Quality Payment PROGRAM



Calendar Year (CY) 2027 Medicare Physician Fee Schedule (PFS) Final Rule: Quality Payment Program (QPP) Fact Sheet and Policy Comparison Table

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QPP Policy Overview: Finalized Policies

In the CY 2027 Medicare PFS Final Rule, we finalized a limited number of significant policy changes for QPP. These policies were designed to move the program into the future with a focus on prevention and wellness in patient care, a reduction in administrative burden, and the promotion of more meaningful participation that drives quality and value.

Digital Transformation

The Centers for Medicare & Medicaid Services (CMS) is driving a major digital transformation with the goals of modernizing national healthcare infrastructure, improving data interoperability, and eliminating outdated paper processes. Changes to the MIPS Promoting Interoperability measure inventory, finalized in this rule, will help to move the needle on these goals while also reducing burden. Specifically, we're finalizing:

- Revisions to the Electronic Prior Authorization measure and the addition of the new Electronic Prior Authorization for Prescription Drugs measure will help to modernize a system that currently creates unnecessary delays for patients, burdens health care providers with excessive paperwork, and erodes trust between patients and their health care providers.

- Removal of the Office of the National Coordinator for Health Information Technology (ONC)-related attestations and the Security Risk Analysis measure will help reduce cost and burden.

The Future of the Merit-based Incentive Payment System (MIPS)

In QPP, we've long signaled that MIPS Value Pathways (MVPs) are the future reporting path for MIPS, and that eventually traditional MIPS would no longer be a reporting option. In this final rule, we modified our initial proposal to finalize the timeline for sunsetting the traditional MIPS reporting option:

- We'll sunset the traditional MIPS reporting option following the CY 2030 performance period/2032 MIPS payment year.
- Beginning in the CY 2031 performance period/2033 MIPS payment year, MIPS eligible clinicians will be required to report an MVP to meet MIPS reporting requirements unless they're eligible to report the Alternative Payment Model (APM) Performance Pathway (APP).

Our finalized policy allows an additional 2 years for MIPS eligible clinicians to identify the MVP most relevant to their practice, develop the workflows needed to implement the quality measures and activities in that MVP, and establish systems for collecting data at the subgroup level, if applicable**.**

Policy Highlights

For a more comprehensive look at finalized QPP policies, review the Policy Comparison Table later in this resource.

MIPS Value Pathways (MVPs) Development & Strategy

- We're **sunsetting the traditional MIPS reporting option after the CY 2030 performance period**. MVPs will be the only MIPS reporting option for MIPS eligible clinicians that don't participate in a MIPS Alternative Payment Model (APM) beginning in the CY 2031 performance period. Clinicians in a MIPS APM will continue to be able to report the APP.
- **Virtual groups will be able to report MVPs** beginning with the CY **2029** performance period.
- **3 new MVPs** will be available for reporting in the CY 2027 performance period.
  - Diabetic Disease
  - Hospitalist
  - Hypertension
- We're **modifying all 27 existing MVPs** to include MIPS core measure selections for each MVP, add measures that expand upon a clinical concept or capture additional specialties most applicable to report an MVP, address maintenance requests from the public, and remove measures and activities that will either be finalized for removal from their respective MIPS inventory or replaced by more robust measures. We also renamed Rehabilitative Support for Musculoskeletal Care MVP to Rehabilitative Support MVP to better reflect the measures and activities included in the MVP.

MIPS Performance Categories

- We're finalizing a new MIPS **core measure** requirement for the quality performance category.
- **We're removing the outcome / high priority measure reporting requirement** in traditional MIPS and MVP quality reporting and replacing it **with a MIPS core measure reporting requirement.**
- We're **removing** the **ONC (Office of the National Coordinator for Health Information Technology) Direct Review (required)** and **ONC-Authorized Certification Body (ACB) Surveillance (optional) attestations** for the CY 2026 performance period **and the Security Risk Analysis measure** for the CY 2027 performance period for the Promoting Interoperability performance category.

- The previously finalized **Electronic Prior Authorization measure will be an optional/bonus measure for the CY 2027 performance period** for the Promoting Interoperability performance category; it will become **required starting with the CY 2028 performance period.**
- A **new Electronic Prior Authorization for Prescription Drugs measure** will be **required** starting with the **CY 2028 performance period** for the Promoting Interoperability performance category.

Advanced APMs

- We'll **apply** Qualifying APM Participant (**QP**) **and Partial QP determinations at the** Taxpayer Identification Number/National Provider Identifier (**TIN/NPI**) **level** instead of the NPI level, ensuring that financial incentives are directed only to TINs actively participating in Advanced APMs. Partial QP status will be extended to all TIN/NPI combinations for NPIs that achieve QP and Partial QP status based on individual determinations.
- We're **updating the QP and Partial QP thresholds for the CY 2026 performance period, 2028 payment year and APM Incentive Payment**, as a result of the Consolidated Appropriations Act, 2026.

Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs)

- We're **extending the availability of the MIPS Clinical Quality Measures (MIPS CQMs)** collection type for Shared Savings Program ACOs and the MIPS CQM reporting incentive for the CY 2027 performance period and subsequent years.
- All measures of the Medicare CQMs for ACOs Participating in the Medicare Shared Savings Program (**Medicare CQMs) collection type will be scored using flat benchmarks for the CY 2027 performance period and subsequent performance periods**; we're also **retroactively applying flat benchmarks** to 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), if reported via the Medicare CQMs collection type in the **CY 2026 performance period**.
- We're **establishing a new collection type for Shared Savings Program ACOs** reporting the APM Performance Pathway (APP) Plus quality measure set for the CY 2027 performance period and subsequent performance periods: Medicare Electronic Clinical Quality Measures for Accountable Care Organizations Participating in the Medicare Shared Savings Program **(Medicare eCQMs)**. The Medicare eCQM patient population will be based on the ACO's assigned beneficiaries.
- We're revising the definition of a "beneficiary eligible for Medicare CQMs" for the CY 2027 performance period and subsequent performance periods, to align with the population of beneficiaries assigned to the ACO.
- We're **modifying the Shared Savings Program Certified Electronic Health Record Technology (CEHRT) use requirements**.
- For more information on the finalized policies specific to participation in the Shared Savings Program, review the Medicare Shared Savings Program Policies Fact Sheet**.** (Link to be added once available.)

QPP Policy Comparison Table: Previous Policies vs. Newly Finalized Policies

- MIPS Overview
- Public Reporting Overview
- Advanced APMs Overview
- Frequently Asked Questions

Appendices

- Appendix A: Previously Finalized Policies for the 2027 Performance Period
- Appendix B: New Quality Measures Finalized for the 2027 Performance Period and Future Years
- Appendix C: New Quality Measures Finalized for the 2028 Performance Period and Future Years
- Appendix D: Quality Measures Finalized for Removal in the 2027 Performance Period and Future Years
- Appendix E: APP Plus Quality Measure Set and Collection Types Finalized for the 2027 Performance Period and Future Years
- Appendix F: New Improvement Activities Finalized for the 2027 Performance Period and Future Years
- Appendix G: Improvement Activities Finalized for Removal in the 2027 Performance Period and Future Years
- Appendix H: MIPS Core Measures and Their Associated MVPs

The **2027 Finalized MVPs Guide (PDF)** (available shortly after the publication of the final rule) documents information about the new and updated MVPs finalized for 2027.

The **Medicare Shared Savings Program Policies Fact Sheet** documents information about policies specific to Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs). (Link to be added once available.)

MIPS Overview

The following table outlines finalized policies applicable to one or more MIPS reporting options. There are 3 MIPS reporting options available:

- Traditional MIPS
- MIPS Value Pathways (MVPs)
- Alternative Payment Model (APM) Performance Pathway (APP)

Refer to the **2027 Finalized MVPs Guide** (once available) for information about the new and modified MVPs finalized for the CY 2027 performance period.

