Quality Payment
PROGRAM

# Merit-based Incentive Payment System (MIPS) Value Pathways (MVP) Candidate

## 2027 Performance Year

## Diabetic Disease

## MVP Candidate Feedback Process

The MVP Candidate Feedback Process is an opportunity for the general public to participate in the MVP development process and provide feedback on MVP candidates before they're potentially proposed in rulemaking. Learn more about the MVP Candidate Feedback Process on the Quality Payment Program (QPP) website.

Note: This document is for 2027 MVP Candidate Feedback only and shouldn't be used as a reference for reporting MVPs in the 2026 performance year.

## MVP Candidate Feedback Instructions

Review the measures and activities included in TABLE 1: Diabetic Disease MVP below.

**MVP candidate feedback should be submitted to MVPSupport@cms.hhs.gov for Centers for Medicare & Medicaid Services (CMS) consideration between January 5, 2026, and 11:59 p.m. ET on February 6, 2026.**

Please include the following information in the email:

- **Subject Line:** Draft 2027 MVP Candidate Feedback
- **Email Body:** Your feedback for consideration and public posting. Please indicate the MVP name to which your feedback relates.

CMS will publish feedback received and considered relevant to a draft 2027 MVP candidate on the QPP website.

## TABLE 1: Diabetic Disease MVP

| Diabetic Disease MVP – Quality and Cost Clinical Grouping | | | | |
|---|---|---|---|---|
| **Clinical Grouping** | **Quality** | | | **Cost** |
| | **Measure** | **Outcome** | **High Priority** | |
| **Ophthalmology** | **Q019:** Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care (Collection Type: eCQM) | No | Yes | **N/A** |
| | **Q117:** Diabetes: Eye Exam (Collection Type: eCQM, MIPS CQM) | No | No | |
| | **IRIS13:** Diabetic Macular Edema - Loss of Visual Acuity (Collection Type: QCDR) | Yes | Yes | |
| | **IRIS58:** Improved Visual Acuity after Vitrectomy for Complications of Diabetic Retinopathy within 120 Days (Collection Type: QCDR) | Yes | Yes | |
| **Podiatry** | **Q126:** Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation (Collection Type: MIPS CQM) | No | No | **N/A** |
| | **Q127:** Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear (Collection Type: MIPS CQM) | No | No | |
| | **USWR35:** Adequate Off-loading of Diabetic Foot Ulcers performed at each visit, appropriate to location of ulcer (Collection Type: QCDR) | No | No | |
| **Multispecialty** | **Q001:** Diabetes: Glycemic Status Assessment Greater Than 9% (Collection Type: eCQM, MIPS CQM, Medicare Part B Claims) | Yes | Yes | **COST_D_1:** Diabetes<br>**TPCC_1:** Total Per Capita Cost |
| | **Q438:** Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (Collection Type: eCQM, MIPS CQM) | No | No | |
| | **Q488:** Kidney Health Evaluation (Collection Type: eCQM, MIPS CQM) | No | No | |
| **Advancing Health and Wellness** | **Q128:** Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (Collection Type: eCQM, MIPS CQM, Medicare Part B Claims) | No | No | **COST_D_1:** Diabetes<br>**TPCC_1:** Total Per Capita Cost |
| | **Q226:** Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (Collection Type: eCQM, MIPS CQM, Medicare Part B Claims) | No | No | |
| | **Q317:** Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented | No | No | |

## Diabetic Disease MVP – Quality and Cost Clinical Grouping

| Clinical Grouping | Quality | | | Cost |
|---|---|---|---|---|
| | Measure | Outcome | High Priority | |
| | (Collection Type: eCQM, MIPS CQM, Medicare Part B Claims) | | | |
| | **Q431:** Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (Collection Type: MIPS CQM) | No | No | |

**Diabetic Disease Improvement Activities**

- **IA_AHW_1:** Chronic Care and Preventative Care Management for Empaneled Patients
- **IA_BE_1:** Use of certified EHR to capture patient reported outcomes
- **IA_BE_3:** Engagement with QIN-QIO to implement self-management training programs
- **IA_BE_4:** Engagement of patients through implementation of improvements in new patient portal
- **IA_BE_12:** Use evidence-based decision aids to support shared decision-making
- **IA_BE_15:** Engagement of Patients, Family, and Caregivers in Developing a Plan of Care
- **IA_BE_16:** Promote Self-management in Usual Care
- **IA_BE_19:** Use group visits for common chronic conditions (e.g., diabetes)
- **IA_BE_23:** Integration of patient coaching practices between visits
- **IA_CC_14:** Practice Improvements that Engage Community Resources to Support Patient Health Goals
- **IA_MVP:** Practice-Wide Quality Improvement in MIPS Value Pathways
- **IA_PM_4:** Glycemic management services
- **IA_PM_5:** Engagement of community for health status improvement
- **IA_PM_16:** Implementation of medication management practice improvements
- **IA_PM_19:** Glycemic Screening Services
- **IA_PM_20:** Glycemic Referring Services
- **IA_PM_25:** Save a Million Hearts: Standardization of Approach to Screening and Treatment for Cardiovascular Disease Risk

## TABLE 2: Foundational Layer

The foundational layer is the same for every MVP.

| Foundational Layer | |
|---|---|
| **Population Health Measures** | **Promoting Interoperability** |
| **Q479: Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment Systems (MIPS) Eligible Clinician Groups** (Collection Type: Administrative Claims)<br><br>**Q484: Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions** (Collection Type: Administrative Claims) | • **PI_PPHI_1:** Security Risk Analysis<br>• **PI_PPHI_2:** High Priority Practices Safety Assurance Factors for EHR Resilience Guide (SAFER Guide)<br>• **PI_EP_1:** e-Prescribing<br>• **PI_EP_2:** Query of Prescription Drug Monitoring Program (PDMP)<br>• **PI_PEA_1:** Provide Patients Electronic Access to Their Health Information<br>• **PI_HIE_1:** Support Electronic Referral Loops By Sending Health Information<br>AND<br>• **PI_HIE_4:** Support Electronic Referral Loops By Receiving and Reconciling Health Information<br>OR<br>• **PI_HIE_5:** Health Information Exchange (HIE) Bi-Directional Exchange<br>OR<br>• **PI_HIE_6:** Enabling Exchange Under the Trusted Exchange Framework and Common Agreement (TEFCA)<br>• **PI_PHCDRR_1:** Immunization Registry Reporting<br>• **PI_PHCDRR_2:** Syndromic Surveillance Reporting (Optional)<br>• **PI_PHCDRR_3:** Electronic Case Reporting<br>• **PI_PHCDRR_4:** Public Health Registry Reporting (Optional)<br>• **PI_PHCDRR_5:** Clinical Data Registry Reporting (Optional)<br>• **PI_PHCDRR_6:** Public Health Reporting Under TEFCA (Optional)<br>• **PI_ONCACB_1:** ONC-ACB Surveillance Attestation (Optional)<br>• **PI_INFBLO_1:** Actions to Limit or Restrict Compatibility or Interoperability of CEHRT Attestation<br>• **PI_ONCDIR_1:** ONC Direct Review Attestation |