beneficiaries for whom the Shared Savings Program ACO does not readily have data.” All commenters supported the change; CMS declined to apply it to PY2026.

91 FR 71373-71375 · PDF 382-384

eCQMs and MIPS CQMs: still all payer/all patient

Data completeness for these collection types still covers patients who meet the denominator criteria regardless of payer. The new TIN exclusion (slide 11) applies to these collection types too.

“…patients that meet the measure’s denominator criteria, regardless of payer…” (91 FR 71356 / PDF 365)

91 FR 71356, 71365 · PDF 365, 374

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APP Plus Scoring & Measure Set

FINALIZED: Narrows scoring protection for excluded measures (III.G.3.e)

Finalized as proposed: the 40th percentile floor applies only when fewer than 5 measures are scored due to exclusion, and the protection for measures lacking a benchmark is removed.

"…our intent is for this policy to function as a relief mechanism to address rare circumstances when four or more measures are excluded…" (91 FR 71378 / PDF 387)

91 FR 71378-71379 · PDF 387-388

FINALIZED: Update the APP Plus quality measure set, PY2027+ (III.G.3.f)

Moves to eight measures: five eCQMs/MIPS CQMs/Medicare CQMs/Medicare eCQMs, two administrative claims-based measures, and CAHPS for MIPS.

Removes Quality IDs 305 (SUD treatment) and 493 (adult immunization); spec changes to 001, 134, and 479 finalized as proposed.

91 FR 71380 · PDF 389

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MEDICARE SHARED SAVINGS PROGRAM (MSSP)

2027 APP+ Quality Measure Set

Patient360 supports all finalized APP Plus collection types, including the new Medicare eCQMs.

QID 001

Diabetes: Glycemic Status Assessment Greater Than 9%

eCQM · MIPS CQM · Medicare CQM · Medicare eCQM

QID 134

Preventive Care and Screening: Screening for Depression and Follow-up Plan

eCQM · MIPS CQM · Medicare CQM · Medicare eCQM

QID 236

Controlling High Blood Pressure

eCQM · MIPS CQM · Medicare CQM · Medicare eCQM

QID 112

Breast Cancer Screening

eCQM · MIPS CQM · Medicare CQM · Medicare eCQM

QID 113

Colorectal Cancer Screening

eCQM · MIPS CQM · Medicare CQM · Medicare eCQM

QID 321

CAHPS for MIPS

CAHPS for MIPS Survey

QID 479

Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups

Claims

QID 484

Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions

Claims

eCQMs and MIPS CQMs: include 100% of denominator-eligible patients (all payers); at least 75% of them must have a reported performance result (met, not met, or exception). eCQMs are expected to reach 100%.

Medicare CQMs/eCQMs: include 100% of denominator-eligible assigned beneficiaries; at least 75% must have a reported performance result.

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Simplifying CEHRT Use Requirements

FINALIZED: Simplify CEHRT use requirements (III.G.4.b)

Finalized as proposed: beginning PY2027, the § 425.507(a) rule to report all MIPS Promoting Interoperability measures sunsets; an ACO instead performs one of three activities (§ 425.507(c)).

91 FR 71384-71385, 71402-71403 · PDF 393-394, 411-412

Pick at least one of three ways

- Report at least one of the five ACO-reported APP Plus measures via the eCQMs or Medicare eCQMs collection type, using CEHRT (b.(1)).
- Attest to using FHIR capabilities in certified health IT to support reporting one of those measures (b.(2)).
- Attest to one of three ACO CEHRT use metrics, e.g., bi-directional exchange of health information (b.(3)).

91 FR 71385-71390, 71403 · PDF 394-399, 412

Relief is at the ACO level, not the clinician level (III.G.4.b.(6))

ACO-level requirement lifted; non-QP MIPS-eligible clinicians still report MIPS PI.

“…the MIPS Promoting Interoperability performance category reporting requirements for MIPS eligible clinicians participating in an ACO will remain unaffected.” (91 FR 71392 / PDF 401)

91 FR 71392 · PDF 401

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Financial Methodology & Participation: Finalized

FINALIZED: Financial methodology (III.G.5)

- Level E sharing rate rises to 60%; ENHANCED positive regional adjustment weight capped at 35%; prior savings scaling factor rises to 75%.
- Benchmarks: risk-adjusted 5% cap, a new growth adjustment, and ACPT reforms with a retroactive guardrail from PY2025.
- These apply to agreement periods beginning 2027+ (except the retroactive guardrail).