MIPS Value Pathways (MVPs) Development and Strategy

POLICY AREA	EXISTING POLICY	CY 2027 FINAL POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Full MVP Implementation	**Sunsetting Traditional MIPS** No existing policy, but since 2019 we've signaled our intent to sunset the traditional MIPS reporting option through future rulemaking.	**Sunsetting Traditional MIPS** We modified our proposal to sunset the traditional MIPS reporting option; while we proposed to sunset traditional MIPS after the CY 2028 performance period, **we're finalizing a policy to sunset traditional MIPS after the CY 2030 performance period**. Beginning with the CY 2031 performance period, MVPs will be the only MIPS reporting option for clinicians who don't participate in a MIPS APM. Clinicians participating in a MIPS APM will continue to have the option to report the APM Performance Pathway (APP)/APP Plus.	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2027 FINAL POLICY	APPLICABLE MIPS REPORTING OPTION(S)
MVP Development and Maintenance	**MVP Inventory** There are 27 MVPs finalized for reporting in the CY 2026 performance period.	**MVP Inventory** We're adding 3 new MVPs to the MVP inventory (for a total of 30 MVPs) in the CY 2027 performance period: • Diabetic Disease • Hypertension • Hospitalist We're also finalizing modifications to the 27 previously finalized MVPs, as proposed, including renaming the Rehabilitative Support for Musculoskeletal Care MVP to Rehabilitative Support MVP, and the identification of MIPS core measures in each MVP.	• **MVPs**
Virtual Group Reporting	**MVP Reporting** Virtual groups can't report an MVP.	**MVP Reporting** Virtual groups will be able to report an MVP beginning with the CY 2029 performance period.	• **MVPs**

Quality Performance Category

POLICY AREA	EXISTING POLICY	CY 2027 FINAL POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Quality Measures	**Quality Measure Inventory** There are 190 quality measures available for the 2026 performance period, excluding Qualified Clinical Data Registry (QCDR) measures which are approved outside the rulemaking process and are excluded from this total.	**Quality Measure Inventory** We're finalizing a total of 180 quality measures for the CY 2027 performance period. (QCDR measures are approved outside the rulemaking process and are excluded from this total.) The finalized inventory reflects: • Addition of 2 quality measures that focus on prevention and chronic disease management; one of these has a 1-year implementation delay to the CY 2028 performance period. (See Appendix B and Appendix C) • Adoption of 4 current QCDR measures as MIPS CQMs. (See Appendix B) • Replacement of 7 existing, functional improvement MIPS measures with 5 functional outcome measures for orthopedic patients. The 5 new measures were QCDR measures that are being finalized as MIPS CQMs. (See Appendix B) • Removal of 20 quality measures from the MIPS quality measure inventory. (See Appendix D). • Substantive changes to 43 existing quality measures.	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2027 FINAL POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Quality Measures	**High Priority Measure Designation** A high priority measure is defined as an outcome (including intermediate-outcome and patient-reported outcome), appropriate use, patient safety, efficiency, patient experience, care coordination, or opioid quality measure. A quality measure that otherwise meets the criteria for removal may be retained based on considerations including whether the quality measure is designated as high priority or not.	**High Priority Measure Designation** We're **removing the high priority designation** for quality measures**.** To align with this policy, we also will no longer include the use of a high priority measure designation as one of the considerations for retaining a MIPS quality measure.	• **Traditional MIPS** • **MVPs**
Quality Measures	**MIPS Core Measure Designation** No existing policy	**MIPS Core Measure Designation** We're finalizing a MIPS **core measure designation** for MVP and traditional MIPS quality reporting**.** This designation will apply to 78 measures in the MIPS inventory. (Refer to Appendix H.)	• **Traditional MIPS** • **MVPs**
Quality Reporting Requirements	**Requirement to Report an Outcome or High Priority Measure** MIPS eligible clinicians must report at least one outcome measure. If an applicable outcome measure isn't available, they can report a high priority measure instead.	**Requirement to Report an Outcome or High Priority Measure** We're **removing the requirement** that MIPS eligible clinicians report at least one outcome measure as one of their required measures, or a high priority measure if an applicable outcome measure isn't available.	• **Traditional MIPS** • **MVPs**

Quality Reporting Requirements	**Requirement to Report a MIPS Core Measure** No existing policy	**Requirement to Report a MIPS Core Measure** Instead of reporting an outcome measure (or high priority measure if an outcome measure isn't available), MIPS eligible clinicians will be required to report a MIPS core measure. **Small practices will be exempt from this requirement.** Specifically: • For traditional MIPS, clinicians will be required to report a MIPS core measure as 1 of their 6 quality measures. They can select any measure in the MIPS quality measure inventory with the MIPS core measure designation • For MVPs, clinicians will be required to report a MIPS core measure as 1 of their 4 quality measures. They can select any measure with the MIPS core measure designation for their selected MVP. If a clinician, group, virtual group, subgroup, or APM Entity reporting an MVP or traditional MIPS doesn't have an applicable MIPS core measure available to report: • They must attest that there are no applicable MIPS core measures available for them to report. • They must choose another measure to report in place of the MIPS core measure. **Small practices are exempt from the MIPS core measure requirement and the self-attestation process.**	• **Traditional MIPS** • **MVPs**

POLICY AREA	EXISTING POLICY	CY 2027 FINAL POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Quality Measure Scoring	**Scoring MIPS Core Measures** No existing policy	**Scoring MIPS Core Measures** If a MIPS eligible clinician, group, virtual group, subgroup, or APM Entity reporting an MVP or traditional MIPS doesn't report a MIPS core measure and isn't a small practice, they will receive 0 out of 10 points for one of their required measures unless they: • Submit an attestation that they don't have an applicable MIPS core measure. **AND** • Submit another measure in its place.	• **Traditional MIPS** • **MVPs**

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<tr><th>POLICY AREA</th><th>EXISTING POLICY</th><th>CY 2027 FINAL POLICY</th><th>APPLICABLE MIPS REPORTING OPTION(S)</th></tr>
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<td>Quality Measure Scoring</td>
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Defined Topped Out Measure Benchmarks
We apply an alternative benchmarking methodology to a subset of topped out measures (those that belong to specialty sets and MVPs with limited measure choice, a high proportion of topped out measures that are subject to the 7-point scoring cap, and in areas that lack measure development, which precludes meaningful participation in MIPS.)
Specifically, we'll apply the following benchmarks:
<table>
<tr><th>Performance Rate</th><th>Available Points</th></tr>
<tr><td>84-85.9%</td><td>1-1.9</td></tr>
<tr><td>86-87.9%</td><td>2- 2.9</td></tr>
<tr><td>88-89.9%</td><td>3-3.9</td></tr>
<tr><td>90-91.9%</td><td>4-4.9</td></tr>
<tr><td>92-93.9%</td><td>5-5.9</td></tr>
<tr><td>94-95.9%</td><td>6-6.9</td></tr>
<tr><td>96-97.9%</td><td>7-7.9</td></tr>
<tr><td>98-98.9%</td><td>8-8.9</td></tr>
<tr><td>99-99.99%</td><td>9-9.9</td></tr>
<tr><td>100%</td><td>10</td></tr>
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Defined Topped Out Measure Benchmarks
15 quality measures will receive the previously defined topped out measure benchmarks for the CY 2027 performance period, including 2 measures that aren't currently receiving the defined topped out measure benchmark. These measures belong to specialty sets and MVPs with limited measure choice and a high proportion of topped out measures, in areas that lack measure development, which precludes meaningful participation in MIPS.

These measures will be published and maintained on the QPP website instead of the Federal Register.
See FAQs below for the list of measures.

Beginning in the CY 2027 performance period, topped out MIPS core measures subject to the 7-point scoring cap (i.e., are topped out for 2 or more consecutive performance period) will no longer be subject to that cap and will instead be scored according to the defined topped out measure benchmark (with a 10-point maximum).
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Traditional MIPS
MVPs
APP

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Alternative Payment Model (APM) Performance Pathway (APP)	**APP Plus Quality Measure Set** Shared Savings Program ACOs are required to report the APP Plus quality measure set. The existing APP Plus quality measure set was established for the CY 2025 performance period and subsequent performance periods. (We note that the measure set was updated in the CY 2026 PFS final rule to reflect changes to the MIPS quality measure inventory.) **Measures Available Beginning with Performance Period 2025:** 1. Diabetes: Glycemic Status Assessment Greater than 9% (Quality ID: 001) 2. Preventive Care and Screening: Screening for Depression and Follow-up Plan (Quality ID: 134) 3. Controlling High Blood Pressure (Quality ID: 236) 4. CAHPS for MIPS (Quality ID: 321) 5. Hospital-Wide, 30-day, All Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups (Quality ID: 479) 6. Breast Cancer Screening (Quality ID: 112) **Additional Measures Available Beginning with Performance Period 2026:** 7. Colorectal Cancer Screening (Quality ID: 113) 8. Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions measure (Quality ID: 484)	**APP Plus Quality Measure Set** We're removing 2 previously finalized measures from the APP Plus quality measure set: • Initiation and Engagement of Substance Use Disorder Treatment (Quality ID: 305) • Adult Immunization Status (Quality ID: 493) There will be 8 measures in the APP Plus quality measure set in the CY 2027 performance period and subsequent performance periods. Refer to Appendix E for the APP Plus quality measure set, including the available collection types. Please note that CMS has finalized substantive changes to several MIPS measures included in the APP Plus quality measure set: • Diabetes: Glycemic Status Assessment Greater than 9% (Quality ID: 001) (eCQM 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) (These changes are in addition to the substantive change of creating the Medicare eCQM collection type for ACOs reporting the APP Plus quality measure set.)	• **APP**

