Strengthening Accountable Care: Key Changes in the Proposed 2027 Medicare Physician Fee Schedule Rule

July 27, 2026

1:00pm ET

Q&A will take place at the end of the program

You can submit written questions using the **“Questions” tab** (not chat) at any time during the webinar.

Webinar is being recorded

The recording and slides will be available on the NAACOS website within 48 hours.

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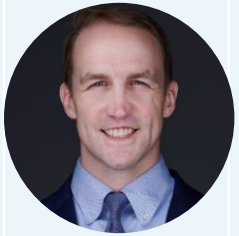

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Overview and Key Payment Changes

Proposed 2027 MPFS Rule

- Proposed rule released July 14, comments due September 14
- Proposed MSSP provisions address key areas including:
  - ✓ ACPT guardrails
  - ✓ Benchmarks
  - ✓ Quality
  - ✓ CEHRT requirements
  - ✓ Assignment
  - ✓ Beneficiary notifications
- Other proposed provisions:
  - Conversion factor decrease from: $33.57 to $33.17 for qualifying APM participants (QPs) and from $33.40 to $32.84 for non-QPs
  - Modifies the E/M complexity add-on to incentivize accountable care
  - Updates policies for the Ambulatory Specialty model (ASM)
  - Shifts QP determinations to the TIN/NPI level
  - Requests feedback on implementing primary care capitation in MSSP and other ACO models

NAACOS Resources:

- Press release
- In-depth summary available
- Email us your feedback– advocacy@naacos.com
- NAACOS Fall conference Oct. 14-16 in Washington, DC

CMS Resources:

- CMS fact sheet
- MSSP fact sheet
- QPP fact sheet
- CMS press release

Physician Payment Provisions

- Proposed CY 2027 Conversion Factor (CF)
  - Under MACRA, base payment updates are at 0.75% for Qualifying APM Participants (QPs) and 0.25% for other items and services
  - However, increases for CY 2027 are offset by the expiration of the temporary 2.5% increase for CY 2026 established under the *One Big Beautiful Bill Act (OBBBA)*
  - After accounting for this expiration and the budget neutrality adjustment, CMS proposes two CFs for CY 2027 – both reflecting a net decrease relative to the CY 2026 CF:
    - $33.17 for Qualifying APM Participants (-1.19% decrease)
    - $32.84 for other items and services (-1.68% decrease)
- New codes
  - Advance care planning furnished by clinical staff
  - Shared medical appointments

Proposed Changes to Medicare Physician Payments

CMS continues to revisit physician payment policies that it views are outdated, proposing targeted recalibration of payment rates

CMS' Stated Goals of Proposed Changes:

- Better align payments with the time, resources, and complexity involved in delivering care
- Account for efficiencies that occur when multiple services are delivered during the same patient encounter
- Improve oversight of billing practices and address areas where claims may not accurately reflect services provided
- Increase transparency into how physician payment rates are calculated

CY 2027 Proposed Policies:

- **Payments using Modifier ~25:** When a separately identifiable office/outpatient E/M is billed the same day as a global procedure, 100% for the most expensive service and 50% for all other services
- **Practice Expense (PE):**
  - Phase out the specialty index over two years and cap annual PE RVU changes at 5 percent
  - Changes to address indirect PE policy finalized last year
- **E/M Complexity Add-on changes**
- **New codes for shared medical appointments and health coaching**

CMS seeks feedback on:

- Alternatives to AMA CPT and RUC committee processes for valuing services
- How primary care services might be valued to better support a shift toward preventive care
- Additional data sources for valuing global surgical services
- Alternative approaches to address indirect practice costs
- Mechanisms to address duplicate diagnostic lab and image testing

E/M Complexity Add-on

- CMS proposes to replace Evaluation and Management (E/M) Complexity Add-on (HCPCS code G2211) with following modifiers:

Modifier	Description	Payment Impact
MOD1	*Visit complexity inherent to new or established office/outpatient or home or residence evaluation and management service, associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition.*	**+16% increase** in associated base E/M code
MOD2	*Visit complexity inherent to new or established office/outpatient or home or residence evaluation and management service, associated with medical care **services furnished by a participant or practitioner participating in a Medicare accountable care organization**. Services must serve as the continuing focal point for all needed health care services and/or be part of ongoing care related to a patient's single, serious condition or a complex condition*	**+32% increase** in associated base E/M code

- Available for participants in MSSP, the ACO Primary Care Flex Model, and the LEAD Model
- ACO participants determine, based on visit complexity, whether to append MOD1, MOD2, or no modifier
- ACO participants may bill MOD2 for all beneficiaries they provide care to, regardless of whether the beneficiary is assigned to an ACO