91 FR 71411, 71423, 71431, 71443, 71459, 71469, 71476-71477 · PDF 420, 432, 440, 452, 468, 478, 485-486

FINALIZED: Participation and payments (III.G.6-9)

- Part B cost sharing support (target start April 1, 2027); prepaid shared savings ends Jan 1, 2027.
- Advance investment payments revised for PY2028+; experienced/inexperienced risk definitions revised.
- Beneficiary notices due by May 30; follow-up communication removed (beginning Jan 1, 2027).

91 FR 71480, 71488, 71492-71493, 71495, 71498-71499 · PDF 489, 497, 501-502, 504, 507-508

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RFIs & Bottom Line

Four requests for information (no policies finalized)

- FHIR-based quality measurement in the Shared Savings Program (IV.A.4.c).
- Integrating and meaningfully engaging specialty care (III.G.10).
- Primary care-focused capitated payment arrangements (II.E).
- Applying electronic prior authorization (ePA) measures to ACOs (III.G.4.c).

91 FR 71180–71185, 71393, 71499, 71526 · PDF 189–194, 402, 508, 535

Bottom line: projected savings (Final Rule)

Taken together, the finalized Shared Savings Program policies are projected to reduce Trust Fund spending by $5.5 billion over 2027-2036 (range: $8.9B to $2.3B lower spending).

“…projected to reduce Trust Fund expenditures by $5.5 billion in total through the end of the 10-year period 2027 through 2036…” (91 FR 71320-71321 / PDF 329-330)

91 FR 71320–71321, 71664–71665 · PDF 329–330, 673–674

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Future of MSSP Reporting

Moving toward FHIR-based digital quality measurement (dQM)

Anticipated: transition PY2028-2029; FHIR reporting required PY2030. No FHIR policies finalized (91 FR 71347, 71526; PDF 356, 535).

COLLECTION TYPES, ANTICIPATED LIFESPAN

- eCQMs (all-payer): continue; FHIR-based dQMs required for applicable measures from PY2030 (91 FR 71347; PDF 356).
- MIPS CQMs (all-payer): extended PY2027+ (finalized); anticipated sunset PY2030 (91 FR 71347, 71349; PDF 356, 358).
- Medicare CQMs (assigned): flat benchmarks; anticipated sunset PY2030 (91 FR 71350-71351, 71355; PDF 359-360, 364).
- Medicare eCQMs (assigned, NEW): PY2027+, flat benchmarks; FHIR: Medicare dQMs (91 FR 71347, 71372; PDF 356, 381).
- CMS Web Interface: sunset beginning PY2025 (91 FR 71357; PDF 366).

All PY2030 dates are anticipated and subject to future rulemaking; measures without FHIR specs keep existing options (91 FR 71347-71348; PDF 356-357).

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ACO Action Items

01 Choose your PY2027 collection type(s): eCQMs, MIPS CQMs, Medicare CQMs, or the new Medicare eCQMs. Populations, benchmarks, and incentives differ.

02 Model the finalized financial changes against your track: BASIC and ENHANCED are affected differently.

03 Pick your PY2027 ACO-level CEHRT use activity; MIPS-eligible clinicians who aren’t QPs still report MIPS PI. Know your QP vs MIPS-eligible clinician mix (QPP Participation Lookup)

04 Use the Q4 aggregate report for TIN exclusions; begin FHIR/dQM readiness.

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Merit-based Incentive Payment System (MIPS)

Summary of Major Finalized Policies: Transforming the Quality Payment Program

- Aligns the QPP with the Making America Healthy Again (MAHA) initiative: a shift from chronic-disease management toward prevention and foundational wellness.
- Traditional MIPS sunset delayed two years: MVPs become the only MIPS reporting option beginning the CY2031 performance period (2033 payment year).
- New Diabetic Disease, Hypertension, and Hospitalist MVPs finalized.
- New “Advancing Health and Wellness” improvement activities finalized: nutrition, lifestyle disease management, and patient wellness.
- 7 FOTO measures removed and replaced by 5 new “Functional Improvement” measures (Q518-Q522) that Patient360 & Limber/NetHealth co-steward.