POLICY AREA	EXISTING POLICY	CY 2027 FINAL POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Alternative Payment Model (APM) Performance Pathway (APP)	**APP Plus Quality Measure Set** (Continued) **Additional Measures to be Available Beginning with Performance Period 2027:** 9. Initiation and Engagement of Substance Use Disorder Treatment (Quality ID: 305) **Additional Measures to be Available Beginning with Performance Period 2028** (or the performance period that is one year after the eCQM specification becomes available, whichever is later): 10. Adult Immunization Status (Quality ID: 493)		
APP Plus Quality Reporting Requirements	**Collection Types for Shared Savings Program ACOs** In addition to ACOs administering the CAHPS for MIPS Survey and 2 administrative claims measures that are calculated by CMS, there are 3 collection types available to Shared Savings Program ACOs when reporting the APP Plus quality measure set: • eCQMs • Medicare CQMs • MIPS CQMs (available through the CY 2026 performance period)	**Collection Types for Shared Savings Program ACOs** We're **extending the availability of the MIPS CQMs collection type** for Shared Savings Program ACOs reporting the APP Plus quality measure set. • The MIPS CQMs collection type will remain available for ACO reporting in the CY 2027 performance period and subsequent performance periods. We're **revising the definition of a "beneficiary eligible for Medicare CQMs"** for the CY 2027 performance period and subsequent performance periods, to align with the population of beneficiaries assigned to the ACO.	• **APP**

POLICY AREA	EXISTING POLICY	CY 2027 FINAL POLICY	APPLICABLE MIPS REPORTING OPTION(S)
	Medicare eCQMs No existing policy	**Medicare eCQMs** For the CY 2027 performance period and subsequent performance periods, we're establishing a new collection type, Medicare eCQMs, which will only be available to Shared Savings Program ACOs reporting the APP Plus quality measure set. • The Medicare eCQM patient population will be based on the ACO's assigned beneficiaries (similar to Medicare CQMs). • We won't provide separate Medicare eCQM measure specifications. ACOs should use the eCQM measure specifications, report data on their assigned beneficiaries, and use a different identifier to distinguish that the submission is for a Medicare eCQM rather than for an eCQM. ACOs that choose to report Medicare eCQMs won't be eligible for the Complex Organization Adjustment or the eCQM/MIPS CQM reporting incentive under the Shared Savings Program.	• **APP**
APP Plus Quality Scoring	**Medicare CQM Benchmarks** Medicare CQMs are scored according to flat benchmarks for their first 2 years in MIPS, after which they're eligible to receive a historical benchmark.	**Medicare CQM Benchmarks** All measures of the Medicare CQMs collection type will be scored using flat benchmarks for the CY 2027 performance period and subsequent performance periods.	• **APP**

POLICY AREA	EXISTING POLICY	CY 2027 FINAL POLICY	APPLICABLE MIPS REPORTING OPTION(S)
	Medicare CQM Benchmarks Medicare CQMs are scored according to flat benchmarks for their first 2 years in MIPS, after which they're eligible to receive a historical benchmark.	**Medicare CQM Benchmarks** (Continued) We're also retroactively applying flat benchmarks to 3 Medicare CQMs for the CY 2026 performance period: • Diabetes: Glycemic Status Assessment Greater Than 9% (Quality ID: 001) • Preventive Care and Screening: Screening for Depression and Follow-up Plan (Quality ID: 134) • Controlling High Blood Pressure (Quality ID: 236) This means that **all Medicare CQMs will be scored using flat benchmarks for the CY 2026 performance period and subsequent performance periods**.	• **APP**
APP Plus Quality Scoring	**Medicare eCQM Benchmarks** No existing policy	**Medicare eCQM Benchmarks** All measures of the Medicare eCQMs collection type will be scored using flat benchmarks for the CY 2027 performance period and subsequent performance periods.	• **APP**

Cost Performance Category

POLICY AREA	EXISTING POLICY	CY 2027 FINAL POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Cost Measures	**Operational List of Care Episode and Patient Condition Groups and Codes** Section 1848(r)(2)(H) of the Act requires that not later than November 1 of each year, CMS revise the operational list of care episode and patient condition codes through rulemaking. This list is updated annually in conjunction with any newly added, removed, or modified cost measures in MIPS or to reflect any changes to codes used in the measure that are identified as part of measure maintenance.	**Operational List of Care Episode and Patient Condition Groups and Codes** We're updating this list to reflect non-substantive measure maintenance updates. The operational list is posted on the QPP Cost Measures Information page of the CMS website. There are no cost measure inventory updates for the CY 2027 performance period.	• Traditional MIPS • MVPs

Improvement Activities Performance Category

POLICY AREA	EXISTING POLICY	CY 2027 FINAL POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Improvement Activities	**Inventory** There are 95 improvement activities available for the 2026 performance period.	**Inventory** We're making the following changes to the improvement activities inventory for the CY 2027 performance period: • Addition of 6 new activities (See Appendix F) • Modification of 5 existing activities • Removal of 11 activities (See Appendix G)	• Traditional MIPS • MVPs

Promoting Interoperability Performance Category

POLICY AREA	EXISTING POLICY	CY 2027 FINAL POLICY	APPLICABLE MIPS REPORTING OPTION(S)
CEHRT Requirements	**Definition of Certified Electronic Health Record Technology (CEHRT)** The definition of CEHRT is as follows. For 2019 and subsequent years, electronic health record (EHR) technology (which could include multiple technologies) certified under the Office of the National Coordinator for Health Information Technology (ONC) Health Information Technology (IT) Certification Program that meets the 2015 Edition Base EHR definition, or subsequent Base EHR definition (as defined in 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) 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) The applicable measure calculation certification criterion at 45 CFR 170.315(g)(1) or (2) for all certification criteria that support an 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)(i) and (ii) and optionally (c)(4) and can be electronically accepted by CMS.	**Definition of Certified Electronic Health Record Technology (CEHRT)** We're modifying the definition of CEHRT at 42 CFR 414.1305 to align with the decertification policies for the ONC Health IT Certification Criteria as outlined in the Health Data, Technology, and Interoperability: ONC Deregulatory Actions to Unleash Prosperity (HTI-5) Final Rule. The following ONC Health IT Certification Criteria will be removed from the definition of CEHRT: • 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) • Clinical Quality Measures – Filter – 45 CFR 170.315 (c)(4) Additionally, we're modifying 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 aligns with policies in the HTI-5 Final Rule.	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2027 FINAL POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Promoting Interoperability Attestation Inventory	**ONC Direct Review Attestation and ONC-Authorized Certification Body (ACB) Surveillance Attestation** The ONC Direct Review attestation is a required attestation. The ONC Authorized Certification Body (ACB) Surveillance attestation is an optional attestation.	**ONC Direct Review Attestation and ONC-ACB Surveillance Attestation** We're **removing** the **required ONC Direct Review attestation** and **the optional ONC-ACB Surveillance attestation** starting with the CY **2026** performance period (data submission in CY 2027). Because these attestations are being removed from the program, clinicians should not submit them with their 2026 performance period data submission. Learn more in this FAQ.	• **Traditional MIPS** • **MVPs** • **APP**
Promoting Interoperability Measure Inventory	**Security Risk Analysis Measure** The Security Risk Analysis measure is a required measure.	**Security Risk Analysis Measure** We're **removing** the required **Security Risk Analysis measure** starting with the CY **2027** performance period.	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2027 FINAL POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Promoting Interoperability Measure Inventory	**Electronic Prior Authorization Measure** This is a "Yes"/ "No" attestation measure within the Health Information Exchange (HIE) objective. • MIPS eligible clinicians must attest that they have requested a prior authorization electronically via a Prior Authorization API using data from CEHRT for at least one medical item or service (excluding drugs) during the reporting period. This measure was finalized for inclusion in the Promoting Interoperability performance category starting with the CY 2027 performance period as outlined in the 2024 CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F).	**Electronic Prior Authorization Measure** We're modifying this measure in the following ways: • The measure will be an optional/bonus measure (10 bonus points) for the CY 2027 performance period. ○ The measure will become required starting with the CY 2028 performance period. • Require the use of CEHRT that includes Health IT Modules, certified to at least 1 of the 3 ONC Health IT certification for electronic prior authorization, to complete at least 1 prior authorization request for at least 1 medical item or service (excluding drugs) for the CY 2027 performance period. • Require the use of CEHRT that includes Health IT Modules certified to all 3 ONC electronic prior authorization criteria to complete at least 1 prior authorization request for at least 1 medical item or service (excluding drugs) beginning with the CY 2028 performance period.	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2027 FINAL POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Promoting Interoperability Measure Inventory	**Electronic Prior Authorization for Prescription Drugs Measure** No existing measure	**Electronic Prior Authorization for Prescription Drugs Measure** We're finalizing a **new measure, Electronic Prior Authorization for Prescription Drugs**, which will require the use of CEHRT to complete at least one prior authorization request for prescription drugs and medications. • This will be **a required measure** beginning with the CY **2028** performance period. This new measure aligns with policies proposed in the 2026 CMS Interoperability Standards and Prior Authorization for Drugs Proposed Rule (CMS-0062-P).	• **Traditional MIPS** • **MVPs** • **APP**