Telehealth and Remote Monitoring

- Telehealth
  - HCPCS codes added for
    - Advance care planning
    - Shared medical appointments
    - Pediatric speech, language voice and communication treatment
    - Vaccine adverse effects
  - New flexibilities for virtual teaching physicians
  - New modifiers for when telehealth services furnished through virtual platforms or incident to (as required by statute)
  - Increase telehealth originating site fee 2.5% to $32.65
- Remote monitoring
  - Only allow payment for remote physiologic monitoring (RPM) and remote therapy monitoring (RTM) services when furnished by clinical staff employed by a direct employee of the practitioner or the practitioner's practice; contracting out to third-party companies would not be allowed
  - RTM for established patients only
  - Require practitioners reporting remote physiologic monitoring (RPM) or RTM services to furnish separately reportable initiating visit in association with the onset of RPM or RTM services
  - Updates to RPM and RTM values
  - CMS also seeks comment on creating of new coding and payment structure for RPM and RTM codes

RHCs and FQHCs

- Add Diabetes Self-Management Training and Medical Nutrition Therapy as qualified preventive services covered under RHC benefit
  - Stand-alone billing
  - Aligns to FQHC and physician office payment policies
- Codify the abeyance of the RHC/FQHC mental health visit in-person requirements through December 31, 2027

Medicare Shared Savings Program (MSSP)

MSSP Financial Methodology Proposals Summary

- Place guardrails on the Accountable Care Prospective Trend (ACPT) component to reduce projection error and improve consistency across agreement periods
- Increase the shared savings rate under BASIC track Level E
- Risk adjust the 5% cap on upward benchmark adjustments
  - Increase the scaling factor for the prior savings adjustment
  - Reduce the regional adjustment weight for ENHANCED track ACOs
  - Add a new growth adjustment to incentivize new participation

Accountable Care Prospective Trend (ACPT)

Proposals	Key Issues/Comments
• Establish performance-year specific modified USPCC annualized growth rates to construct ACPT values • Implement guardrail that would not allow the modified USPCC cumulative growth rate for the ESRD and Aged/Disabled populations to be more than 1% below or 1.5% above the corresponding observed cumulative growth rate, for agreement periods beginning on or after January 1, 2027 • Implement retroactive guardrail that would not allow modified USPCC cumulative growth rate to fall more than 1.0 percentage points below observed cumulative growth rate, for agreement periods beginning on or after January 1, 2024 and before January 1, 2027 • Would be applied beginning with the PY 2025 reconciliation	• Changes the timing of the existing ACPT calculation from an agreement period to performance year basis • Does not change the ACPT methodology • Attempts to lessen ACPT inaccuracies • NAACOS has long advocated for the removal of the ACPT or, at a minimum revise the methodology for accuracy and establishing proper guard rails (see modernizeacos.org)

BASIC Level E Risk Track: Shared Savings Rate

Proposals	Key Issues/Comments
• Increase the BASIC Track Level E shared savings rate from 50% to 60%, while maintaining the 50% shared losses rate • For agreement periods beginning on or after Jan. 1, 2027	• Reduces gap between BASIC and ENHANCED shared savings rates, smoothing ACOs' on-ramps to and success rate with taking on higher risk • Reverses decreased participation (in BASIC Track and overall) through increased incentive • Increases net savings opportunities for the Medicare Trust Funds • NAACOS supports this proposal.

Historical Benchmark Adjustments

Proposals	Key Issues/Comments

• Risk adjust the 5% cap on the positive regional adjustment, prior savings adjustment, and population adjustment to the historical benchmark
  • Effective for agreement periods beginning on Jan. 1, 2027, and subsequent PYs
• Implement a population adjustment scaler that calculates the difference between the 5% national per capita expenditures risk-adjusted cap, specifying the higher of the regional adjustment or prior savings adjustment, or no adjustment
  • Effective for agreement periods beginning on Jan. 1, 2027, and subsequent PYs
	• Allows for a higher positive adjustment ceiling for ACOs serving medically complex populations, while safeguarding CMS against extreme or outlier positive benchmark adjustments
	• Incentivizes ACOs to enroll and manage more medically complex patients
	• NAACOS remains concerned about the constraints of the cap, since successful ACOs often reach it, limiting their upside and has advocated that CMS raise it to at least 7%