91 FR 71509-71510, 71519-71520 · PDF 518-519, 528-529 | Functional Improvement CQMs: 91 FR 71721-71727 · PDF 730-736

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General Policies

For the 2027 MIPS Performance Year (PY)

- Performance threshold: remains at 75 points through PY 2028 (previously finalized)
- Data completeness: remains at 75%
- Total quality measure inventory = 180 for CY2027 (177 in traditional MIPS, 3 MVP-only)

IMPORTANT NEWS

Third party failed to submit? Reweighting requests now due Dec 31 (was Nov 1), from PY2025 (91 FR 71624; PDF 633).

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Quality Category: Finalized

FINALIZED: Inventory 190 to 180 (10 new for CY2027, 1 for CY2028)

- New prevention and chronic-disease measures: Q517 LDL-C Monitoring and Management, and Q527 abnormal screening mammogram follow-up eCQM (starts CY2028).
- New Functional Improvement CQMs Q518-Q522 (Patient360 & Limber/NetHealth co-steward) replace 7 FOTO CQMs (217-222, 478) and join the Rehabilitative Support MVP.

91 FR 71509-71510, 71717-71738, 72005 · PDF 518-519, 726-747, 1014 · Final Rule QPP Fact Sheet Appendices B, C

FINALIZED: Remove 20 CQMs

- Topped-out measures; 7 functional-status measures now duplicative of the new ones; and measures no longer maintained by their steward.

91 FR 71509-71510, 71824 (Table Group C) · PDF 518-519, 833 · Final Rule QPP Fact Sheet Appendix D

FINALIZED: Modify 43 CQMs, substantive changes

- Watch whether a change is specific to a collection type (eCQM, MIPS CQM, or claims). Some specialty sets are unchanged; others have substantive changes.

91 FR 71509-71510, 71845 (Table Group D) · PDF 518-519, 854

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Quality Category: Finalized

MIPS Core Measures & High-Priority Change: FINALIZED

- MIPS core measure designation finalized for 78 quality measures, across the MVP inventory and traditional MIPS.
- Report at least one core measure: 1 of your 6 quality measures in Traditional MIPS, or 1 of your 4 in an MVP.
- Small practices are exempt; others without an applicable core measure may attest and report another measure.
- Replaces the current requirement to report at least one outcome (or high-priority) measure.
- High Priority designation removed; topped out core measures (2+ years) now score up to 10 points, not 7.

91 FR 71532-71534, 71536-71538, 71608 · PDF 541-543, 545-547, 617; Final Rule QPP Fact Sheet p. 8.

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Cost and Improvement Activities

FINALIZED: Cost category, a quiet year (IV.A.4.d.(2))

- No cost measure inventory changes for CY2027; inventory stays at 35 (33 episode-based, 2 population-based).
- Finalized: non-substantive updates to the operational care-episode and patient-condition code lists (annual maintenance).

91 FR 71543-71544 · PDF 552-553

FINALIZED: Improvement Activities: add 6, modify 5, remove 11 (IV.A.4.d.(3))

- Add 6: two in Care Coordination; four in the new Advancing Health and Wellness subcategory (including Clinician Use of AI).
- Modify 5, for example IA_PSPA_16 now covers AI-enabled clinical decision support.
- Remove 11 as duplicative (Removal Factor 1) or obsolete (Removal Factor 7). Detail in Appendix 2.

91 FR 71544-71549 · PDF 553-558

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Promoting Interoperability: Finalized

FINALIZED: Burden reduction and CEHRT definition (IV.A.4.d.(4))

- Removed: Security Risk Analysis measure (CY2027) and ONC Direct Review/Surveillance attestations (CY2026).
- CEHRT definition aligned with ONC's HTI-5: 5 certification criteria removed.

91 FR 71557, 71560, 71562 · PDF 566, 569, 571

FINALIZED: Electronic Prior Authorization (ePA)

- Existing ePA measure: optional with 10 bonus points in CY2027, required in CY2028 (medical items; excludes drugs).
- New measure: ePA for Prescription Drugs, beginning CY2028.