Final Scoring

POLICY AREA	EXISTING POLICY	CY 2027 FINAL POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Reweighting Performance Categories	**Automatic Extreme and Uncontrollable Circumstances Reweighting** We will determine if an individual MIPS eligible clinician is in an impacted area based on the practice location address listed in the Provider Enrollment, Chain and Ownership System (PECOS).	**Automatic Extreme and Uncontrollable Circumstances Reweighting** Beginning with the CY 2027 performance period, 2029 MIPS payment year, we're removing the specification of a data source (PECOS) for clinician location, so we have more flexibility to use the most up to date and accurate data source available to determine eligibility for reweighting under the automatic extreme and uncontrollable circumstances (EUC) policy.	• **Traditional MIPS** • **MVPs** • **APP**
	Reweighting in Cases Where Data Aren't Submitted by a Third-Party Intermediary MIPS eligible clinicians must notify CMS by November 1 of the data submission year if their data wasn't submitted by their third-party intermediary due to circumstances outside of the clinician's control.	**Reweighting in Cases Where Data Aren't Submitted by a Third-Party Intermediary** Beginning with the CY 2025 performance period, 2027 MIPS payment year, we're extending the deadline for clinicians to notify CMS from November 1 to December 31 of the data submission year.	• **Traditional MIPS** • **MVPs** • **APP**

Third-Party Intermediaries

POLICY AREA	EXISTING POLICY	CY 2027 FINAL POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Qualified Clinical Data Registries (QCDRs) and Qualified Registries	**Performance Feedback** QCDRs and qualified registries must provide performance feedback at least 4 times a year to "clinicians and groups", including specific feedback on how QPP participants compare to others who have submitted data on a given measure. **Third-party Intermediaries with Fewer Than 10 QPP Participants** Our sampling methodology for data validation purposes requires that the third-party intermediary must sample a combination of 3 percent of QPP participants for which the QCDR or qualified registry will submit MIPS data for the particular participation option. 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.	**Performance Feedback** We're replacing "clinicians and groups" with "individual clinicians, groups, virtual groups, subgroups, and APM entities" to clarify that the performance feedback should be provided at the level at which the data was submitted to reduce confusion. **Third-party Intermediaries with Fewer Than 10 QPP Participants** We're clarifying that if the QCDR or qualified registry submits MIPS data to CMS for fewer than 10 QPP participants, then the data validation audit sample must include all QPP participants to ensure that the data submitted are true, accurate, and complete.	• **Traditional MIPS** • **MVPs** • **APP**

POLICY AREA	EXISTING POLICY	CY 2027 FINAL POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Qualified Clinical Data Registries (QCDRs) and Qualified Registries	**QPP Participants with Fewer Than Five Patient Records** Our sampling methodology for patients' records data for auditing purposes requires that the third-party intermediary must submit a sample that includes at least 25% of the patients of each participation type in the sample, except that the sample for each must include a minimum of 5 patients and need not include more than 50 patients. **Submit a Participation Plan When Not Submitting Data for One Year** If a third-party intermediary doesn't submit data for either of the 2 years preceding the applicable self-nomination period, they must submit a participation plan with their self-nomination.	**QPP Participants with Fewer Than Five Patient Records** We're clarifying that if there are fewer than 5 patient records the patient record audit sample must include all patient records to ensure that the data submitted are true, accurate, and complete. **Submit a Participation Plan When Not Submitting Data for One Year** A third-party intermediary will be required to submit a participation plan with their self-nomination if they don't submit data for the year preceding the applicable self-nomination period. For example: • The 2028 self-nomination period will be July 1, 2027 – September 1, 2027. • The 2026 data submission period will be January 2, 2027 – March 31, 2027. • Qualified Registry X was approved to submit data for the CY 2026 performance period but didn't, so they would be required to submit a participation plan if they were self-nominating for the CY 2028 performance period.	• **Traditional MIPS** • **MVPs** **APP**

POLICY AREA	EXISTING POLICY	CY 2027 FINAL POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Qualified Clinical Data Registries (QCDRs) and Qualified Registries	**Changes to Qualified Posting** Third-party intermediaries are asked to review the "Qualified Posting", which is a CMS-generated posting that includes information about the measures/activities supported, the cost of the service, and the services included in the cost. **Termination When Not Submitting Data for One Year** A third-party intermediary that doesn't submit data for the performance period for which they submitted a self-nomination participation plan 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. **Data Submission** A QCDR or qualified registry must be able to submit data for at least 6 quality measures including an outcome measure on behalf of their clients; if an outcome measure isn't	**Changes to Qualified Posting** If a third-party intermediary has changes in information on its qualified posting after the qualified posting is publicly posted on the QPP website, then the qualified posting may not be updated for the public, even if the information is provided to CMS. Updates must be included and finalized during the qualified posting review period. **Termination When Not Submitting Data for One Year** Third-party intermediaries with a participation plan will also need to provide CMS with documentation that they have contracted with QPP participants who will submit MIPS data for the given MIPS performance period. CMS' query for documentation will occur before the end of the calendar year for the given MIPS performance period. • If documentation can't be provided by the date specified by CMS, the third-party intermediary will be terminated. **Data Submission** Beginning in the CY 2027 performance period, 2029 MIPS payment year, a QCDR or qualified registry must be able to submit data for at	• **Traditional MIPS** • **MVPs** **APP**

POLICY AREA	EXISTING POLICY	CY 2027 FINAL POLICY	APPLICABLE MIPS REPORTING OPTION(S)
	available, they must be able to submit a high priority measure in its place.	least 6 quality measures including at least one MIPS core measure.	

Public Reporting Overview

POLICY AREA	EXISTING POLICY	CY 2027 FINAL POLICY	APPLICABLE MIPS REPORTING OPTION(S)
Public Reporting Delays	There's a 1-year delay in publicly reporting new improvement activities and Promoting Interoperability measure and attestation information for MVP participants on Compare Tools.	We're removing the requirement that we won't publicly report any MVP data on new improvement activity or Promoting Interoperability measure, objective, or activity during the first year in which it is included in an MVP.	• **MVPs**

Advanced APMs Overview

POLICY AREA	EXISTING POLICY	CY 2027 FINAL POLICY
Qualifying APM Participants (QPs)	**Application of QP and Partial QP Status** Clinicians participating in Advanced APMs (e.g., ACOs) who meet specific thresholds become Qualifying APM Participants (QPs) and receive payment incentives in lieu of MIPS participation. Beginning in 2026, QPs receive a higher fee schedule update that grows by 0.5% annually relative to non-QPs. Under current policy, QP determinations are made at the NPI level, meaning financial incentives flow to all TINs under which the clinician bills, including those not participating in any Advanced APM. • Clinicians who achieve QP status are exempt from MIPS at every TIN they bill under. Partial QPs are provided with the option to participate or remain excluded from MIPS.	**Application of QP and Partial QP Status** We'll apply QP and Partial QP determinations at the TIN/NPI level, ensuring that financial incentives are directed only to TINs actively participating in Advanced APMs. However, we're modifying our final policy in the following way: • Partial QP status will be extended to all TIN/NPI combinations for NPIs that achieve QP and Partial QP status based on individual determinations. • This modification will ensure participants in Advanced APMs who meet these thresholds are able to elect to participate in MIPS or be excluded.

<table>
<tr>
<td>Qualifying APM Participants (QPs)</td>
<td>
QP thresholds

Under existing policy, the QP thresholds are as such:

<table>
<tr><th>Performance Year</th><th>Payment Year</th><th>QP Payment Amount</th><th>QP Patient Count</th></tr>
<tr><td>2024</td><td>2026</td><td>50%</td><td>35%</td></tr>
<tr><td>2025 and beyond</td><td>2027 and beyond</td><td>75%</td><td>50%</td></tr>
</table>
</td>
<td>
QP thresholds

As a result of the Consolidated Appropriations Act, 2026, we're updating the QP thresholds as such:

<table>
<tr><th>Performance Year</th><th>Payment Year</th><th>QP Payment Amount</th><th>QP Patient Count</th></tr>
<tr><td>2024</td><td>2026</td><td>50%</td><td>35%</td></tr>
<tr><td>2025</td><td>2027</td><td>75%</td><td>50%</td></tr>
<tr><td>2026</td><td>2028</td><td>50%</td><td>35%</td></tr>
<tr><td>2027 and beyond</td><td>2029 and beyond</td><td>75%</td><td>50%</td></tr>
</table>
</td>
</tr>
<tr>
<td>Qualifying APM Participants (QPs)</td>
<td>
Partial QP thresholds

Under existing policy, the Partial QP thresholds are as such:

<table>
<tr><th>Performance Year</th><th>Payment Year</th><th>Partial QP Payment Amount</th><th>Partial QP Patient Count</th></tr>
<tr><td>2024</td><td>2026</td><td>40%</td><td>25%</td></tr>
<tr><td>2025 and beyond</td><td>2027 and beyond</td><td>50%</td><td>35%</td></tr>
</table>
</td>
<td>
Partial QP thresholds

As a result of the Consolidated Appropriations Act, 2026, we're updating the Partial QP thresholds as such:

<table>
<tr><th>Performance Year</th><th>Payment Year</th><th>Partial QP Payment Amount</th><th>Partial QP Patient Count</th></tr>
<tr><td>2024</td><td>2026</td><td>40%</td><td>25%</td></tr>
<tr><td>2025</td><td>2027</td><td>50%</td><td>35%</td></tr>
<tr><td>2026</td><td>2028</td><td>40%</td><td>25%</td></tr>
<tr><td>2027 and beyond</td><td>2029 and beyond</td><td>50%</td><td>35%</td></tr>
</table>
</td>
</tr>
</table>

Frequently Asked Questions (FAQs)

Are there any policies that were finalized with modifications?