91 FR 71569, 71572-71582 · PDF 578, 581-591

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MIPS Value Pathways (MVPs)

MVP basics and the coming shift

- An MVP is a streamlined, specialty or condition-specific subset of MIPS: report 4 quality measures and 1 improvement activity, with the same PI and Cost requirements (two fewer quality measures than Traditional MIPS).
- Finalized: Traditional MIPS sunset delayed two years; MIPS clinicians not in the APP report an MVP beginning CY2031 (2033 payment year).

91 FR 71509, 71519 · PDF 518, 528

Finalized for CY2027, and our tip

- 3 new MVPs finalized: Diabetic Disease, Hospitalist, and Hypertension; the inventory grows to 30.
- Tip: consider reporting both Traditional MIPS and an MVP now. CMS awards the higher of the two scores, so minimal downside, and it eases the ramp before the sunset.

91 FR 71921, 71926, 71932 · PDF 930, 935, 941 · Final Rule QPP Fact Sheet

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Updates, Core Measures, Participation

FINALIZED: All 27 existing MVPs updated for CY2027

- MIPS core measures added to each MVP; report at least one (1 of your 4 quality measures). Full list in Appendix 3 and CMS's 2027 MVPs Guide.
- Reflect the CY2027 quality-measure and improvement-activity changes (adds, removals, and modifications carry through into each MVP).
- Renamed: the "Rehabilitative Support for Musculoskeletal Care MVP" is now the "Rehabilitative Support MVP."
- Functional Improvement CQMs Q518-Q522 (formerly MSK1-5 QCDR measures) replace FOTO CQMs 217-222 and 478; Q520 is a core measure.

91 FR 71509, 71521, 71532-71533, 72004-72010 · PDF 518, 530, 541-542, 1013-1019

Participation and registration

- Finalized: virtual groups can report MVPs beginning CY2029, giving solo and small clinicians who band together an MVP pathway.
- Established: multispecialty groups register as subgroups or individuals; small multispecialty practices (15 or fewer clinicians) may register as a group.

91 FR 71509, 71519-71520 · PDF 518, 528-529 · Multispecialty: 90 FR 49839-49846 (CY 2026)

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Action Items and RFIs

MVP action items

- Check if there is an MVP for your specialty (qpp.cms.gov/mips/explore-mips-value-pathways), then register in the QPP Portal by 8 p.m. ET on November 30, 2026 (qpp.cms.gov/login).
- If your MVP requires CAHPS for MIPS, register to report it by June 30.
- In the Patient360 portal, designate your MVP (add Traditional MIPS too to monitor both), keep tracking measure results, and make sure clinicians know where to document each measure in the EHR/PM.

Requests for Information (RFIs are not proposals)

- QPP and MIPS RFIs (no policies finalized): FHIR-based digital quality measurement (91 FR 71526-71527; PDF 535-536); MVP scoring (91 FR 71613-71614; PDF 622-623); future performance-based ePA measures (91 FR 71582-71583; PDF 591-592); star ratings for administrative-claims measures (91 FR 71625-71626; PDF 634-635).
- Plus the four MSSP RFIs covered earlier: FHIR in the Shared Savings Program, specialty care, primary-care capitation, and ePA to ACOs.

`91 FR 71526-71626 · PDF 535-635`

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Ambulatory Specialty Model (ASM)

WHO

ASM Cohorts: Heart Failure and Low Back Pain

WHAT

Mandatory ASM, finalized CY2026; CY2027 Final Rule finalizes refinements

WHY

Improve quality of care and lower costs

TIMEFRAME

2027- 2031

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

91 FR 71217-71218 · PDF 226-227

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What CMS Finalized for CY2027

Measures and reporting

- MRI Lumbar Spine for Low Back Pain (modified for ASM) added, with single-participant attribution (not the proposed multi-participant).
- Q220 removed and replaced with Q182 Functional Outcome Assessment. IA attestation allowed at individual or group level.
- NOT finalized: the voluntary PRO data submission and its 5-point quality scoring incentive.
- Administrative claims-based quality measures scored at TIN/NPI; a required measure with no benchmark is excluded.

91 FR 71233-71234, 71239-71246, 71250-71251 · PDF 242-243, 248-255, 259-260

Promoting Interoperability, scoring, and exceptions

- 2027 only: all PI measures voluntary and unscored; full PI credit for 180 days of CEHRT use plus the CEHRT ID. Both ePA measures required in 2028.
- +5 points for rural participants. TIN-change and HF redesignation exceptions finalized; CMS identifies them from its own data.

91 FR 71225-71230, 71251-71258, 71262 · PDF 234-239, 260-267, 271

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Eligibility

UPDATED FOR CY2027

DETERMINED AT INDIVIDUAL LEVEL

Clinicians with the following specialties:

- 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

Finalized: TIN-change and HF redesignation exceptions; CMS will identify these from its own data. CMS may also terminate participants, with notice.

Finalized: a small practice (a TIN with 15 or fewer clinicians) may report quality once for the whole TIN, and CMS gives that same score to every ASM participant in the practice.

91 FR 71225-71232, 71235-71236, 71273 · PDF 234-241, 244-245, 282

ASM participants are exempt from MIPS reporting for any year they are required to report in ASM

90 FR 49565, 49573

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AMBULATORY SPECIALTY MODEL (ASM)

Heart Failure Cohort

SET UNCHANGED · SCORING UPDATED

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

Measure set: 90 FR 50027 (finalized CY2026) · CY2027 benchmark revisions: 91 FR 71245-71246 · PDF 254-255

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AMBULATORY SPECIALTY MODEL (ASM)

Low Back Pain Cohort

UPDATED FOR CY2027

ID	MEASURE	COLLECTION TYPE
New	MRI Lumbar Spine for LBP (modified for ASM; new)	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/CQM
182	Functional Outcome Assessment (replaces retired Q220)	CQM
COST_LBP_1	Low Back Pain Episode Based Cost Measure	Claims

Required reporting of ALL measures

Reporting Period: Full calendar year

Measure set: 91 FR 71239-71244 · PDF 248-253 (MRI added, Q220 replaced by Q182); CY2026 set: 90 FR 50027

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UPDATED FOR CY2027

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. Finalized for CY2027: attest at the individual (TIN/NPI) or group (TIN) level.

IA: 91 FR 71233-71234 · PDF 242-243

Promoting Interoperability (PI)

Reporting period: 180 days

- CEHRT Required
- All PI Objectives, Attestations, & Measures Required (2028+)
- Note: No PI Hardship Exceptions available!

Finalized for CY2027: PI voluntary and unscored in 2027 (full credit for 180 days of CEHRT use plus CEHRT ID). SRA and ONC attestations removed; ePA required 2028.

PI: 91 FR 71251-71258 · PDF 260-267

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Category Weights and Scoring Adjustments

UPDATED FOR CY2027

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 (2027: full credit for CEHRT use)

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 (a TIN with 15 or fewer clinicians)
- 15 points will be awarded for participants who are solo practitioners
- 5 points will be awarded to participants located in a rural area (finalized for CY2027).

90 FR 49568, 49665, 49672-49674 · CY2027: 91 FR 71251-71252, 71262, 71273 · PDF 260-261, 271, 282

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NO SUBSTANTIVE CHANGES

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	No	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

90 FR 49668-49670 · CY2027 clarification: 91 FR 71258 · PDF 267

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PREVIOUSLY FINALIZED · NO CHANGES

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

90 FR 49687-49690; 50031 (finalized CY2026)

ASM Performance Year	ASM Payment Year	ASM Risk Level
2027	2029	**9%**
2028	2030	**9%**
2029	2031	**10%**
2030	2032	**11%**
2031	2033	**12%**

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

Finalized in CY2026: the ASM Redistribution Percentage is 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

90 FR 49690-49691; 50032 (finalized CY2026)

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Incentive Pool and Scoring Overview

PREVIOUSLY FINALIZED · NO CHANGES

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

90 FR 49685-49687 (finalized CY2026)

Scoring Overview

CMS will calculate the following:

- The ASM Incentive Pool
- The ASM Adjustment Factor
- The Payment Multiplier
- The overall Payment Adjustment