Yes, there are 2 policies that were finalized with modification from the original proposal.

We proposed:	We finalized:
Sunsetting traditional MIPS after CY 2028 performance period	Sunsetting traditional MIPS after CY 2030 performance period
Applying a clinician's QP and partial QP status to the TIN/NPI combination(s) under which it was received. • Any TIN/NPI combination that didn't achieve QP or partial QP status would be subject to MIPS eligibility determinations.	Applying a clinician's QP status to the TIN/NPI combination(s) under which it was received. • Applying partial QP status to the TIN/NPI combinations that aren't listed as participants in an Advanced APM.

Are there any policies previously finalized for the 2027 performance period?

Yes. Please refer to Appendix A for a list of policies previously finalized for the 2027 performance period.

Are MVPs required in 2027?

No, MVPs will remain optional through the CY 2030 performance period. During this time, MVPs will be 1 of 3 MIPS reporting options, along with traditional MIPS and the APM Performance Pathway (APP). **However, MVPs will become required in the CY 2031 performance period** for MIPS eligible clinicians who aren't also participants in a MIPS APM. (Clinicians in a MIPS APM will continue to have the option to report the APP.)

What MVPs are available for reporting in 2027?

There are 30 MVPs available to report in the 2027 performance period:

- Diabetic Disease (NEW)
- Hypertension (NEW)
- Hospitalist (NEW)
- 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
- Optimal Care for Kidney Health
- Optimal Care for Patients with Urologic Conditions
- Pathology
- Patient Safety and Support of Positive Experiences with Anesthesia
- Podiatry
- Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV
- Pulmonology Care
- Quality Care for Patients with Neurological Conditions
- Quality Care for the Treatment of Ear, Nose, and Throat Disorders
- Quality Care in Mental Health and Substance Use Disorders
- Rehabilitative Support (UPDATED NAME)
- Surgical Care
- Value in Primary Care
- Vascular Surgery

Where can I learn more about the MVP reporting option?

Visit these pages on the QPP website:

- MIPS Value Pathways (MVPs) webpage (general information)
- MVP Registration
- Compare Reporting Requirements

Access these resources on the QPP Resource Library

- MVPs Group and Subgroup Participation Examples (PDF)
- MVP Transition Toolkit for Small Practices (ZIP)
- The 2027 MVPs Implementation Guide will be available in early 2027.

Which quality measures are eligible for the topped out measure benchmarks for the 2027 performance period?

The following measures (in a table beginning on the next page) will be scored according to topped out measure benchmarks if they're identified as topped out measures when we calculate 2027 historical benchmarks. If any of these measures aren't identified as topped out for 2027, they'll be scored according to a historical benchmark. In addition to these measures, we'll apply the topped out measure benchmarks to any MIPS core measure that's determined to qualify for the 7 point scoring cap.

Quality ID	Measure Title	Collection Type
127	Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear	MIPS CQM
144	Oncology: Medical and Radiation - Plan of Care for Pain	MIPS CQM
145	Radiology: Exposure Dose Indices Reported for Procedures Using Fluoroscopy	MIPS CQM
249	Barret's Esophagus	Medicare Part B Claims Measure, MIPS CQM
250	Radical Prostatectomy Pathology Reporting	Medicare Part B Claims Measure, MIPS CQM
351	Total Knee or Hip Replacement: Venous Thromboembolic and Cardiovascular Risk Evaluation	MIPS CQM
360	Optimizing Patient Exposure to Ionizing Radiation: Count of Potential High Dose Radiation Imaging Studies: Computed Tomography (CT) and Cardiac Nuclear Medical Studies	MIPS CQM
364	Optimized Patient Exposure to Ionizing Radiation: Appropriateness: Follow-up CT imaging for Incidentally Detected Pulmonary Nodules According to Recommended Guidelines	MIPS CQM
395	Lung Cancer Reporting (Biopsy/Cytology Specimens)	Medicare Part B Claims Measure, MIPS CQM
396	Lung Cancer Reporting (Resection Specimens)	MIPS CQM
397	Melanoma Reporting	Medicare Part B Claims Measure, MIPS CQM
405	Appropriate Follow-up Imaging for Incidental Abdominal Lesions	MIPS CQM
406	Appropriate Follow-up Imaging for Incidental Thyroid Nodules in Patients	Medicare Part B Claims Measure, MIPS CQM
440	Skin Cancer: Biopsy Reporting Time Pathologist to Clinician	MIPS CQM
477	Multimodal Pain Management	MIPS CQM

Which quality measures are identified as MIPS core measures for the CY 2027 performance period?

There are 77 quality measures identified as MIPS core measures for the CY 2027 performance period. Please refer to Appendix H for a list of these measures, and the MVP (or MVPs) in which they're considered a MIPS core measure. Except as noted in this Appendix, any of these measures will meet the MIPS core measure reporting requirement in traditional MIPS.

Will Medicare CQMs be score according to flat benchmarks in the CY 2026 and subsequent performance periods?

Yes, as finalized in this rule, all Medicare CQMs (only available to Shared Savings Program ACOs reporting the APP Plus quality measure set) will be scored using flat benchmarks in the 2026 performance period and subsequent performance periods.

When will measure specifications, supporting documentation, and activity descriptions be available for finalized measures/activities?
Measure specifications, activity descriptions, and supporting documentation (such as single source documentation that lets you search for codes that qualify for a given measure) will be posted on the QPP Resource Library before the performance period begins on January 1, 2027.

(When searching in the QPP Resource Library, scroll past the General and Regulatory Resource sections until you reach the "Full Resource Library." Filter by the 2027 Performance Year and choose "Measure Specifications and Benchmarks" as the Resource type.)

When will historical quality benchmarks be available for the 2027 performance period?
We anticipate that the historical 2027 quality measure benchmarks will be available on the Benchmarks page of the QPP website in late January 2027.

Where can I find a list of quality measures topped out for the 2027 performance period?
We identify topped out quality measures, including those capped at 7 points or subject to the topped out benchmarking methodology, through the benchmarking process. We anticipate that the 2027 historical quality benchmarks will be available in late January 2027.

What's the maximum negative payment adjustment for the CY 2027 performance period, 2029 MIPS payment year?
As specified in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the maximum negative payment adjustment for the 2022 payment year (2020 performance year) and beyond is **-9%**.

The **actual** payment adjustment (positive, neutral, or negative) you'll receive for the 2029 MIPS payment year will be based on your MIPS final score from the 2027 performance period and may be subject to a scaling factor to ensure budget neutrality, as required by MACRA.

Will the removal of the ONC Direct Review attestation or ONC-ACB Surveillance (optional) attestation affect CY 2026 performance period submissions?

Yes, these attestations will need to be removed from any data that will be submitted via file upload or Application Programming Interface (API) prior to submission (data submission period January 4 – March 31, 2027). Any file upload or Application Programming Interface (API) submission that includes either of these attestations will be rejected. (We'll remove the option to attest to either the ONC Direct Review or the ONC-ACB Surveillance from manual entry submissions.)

How many points do I need to avoid a negative payment adjustment for the CY 2027 performance period, 2029 MIPS payment year?
The performance threshold is the number against which your final score is compared to determine your payment adjustment.

- **As previously finalized, the performance threshold will be 75 points through the CY 2028 performance period, 2030 MIPS payment year.**

The table below provides more information about the relationship between 2027 (and 2028) final scores and 2029 (and 2030) payment adjustments.

Your 2027 (and 2028) Final Score	Payment Impact for MIPS Eligible Clinicians for the 2029 (and 2030) MIPS Payment Year
0.00 – 18.75 points	-9% payment adjustment
18.76 – 74.99 points	Negative payment adjustment (between -9% and 0%)
75.00 points (Performance threshold=75.00 points)	Neutral payment adjustment (0%)
75.01 – 100.00 points	Positive payment adjustment (scaling factor applied to meet statutory budget neutrality requirements)

Contact Us

We encourage clinicians to contact the QPP Service Center. Contact the Quality Payment Program Service Center by emailing QPP@cms.hhs.gov, submitting a QPP Service Center ticket, or calling at 1-866-288-8292 (Monday-Friday, 8 a.m. - 8 p.m. ET). People who are deaf or hard of hearing can dial 711 to be connected to a TRS Communications Assistant. You can also visit the Quality Payment Program website for educational resources, information, and upcoming webinars.

Version History

Date	Change Description
11/02/2026	Original Version.

Appendix A: Previously Finalized Policies for the 2027 Performance Period

The table below identifies policies finalized in an earlier rule that apply to the 2027 performance period.

Policy Area	Previously Finalized Policy Applicable to the CY 2027 Performance Period
Final Scoring	
Performance Threshold	We previously finalized that the performance threshold is set at 75 points through the CY 2028 performance period.