90 FR 49685-49686 (finalized CY2026)

Main Takeaways

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

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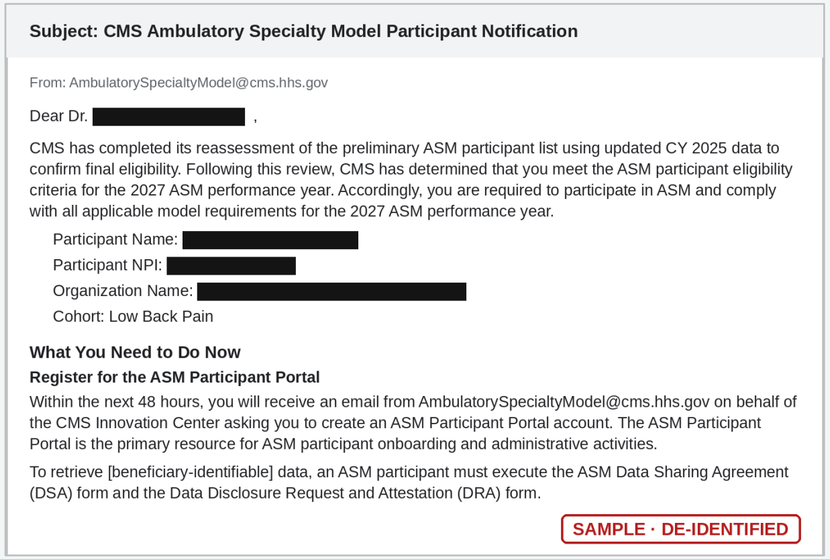
ASM Action Items

01 Q182 Functional Outcome Assessment was finalized for the Low Back Pain cohort. Work with your EHR now so documentation starts January 1; an unreported required measure scores zero.

02 Got a participant notification letter? Do NOT ignore it. Register for the ASM Participant Portal (portal.cms.gov) and add your organizational contacts.

03 In the portal, confirm your profile and TIN, and sign the Data Sharing Agreement and DRA forms (coming soon) to access CMS beneficiary data.

04 Attend CMS's ASM Performance Categories and Measure Reporting Methodology Webinar: Dec. 16, 2026, 1:00-2:00 PM ET.



Subject: CMS Ambulatory Specialty Model Participant Notification

From: AmbulatorySpecialtyModel@cms.hhs.gov

Dear Dr. [redacted] ,

CMS has completed its reassessment of the preliminary ASM participant list using updated CY 2025 data to confirm final eligibility. Following this review, CMS has determined that you meet the ASM participant eligibility criteria for the 2027 ASM performance year. Accordingly, you are required to participate in ASM and comply with all applicable model requirements for the 2027 ASM performance year.

Participant Name: [redacted]
Participant NPI: [redacted]
Organization Name: [redacted]
Cohort: Low Back Pain

What You Need to Do Now

Register for the ASM Participant Portal

Within the next 48 hours, you will receive an email from AmbulatorySpecialtyModel@cms.hhs.gov on behalf of the CMS Innovation Center asking you to create an ASM Participant Portal account. The ASM Participant Portal is the primary resource for ASM participant onboarding and administrative activities.

To retrieve [beneficiary-identifiable] data, an ASM participant must execute the ASM Data Sharing Agreement (DSA) form and the Data Disclosure Request and Attestation (DRA) form.

SAMPLE · DE-IDENTIFIED

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POLLING QUESTION 2

Did you submit comments on the CY 2027 Proposed Rule?

A No, our QCDR commented for us

B Not this time, maybe next year!

C Yes, and CMS responded to them

D Yes, but most were ignored

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PUBLIC COMMENTS: HOW CMS RESPONDED

Favorable: Functional Improvement CQMs

What Patient360 commented

As co-steward with Limber/NetHealth, we supported adopting the five functional improvement measures. In a separate comment, we asked what happens to measures, including these five, that are never placed in an MVP.

“As co-steward of the proposed functional Patient-Reported Outcome-Based Performance Measures (PRO-PMs), Patient360 strongly supports their adoption…” (Patient360 comment letter, Sept. 11, 2026)

`Proposed rule: 91 FR 44307-44316`

Outcome: FINALIZED as proposed

All five finalized as Q518-Q522 and, as proposed, included in the Rehabilitative Support MVP, with Q520 a MIPS core measure.

`91 FR 71721-71727, 72005, 72010 · PDF 730-736, 1014, 1019`

What CMS said

CMS addressed other commenters’ transparency concerns directly, and confirmed no platform is required to report the measures.

“…the complete measure specifications will be publicly posted after publication of the final rule. The eligible tools and calculations necessary for reporting the measures will be publicly available at no cost…” (91 FR 71720 / PDF 729)

`91 FR 71720 · PDF 729`

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Favorable: MIPS CQMs for ACOs

What Patient360 commented

We supported keeping the MIPS CQMs collection type and reporting incentive for ACOs, and asked CMS to keep it on the same timeline as the other collection types.