Appendix B: New Quality Measures Finalized for the 2027 Performance Period and Future Years

Measure Title And Steward	Description	Collection Type	Measure Type	Rationale for Inclusion
Q517: Low Density Lipoprotein Cholesterol (LDL-C) Monitoring and Management American Heart Association	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.	MIPS CQM	Intermediate Outcome	We are finalizing this outcome measure because it addresses care for adult patients with clinical atherosclerotic cardiovascular disease (ASCVD), ensuring they are tested annually for LDL-C and have achieved a desired LDL-C outcome. Studies support that lowering LDL-C produces marked reduction in clinical ASCVD and that lower is better for LDL-C. This measure aims to ensure that patients receiving cholesterol lowering treatment, such as statin therapy, achieve an LDL-C of <70 mg/dL, resulting in a reduction in ASCVD risk and improved patient outcomes.
Q518: Functional Improvement for Patients with Neck Impairments Limber Health, Inc. and Patient360, LLC	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).	MIPS CQM	Patient-Reported Outcome-Based Performance Measure (PRO-PM)	We are finalizing this current QCDR patient-reported outcome-based performance measure to replace current MIPS CQM, Q478: Functional Status Change for Patients with Neck Impairments. This new measure addresses the same clinical topic but allows for broader implementation by including widely available 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, allowing for more streamlined reporting of rehabilitative care.

Measure Title And Steward	Description	Collection Type	Measure Type	Rationale for Inclusion
Q519: Functional Improvement for Patients with Upper Extremity Impairments Limber Health, Inc. and Patient360, LLC	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).	MIPS CQM	Patient-Reported Outcome-Based Performance Measure (PRO-PM)	We are finalizing this current QCDR patient-reported outcome-based performance measure to replace current MIPS CQM, Q222: Functional Status Change for Patients with Elbow, Wrist or Hand Impairments. This new measure addresses the same clinical topic but allows for broader implementation by including widely available 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, reducing burden for reporting this important aspect of rehabilitative care.
Q520: Functional Improvement for Patients with Back Impairments Limber Health, Inc. and Patient360, LLC	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).	MIPS CQM	Patient-Reported Outcome-Based Performance Measure (PRO-PM)	We are finalizing this current QCDR patient-reported outcome-based performance measure to replace current MIPS CQM, Q220: Functional Status Change for Patients with Low Back Impairments. This new measure addresses the same clinical topic but allows for broader implementation by including widely available 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, reducing burden for reporting this important aspect of rehabilitative care.

Measure Title And Steward	Description	Collection Type	Measure Type	Rationale for Inclusion
Q521: Functional Improvement for Patients with Lower Extremity Impairments Limber Health, Inc. and Patient360, LLC	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).	MIPS CQM	Patient-Reported Outcome-Based Performance Measure (PRO-PM)	We are finalizing this current QCDR patient-reported outcome-based performance measure to replace current MIPS CQMs, 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 addresses the same clinical topic but allows for broader implementation by including widely available 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, reducing burden for reporting this important aspect of rehabilitative care.
Q522: Functional Improvement for Patients with Knee Impairments Limber Health, Inc. and Patient360, LLC	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).	MIPS CQM	Patient-Reported Outcome-Based Performance Measure (PRO-PM)	We are finalizing this current QCDR patient-reported outcome-based performance measure to replace current MIPS CQM, Q217: Functional Status Change for Patients with Knee Impairments. This new measure addresses the same clinical topic but allows for broader implementation by including widely available 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, reducing burden for reporting this important aspect of rehabilitative care.

Measure Title And Steward	Description	Collection Type	Measure Type	Rationale for Inclusion
Q523: Age-Related Hearing Loss: Comprehensive Audiometric Evaluation American Academy of Otolaryngology - Head and Neck Surgery Foundation	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.	MIPS CQM	Process	We are finalizing this current QCDR measure as it fills a gap in the Quality Care for the Treatment of Ear, Nose, and Throat Disorders MVP, is specific to audiology, and ensures that patients that fail a hearing screen receive a comprehensive audiometric evaluation. Age-related hearing loss is a prevalent condition, though often undiagnosed in patients aged 50 and older. Deleterious downstream health risks include dementia, depression, cardiovascular disease, and falls. Implementation of this measure as a MIPS CQM will allow wider availability for reporting by MIPS eligible clinicians.
Q524: Patient-Reported Experience with Anesthesia American Society of Anesthesiologists Anesthesia Quality Institute	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.	MIPS CQM	Patient-Reported Outcome-Based Performance Measure (PRO-PM)	We are finalizing this current QCDR patient-reported outcome-based performance measure as it fills a gap in the Anesthesiology Specialty Set and is a potential addition to the Patient Safety and Support of Positive Experiences with Anesthesia MVP. It would be the only patient experience of care measure for that specialty and is reported for each procedure. It ensures patients receive a valid survey and assesses for reports of 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 delivered. There is a vast array of tools available for practices and individual clinicians to implement based upon local patient populations.

Measure Title And Steward	Description	Collection Type	Measure Type	Rationale for Inclusion
Q525: 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)	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.	MIPS CQM	Intermediate Outcome	We are finalizing this current QCDR measure as it fills a gap in the Anesthesiology Specialty Set and is a potential addition to the Patient Safety and Support of Positive Experiences with Anesthesia MVP. This inverse, intermediate outcome measure ensures a patient's MAP does not fall below 65mmHg for greater than 15 minutes during a procedure as this clinical event is associated with adverse outcomes such as kidney or myocardial injury.
Q526: SGLT2 Inhibitors for Patients with Chronic Kidney Disease (CKD) With or Without type 2 Diabetes Mellitus A Value-Based Care Registry	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.	MIPS CQM	Process	We are finalizing this current QCDR measure as it fills a gap in the MIPS Quality Measure Inventory and promotes appropriate, evidence based treatment of patients diagnosed with CKD with SGLT2 inhibitors. These medications have been shown to slow the progression of CKD and reduce cardiovascular events in this patient population. This measure has potential to be included in multiple Specialty Sets and MVPs, as it could be reported by Cardiology, Endocrinology, Family Medicine, Geriatrics, Internal Medicine, Nephrology, and Primary Care.

Appendix C: New Quality Measure Finalized for the 2028 Performance Period and Future Years

Measure Title And Steward	Description	Collection Type	Measure Type	Rationale for Inclusion
Q527: Rate of Timely Follow-up on Abnormal Screening Mammograms for Breast Cancer Detection Brigham and Women's Hospital	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.	eCQM	Process	We are finalizing this eCQM because it addresses timely follow up 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. We are finalizing a one-year delay in implementation to allow time for clinicians to adapt their workflows and therefore ensure greater feasibility of reporting this measure within MIPS.

Appendix D: Quality Measures Finalized for Removal in the 2027 Performance Period and Future Years

Quality #	Collection Type / Measure Type	Measure Title and Description	Measure Steward	Rationale for Removal
006	MIPS CQM Process	**Coronary Artery Disease (CAD): Antiplatelet Therapy:** 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.	American Heart Association	No longer maintained by measure steward
007	eCQM, MIPS CQM Process	**Coronary Artery Disease (CAD): Beta-Blocker Therapy – Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF ≤ 40%):** 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.	American Heart Association	No longer maintained by measure steward
143	eCQM, MIPS CQM Process	**Oncology: Medical and Radiation – Pain Intensity Quantified:** 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.	American Society of Clinical Oncology	End of topped out lifecycle with limited opportunity to improve clinical outcomes
217	MIPS CQM Patient-Reported Outcome-Based Performance Measure	**Functional Status Change for Patients with Knee Impairments:** 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.	Focus on Therapeutic Outcomes, Inc.	Duplicative of new measure: Functional Improvement for Patients with Knee Impairments

Quality #	Collection Type / Measure Type	Measure Title and Description	Measure Steward	Rationale for Removal
218	MIPS CQM Patient-Reported Outcome-Based Performance Measure	**Functional Status Change for Patients with Hip Impairments:** 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.	Focus on Therapeutic Outcomes, Inc.	Duplicative of new measure: Functional Improvement for Patients with Lower Extremity Impairments
219	MIPS CQM Patient-Reported Outcome-Based Performance Measure	**Functional Status Change for Patients with Lower Leg, Foot or Ankle Impairments:** 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.	Focus on Therapeutic Outcomes, Inc.	Duplicative of new measure: Functional Improvement for Patients with Lower Extremity Impairments
220	MIPS CQM Patient-Reported Outcome-Based Performance Measure	**Functional Status Change for Patients with Low Back Impairments:** 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.	Focus on Therapeutic Outcomes, Inc.	Duplicative of new measure: Functional Improvement for Patients with Back Impairments

Quality #	Collection Type / Measure Type	Measure Title and Description	Measure Steward	Rationale for Removal
221	MIPS CQM Patient-Reported Outcome-Based Performance Measure	**Functional Status Change for Patients with Shoulder Impairments:** 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.	Focus on Therapeutic Outcomes, Inc.	Duplicative of new measure: Functional Improvement for Patients with Upper Extremity Impairments
222	MIPS CQM Patient-Reported Outcome-Based Performance Measure	**Functional Status Change for Patients with Elbow, Wrist or Hand Impairments:** 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.	Focus on Therapeutic Outcomes, Inc.	Duplicative of new measure: Functional Improvement for Patients with Upper Extremity Impairments
320	Medicare Part B Claims Measure, MIPS CQM Process	**Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients:** 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.	American Gastroenterological Association	End of topped out lifecycle with limited opportunity to improve clinical outcomes
326	MIPS CQM Process	**Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy:** 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.	American Heart Association	No longer maintained by measure steward

Quality #	Collection Type / Measure Type	Measure Title and Description	Measure Steward	Rationale for Removal
332	MPS CQM Process	**Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use):** 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.	American Academy of Otolaryngology – Head and Neck Surgery Foundation	Duplicative of existing measure: Q331: Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse)
350	MIPS CQM Process	**Total Knee or Hip Replacement: Shared Decision-Making: Trial of Conservative (Non-surgical) Therapy:** 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.	American Association of Hip and Knee Surgeons	Process measure
378	eCQM Outcome	**Children Who Have Dental Decay or Cavities:** 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.	Centers for Medicare & Medicaid Services	The robustness of the quality measure (assesses incidence only)
384	MIPS CQM Outcome	**Adult Primary Rhegmatogenous Retinal Detachment Surgery: No Return to the Operating Room Within 90 Days of Surgery:** 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.	American Academy of Ophthalmology	End of topped out lifecycle with limited opportunity to improve clinical outcomes
415	MIPS CQM Efficiency	**Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older:** 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.	American College of Emergency Physicians	End of topped out lifecycle with limited opportunity to improve clinical outcomes

Quality #	Collection Type / Measure Type	Measure Title and Description	Measure Steward	Rationale for Removal
430	MIPS CQM Process	**Prevention of Post-Operative Nausea and Vomiting (PONV) – Combination Therapy:** 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.	American Society of Anesthesiologists	End of topped out lifecycle with limited opportunity to improve clinical outcomes
463	MIPS CQM Process	**Prevention of Post-Operative Vomiting (POV) – Combination Therapy (Pediatrics):** 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.	American Society of Anesthesiologists	End of topped out lifecycle with limited opportunity to improve clinical outcomes
478	MIPS CQM Patient-Reported Outcome-Based Performance Measures	**Functional Status Change for Patients with Neck Impairments:** 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.	Focus on Therapeutic Outcomes, Inc.	Duplicative of new measure: Functional Improvement for Patients with Neck Impairments

Quality #	Collection Type / Measure Type	Measure Title and Description	Measure Steward	Rationale for Removal
483	MIPS CQM Patient-Reported Outcome-Based Performance Measure	**Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM):** 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.	The American Board of Family Medicine	Limited adoption of this quality measure does not allow for the creation of a benchmark

Appendix E: APP Plus Quality Measure Set and Collection Types Finalized for the 2027 Performance Period and Future Years

Quality #	Measure Title	Collection Type
001	Diabetes: Glycemic Status Assessment Greater Than 9%	• eCQMs • Medicare eCQMs (Shared Savings Program ACOs only) • Medicare CQMs (Shared Savings Program ACOs only) • Medicare Part B Claims (excluding Shared Savings Program ACOs) • MIPS CQMs
112	Breast Cancer Screening	• eCQMs • Medicare eCQMs (Shared Savings Program ACOs only) • Medicare CQMs (Shared Savings Program ACOs only) • Medicare Part B Claims (excluding Shared Savings Program ACOs) • MIPS CQMs
113	Colorectal Cancer Screening	• eCQMs • Medicare eCQMs (Shared Savings Program ACOs only) • Medicare CQMs (Shared Savings Program ACOs only) • Medicare Part B Claims (excluding Shared Savings Program ACOs) • MIPS CQMs
134	Preventive Care and Screening: Screening for Depression and Follow-up Plan	• eCQMs • Medicare eCQMs (Shared Savings Program ACOs only) • Medicare CQM (Shared Savings Program ACOs only) • Medicare Part B Claims (excluding Shared Savings Program ACOs) • MIPS CQM
236	Controlling High Blood Pressure	• eCQM • Medicare eCQM (Shared Savings Program ACOs only) • Medicare CQMs (Shared Savings Program ACOs only) • Medicare Part B Claims (excluding Shared Savings Program ACOs) • MIPS CQMs
321	CAHPS for MIPS	• CAHPS for MIPS Survey
479	Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups	• Administrative Claims
484	Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	• Administrative Claims

Appendix F: New Improvement Activities Finalized for the 2027 Performance Period and Future Years

Activity Title	Activity Description	Subcategory	Rationale
Use of Data to Improve Practice Workflows	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 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.	Care Coordination	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. Development of such pathways requires clinical expertise and time, although a 10-step process has been established by other organizations. By including a multi-disciplinary team in the 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.

Activity Title	Activity Description	Subcategory	Rationale
Understand and Improve Diagnostic Performance	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 supports diagnostic transparency, builds staff competency through training, and improves 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 should 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.	Care Coordination	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. 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.

Activity Title	Activity Description	Subcategory	Rationale
Systematic Screening and Intervention for Nutrition and other Health-Impacting, Non-Clinical Issues	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.	Advancing Health and Wellness	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.

Activity Title	Activity Description	Subcategory	Rationale
Advance Care Planning Conversations to Support Patient Wellness and Care Preferences	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 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.	Advancing Health and Wellness	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.

Activity Title	Activity Description	Subcategory	Rationale
Clinician Use of Artificial Intelligence (AI) to Improve Patient Care	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 • 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.	Advancing Health and Wellness	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 wellbeing. 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.

Activity Title	Activity Description	Subcategory	Rationale
Lifestyle Approaches to Diabetes Remediation	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) • CDC Diabetes Self-Management Education and Support (DSMES) • American Diabetes Association Institute of Learning – Hands On Webinar: Diet, Lifestyle, Medicine, and Beyond—Cardio Kidney Metabolic Strategies for Managing Obesity in People with Type 2 Diabetes	Advancing Health and Wellness	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.

Appendix G: Improvement Activities Finalized for Removal in the 2027 Performance Period and Future Years

Activity ID	Subcategory	Activity Title and Description
IA_BMH_5	Behavioral and Mental Health	**MDD prevention and treatment interventions:** Major depressive disorder: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including suicide risk assessment for mental health patients with co-occurring conditions of behavioral or mental health conditions.
IA_CC_10	Care Coordination	**Care transition documentation practice improvements:** 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.
IA_CC_11	Care Coordination	**Care transition standard operational improvements:** 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.
IA_CC_12	Care Coordination	**Care coordination agreements that promote improvements in patient tracking across settings:** 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.

Activity ID	Subcategory	Activity Title and Description
IA_PSPA_2	Patient Safety and Practice Assessment	**Participation in MOC Part IV:** 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.
IA_CC_16	Care Coordination	**Primary Care Physician and Behavioral Health Bilateral Electronic Exchange of Information for Shared Patients:** 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.
IA_BE_15	Beneficiary Engagement	**Engagement of Patients, Family, and Caregivers in Developing a Plan of Care:** 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.
IA_PM_19	Population Management	**Glycemic Screening Services:** 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.

Activity ID	Subcategory	Activity Title and Description
IA_PM_20	Population Management	**Glycemic Referring Services:** 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.
IA_EPA_4	Expanded Practice Access	**Additional improvements in access as a result of QIN/QIO TA:** As a result of Quality Innovation Network-Quality Improvement Organization technical assistance, performance of additional activities that improve access to services or improve care coordination (for example, investment of on-site diabetes educator).
IA_PM_2	Population Management	**Anticoagulant management improvements:** 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.

Appendix H. MIPS Core Measures and Their Associated MVPs

The following measures have been finalized as MIPS core measures for the 2027 performance period. These measures satisfy the MIPS core measure reporting requirement for traditional MIPS (except as noted) and for the applicable MVP(s) listed in the table below.

QUALITY ID	MEASURE NAME	Applicable MVPs
001	Diabetes: Glycemic Status Assessment Greater Than 9%	Diabetes (MVP ID: M1504), Value in Primary Care (MVP ID: M0005)
005	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)	Hospitalist (MVP ID: M1505)
008	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Hospitalist (MVP ID: M1505)
012	Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation	Complete Ophthalmologic Care (MVP ID: M1420)
039	Screening for Osteoporosis for Women Aged 65-85 Years of Age	Advancing Rheumatology Patient Care (MVP ID: G0053), Focusing on Women's Health (MVP ID: M1366)
047	Advance Care Plan	Hospitalist (MVP ID: M1505), Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes (MVP ID: G0054), Surgical Care (MVP ID: M1425)
050	Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older	Optimal Care for Patients with Urologic Conditions (MVP ID: M1423), Rehabilitative Support (MVP ID: M1370)
052	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation and Long-Acting Inhaled Bronchodilator Therapy	Pulmonology Care (MVP ID: M1424)
102	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	Advancing Cancer Care (MVP ID: M0001)
112	Breast Cancer Screening[1]	Focusing on Women's Health (MVP ID: M1366)
116	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	Adopting Best Practices and Promoting Patient Safety within Emergency Medicine (MVP ID: G0057)
126	Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy - Neurological Evaluation	Podiatry (MVP ID: M1502)
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan[1]	Diabetes (MVP ID: M1504), Hypertension (MVP ID: M1506)

[1] This measure has been removed from traditional MIPS; it can only be reported for specific MVPs.