“We strongly support CMS’s proposal to keep the MIPS CQMs collection type, and the associated reporting incentive, available…” (Patient360 comment letter, Sept. 11, 2026)

`Proposed rule: 91 FR 44036-44039`

Outcome: FINALIZED as proposed

All commenters supported it. CMS also stated all four ACO collection types remain available through the FHIR transition.

`91 FR 71348, 71368 · PDF 357, 377`

What CMS said

The collection type and incentive are extended for PY2027 and subsequent PYs; any future sunset requires rulemaking.

“…we are finalizing as proposed 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.” (91 FR 71349 / PDF 358)

`91 FR 71348-71349 · PDF 357-358`

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PUBLIC COMMENTS: HOW CMS RESPONDED

Denied: Our Request to Lower the 95% TIN Threshold to 90%

What Patient360 commented

We supported the new TIN exclusion but asked CMS to lower the threshold from 95% to 90%, since one specialty TIN can be 7-8% of assigned beneficiaries.

“Increase the beneficiary threshold from 95 percent to 90 percent… so the accommodation actually reaches the ACOs it is designed for.” (Patient360 comment letter, Sept. 11, 2026)

Proposed rule: 91 FR 44045-44048

Outcome: REJECTED; finalized at 95%

CMS also rejected 80% and 85%, a phase-in for smaller ACOs, an attestation approach, and NPI-level exclusions.

91 FR 71364 · PDF 373

What CMS said

CMS views the exclusion as a narrow safety valve, not a general flexibility, and wants enough data to assess ACO quality.

“…we believe that the 95 percent beneficiary threshold remains appropriate as this policy is intended to address limited and unusual circumstances in which the ACO is unable to obtain data from an ACO participant TIN.” (91 FR 71364 / PDF 373)

91 FR 71364 · PDF 373

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What CMS’s Responses Teach Us

01 Specific asks get specific answers: CMS restated our Q3 vs. Q4 report question and answered it (91 FR 71363; PDF 372).

02 Expect “out of scope” for changes CMS didn’t propose (our Q470 fix, 91 FR 71845; PDF 854), but keep raising priority issues through every channel.

03 Broad, consistent feedback can move CMS: “many commenters” asked to delay the MIPS sunset, now CY2031 (91 FR 71518; PDF 527), and CMS called its ASM PI change “responsive to commenters’ concerns” (91 FR 71252; PDF 261).

04 RFIs get general acknowledgment, not point-by-point replies (91 FR 71526; PDF 535).

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2027 Final Rule Resources

Access the CMS 2027 Final Rule and Fact Sheets:

2027 Final Rule (published November 9, 2026, at 91 FR 70992)

QPP Resource Library

- 2027 Final Rule QPP Fact Sheet and Policy Comparison Table
- 2027 Finalized MVPs Guide

2027 Medicare Shared Savings Program Policies Fact Sheet (CMS link pending)

Ambulatory Specialty Model (CMS ASM page)

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ALL PROGRAMS: 2026 PERFORMANCE YEAR DATA

2026 Data: Where You Should Be Right Now

01 Q1-Q3 2026 data should already be in Patient360 and validated.

02 Validate against the clinical record: data must be true, accurate, and complete, and CMS tightened registry validation rules (91 FR 71616-71617; PDF 625-626).

03 Plan the final push: Q4 data and validation in January.

04 MSSP ACOs: TIN exclusions rely on the Q4 report arriving February 2027, so build in time (91 FR 71364, 71366; PDF 373, 375).

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Final Recommended Action Items

Log in to the QPP Portal now (and at least once per quarter)

- Review your 2025 MIPS final score and 2027 payment adjustment
- Disagree with your score? Request a Targeted Review by 8 p.m. ET, Nov. 30, 2026
- Register for an MVP by 8 p.m. ET, Nov. 30, 2026

Review the Final Rule’s quality measure changes (added, removed, and substantively changed) and your MVP’s measures and core measures for 2027

Prepare for January 1: confirm 2027 measure specifications, collection types, and EHR/vendor readiness. MSSP ACOs: pick your collection type, including the new Medicare eCQMs

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Thank you



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