134	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Neuropsychology (MVP ID: M1500), Value in Primary Care (MVP ID: M0005)
141	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 20% OR Documentation of a Plan of Care.	Complete Ophthalmologic Care (MVP ID: M1420)
144	Oncology: Medical and Radiation - Plan of Care for Pain	Advancing Cancer Care (MVP ID: M0001)
145	Radiology: Exposure Dose Indices Reported for Procedures Using Fluoroscopy	Diagnostic Radiology (MVP ID: M1498), Interventional Radiology (MVP ID: M1499)
155	Falls: Plan of Care	Podiatry (MVP ID: M1502), Rehabilitative Support (MVP ID: M1370)
164	Coronary Artery Bypass Graft (CABG): Prolonged Intubation	Surgical Care (MVP ID: M1425)
176	Tuberculosis Screening Prior to First Course of Biologic and/or Immune Response Modifier Therapy	Dermatological Care (MVP ID: M1421)
178	Rheumatoid Arthritis (RA): Functional Status Assessment	Advancing Rheumatology Patient Care (MVP ID: G0053)
180	Rheumatoid Arthritis (RA): Glucocorticoid Management	Advancing Rheumatology Patient Care (MVP ID: G0053)
181	Elder Maltreatment Screen and Follow-Up Plan	Neuropsychology (MVP ID: M1500)
205	Sexually Transmitted Infection (STI) Testing for People with HIV	Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV (MVP ID: M1368)
226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Hypertension (MVP ID: M1506), Gastroenterology Care (MVP ID: M1422)
236	Controlling High Blood Pressure	Hypertension (MVP ID: M1506), Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes (MVP ID: G0054), Optimal Care for Kidney Health (MVP ID: M0002), Value in Primary Care (MVP ID: M0005)
238	Use of High-Risk Medications in Older Adults	Quality Care for Patients with Neurological Conditions (MVP ID: M0004)
275	Inflammatory Bowel Disease (IBD): Assessment of Hepatitis B Virus (HBV) Status Before Initiating Anti-TNF (Tumor Necrosis Factor) Therapy	Gastroenterology Care (MVP ID: M1422)
279	Sleep Apnea: Assessment of Adherence to Obstructive Sleep Apnea (OSA) Therapy.	Pulmonology Care (MVP ID: M1424)
282	Dementia: Functional Status Assessment	Neuropsychology (MVP ID: M1500), Quality Care for Patients with Neurological Conditions (MVP ID: M0004)
304	Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery	Complete Ophthalmologic Care (MVP ID: M1420)
305	Initiation and Engagement of Substance Use Disorder Treatment	Quality Care in Mental Health and Substance Use Disorders (MVP ID: M1369)

317	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Diabetes (MVP ID: M1504)
331	Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse)	Adopting Best Practices and Promoting Patient Safety within Emergency Medicine (MVP ID: G0057), Quality Care for the Treatment of Ear, Nose, and Throat Disorders (MVP ID: M1367)
338	HIV Viral Suppression	Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV (MVP ID: M1368)
344	Rate of Carotid Endarterectomy (CEA) or Carotid Artery Stenting (CAS) for Asymptomatic Patients, Without Major Complications (Discharged to Home by Post-Operative Day #2)	Vascular Surgery (MVP ID: M1503)
351	Total Knee or Hip Replacement: Venous Thromboembolic and Cardiovascular Risk Evaluation	Improving Care for Lower Extremity Joint Repair (MVP ID: G0058)
354	Anastomotic Leak Intervention	Surgical Care (MVP ID: M1425)
356	Unplanned Hospital Readmission within 30 Days of Principal Procedure	Vascular Surgery (MVP ID: M1503)
357	Surgical Site Infection (SSI)	Quality Care for the Treatment of Ear, Nose, and Throat Disorders (MVP ID: M1367), Surgical Care (MVP ID: M1425)
358	Patient-Centered Surgical Risk Assessment and Communication	Optimal Care for Patients with Urologic Conditions (MVP ID: M1423), Podiatry (MVP ID: M1502), Surgical Care (MVP ID: M1425), Vascular Surgery (MVP ID: M1503)
360	Optimizing Patient Exposure to Ionizing Radiation: Count of Potential High Dose Radiation Imaging Studies: Computed Tomography (CT) and Cardiac Nuclear Medicine Studies	Diagnostic Radiology (MVP ID: M1498)
370	Depression Remission at Twelve Months	Quality Care in Mental Health and Substance Use Disorders (MVP ID: M1369)
383	Adherence to Antipsychotic Medications For Individuals with Schizophrenia	Quality Care in Mental Health and Substance Use Disorders (MVP ID: M1369)
385	Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery	Complete Ophthalmologic Care (MVP ID: M1420)
396	Lung Cancer Reporting (Resection Specimens)	Pathology (MVP ID: M1501)
398	Optimal Asthma Control	Pulmonology Care (MVP ID: M1424)
404	Anesthesiology Smoking Abstinence	Patient Safety and Support of Positive Experiences with Anesthesia (MVP ID: G0059)

405	Appropriate Follow-up Imaging for Incidental Abdominal Lesions	Diagnostic Radiology (MVP ID: M1498)
410	Psoriasis: Clinical Response to Systemic Medications	Dermatological Care (MVP ID: M1421)
413	Door to Puncture Time for Endovascular Stroke Treatment	Interventional Radiology (MVP ID: M1499)
416	Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 Through 17 Years	Adopting Best Practices and Promoting Patient Safety within Emergency Medicine (MVP ID: G0057)
420	Varicose Vein Treatment with Saphenous Ablation: Outcome Survey	Interventional Radiology (MVP ID: M1499)
432	Proportion of Patients Sustaining a Bladder or Bowel Injury at the time of any Pelvic Organ Prolapse Repair	Focusing on Women's Health (MVP ID: M1366)
440	Skin Cancer: Biopsy Reporting Time - Pathologist to Clinician	Pathology (MVP ID: M1501)
441	Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control)	Advancing Care for Heart Disease (MVP ID: G0055), Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes (MVP ID: G0054)
451	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	Advancing Cancer Care (MVP ID: M0001)
457	Percentage of Patients Who Died from Cancer Admitted to Hospice for Less than 3 days (lower score - better)	Advancing Cancer Care (MVP ID: M0001)
459	Back Pain After Lumbar Surgery	Surgical Care (MVP ID: M1425)
462	Bone Density Evaluation for Patients with Prostate Cancer and Receiving Androgen Deprivation Therapy	Optimal Care for Patients with Urologic Conditions (MVP ID: M1423)
470	Functional Status After Primary Total Knee Replacement	Improving Care for Lower Extremity Joint Repair (MVP ID: G0058)
477	Multimodal Pain Management	Patient Safety and Support of Positive Experiences with Anesthesia (MVP ID: G0059)
480	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)	Improving Care for Lower Extremity Joint Repair (MVP ID: G0058)
482	Hemodialysis Vascular Access: Practitioner Level Long-term Catheter Rate	Optimal Care for Kidney Health (MVP ID: M0002)
486	Dermatitis – Improvement in Patient-Reported Itch Severity	Dermatological Care (MVP ID: M1421)
488	Kidney Health Evaluation	Diabetes (MVP ID: M1504)

489	Adult Kidney Disease: Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy	Optimal Care for Kidney Health (MVP ID: M0002)
491	Mismatch Repair (MMR) or Microsatellite Instability (MSI) Biomarker Testing Status	Pathology (MVP ID: M1501)
492	Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with Heart Failure under the Merit-based Incentive Payment System	Advancing Care for Heart Disease (MVP ID: G0055)
495	Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood	Advancing Cancer Care (MVP ID: M0001), Quality Care for Patients with Neurological Conditions (MVP ID: M0004)
501	Acute Posterior Vitreous Detachment and Acute Vitreous Hemorrhage Appropriate Examination and Follow-up	Complete Ophthalmologic Care (MVP ID: M1420)
506	Positive PD-L1 Biomarker Expression Test Result Prior to First-Line Immune Checkpoint Inhibitor Therapy	Advancing Cancer Care (MVP ID: M0001)
516	Hepatitis C Virus (HCV): Sustained Virological Response (SVR)	Gastroenterology Care (MVP ID: M1422), Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV (MVP ID: M1368)
517	LDL-C Monitoring and Management	Advancing Care for Heart Disease (MVP ID: G0055)
520	Functional Improvement for Patients with Back Impairments	Rehabilitative Support (MVP ID: M1370)
523	Age-Related Hearing Loss: Comprehensive Audiometric Evaluation	Quality Care for the Treatment of Ear, Nose, and Throat Disorders (MVP ID: M1367)
525	Intraoperative Hypertension among Non-Emergent Noncardiac Surgical Cases	Patient Safety and Support of Positive Experiences with Anesthesia (MVP ID: G0059)