ENHANCED Risk Track: Regional Adjustment

Proposals	Key Issues/Comments
• Reduce the ENHANCED track positive regional adjustment maximum weight from 50% to 35% for lower-spending ACOs • Effective for agreement periods beginning on Jan. 1, 2027, and subsequent PYs	• Mitigates CMS concern that gross savings may be a product of the adjustment structure rather than true cost reduction based on ACO efficiency • Rebalances financial incentives across tracks and encourages ACOs to select their tracks based on actual capacity to reduce costs • NAACOS has concerns this reduction may disincentivize high-performing ACO participation by unintentionally reducing incentives to grow or consolidate

Prior Savings Adjustment

Proposals	Key Issues/Comments
• Increase the prior savings adjustment by increasing the scaling factor from 50% to 75% • Effective for agreement periods beginning on Jan. 1, 2027, and subsequent PYs	• Provides more incentive to generate and sustain savings by reducing negative rebasing and ratcheting effects • Increases the number of ACOs that would benefit from the adjustment, particularly in later years (i.e., by receiving the PSA instead of the regional adjustment)

New Growth Adjustment

Proposals	Key Issues/Comments
• Introduce a growth adjustment, to incentivize new participation, up to the proposed 5% of ACO risk-adjusted national per capita expenditures cap • Effective for agreement periods beginning on Jan. 1, 2027, and subsequent PYs	• Applies in addition to the other adjustments • Proposed risk adjustment policy would apply, if finalized • Is calculated as the product of the ACO's "new growth share" and "incentive factor"

Claims-Based Assignment Methodology

Proposals	Key Issues/Comments

• Modify the claims-based assignment methodology to exclude from calculations allowed charges for primary care services delivered by an ACO professional billed through a non-ACO TIN
  • Also applies to charges billed through non-ACO CCNs
  • Applies to all 3 steps of the claims-based methodology
  • Effective starting PY 2028
	• Does not affect calculation of beneficiary expenditures under financial methodology
	• Does not affect assignment calculations when an ACO professional participates in multiple ACOs
	• Part of CMS' goal to increase beneficiaries in ACOs
	  • Simulations of PY 2024 data predict this change could increase MSSP assignment by ~98k beneficiaries; 97% of ACOs would see <1% growth and 3% would see 4-12% growth
	  • Beneficiaries added tended to have higher costs and risk scores; CMS believes they could benefit from additional coordination offered by ACOs
	  • NAACOS is assessing whether certain types of ACOs are disproportionately affected

Beneficiary Assignment Eligibility

Proposals	Key Issues/Comments

• Expand assignment eligibility criteria to mirror the definition of an "assignable beneficiary"
  • New criteria would include beneficiaries with at least 1 month of Part A +B enrollment & no Medicare group enrollment during that same month during the assignment window
  • Applies to both claims-based and voluntary assignment eligibility and to prospective assignment exclusion criteria
  • Effective starting PY 2028
	• Effectively expands the population of assigned beneficiaries who have fewer than 12 months of Parts A and B enrollment
	• Aligns with use of MSSP-eligible months in calculation of assigned beneficiary expenditures and other program operations
	  • Would not consider expenditures for months with only A or B enrollment
	• Simulations of PY 2024 data predict this change could increase MSSP assignment by ~250k beneficiaries

Beneficiary Assignment

Proposed additions

- Update the definition of primary care services used in determining claims-based assignment to add codes for:
  - Screening, Brief Intervention, and Referral to Treatment (G2011, G0396, G0397)
  - Vaccine Adverse Effects Management (GADV1) – *if finalized*
    - Add-on payment for diagnosis and management of suspected vaccine adverse reaction in conjunction with an E/M visit
  - Advance Care Planning (GACP1, GACP2) – *if finalized*
    - ACP services furnished by clinical staff under direct supervision of billing practitioner
    - Existing ACP codes already included in definition
- Effective beginning PY 2027

Application and Participation Policies

Proposals	Key Issues/Comments
• CMS anticipates allowing current applicants for a PY 2027 start a time-limited opportunity to change their final selection between the BASIC and ENHANCED Tracks	• CMS notes that finalized policies may influence an ACO's decision to enter an agreement period under Level E or ENHANCED • Final rule will not be released until after September deadline to finalize track selection
• Modify the definition of "experienced with performance-based risk Medicare ACO initiatives" to exclude TINs that did not have a written agreement to participate in the applicable ACO • Effective PY 2027	• Legacy TIN/CCN policies for CMMI models mean that there may be legacy TINs or CCNs currently included in the experience determination threshold for MSSP despite the TIN/CCN not having a written agreement to participate in an ACO

Beneficiary Engagement Policies

Proposals	Key Issues/Comments
***Part B cost sharing waiver:** • Creates a new, tailored Part B cost sharing waiver similar to ACO REACH • ACOs would submit and be approved for a waiver application with an implementation plan • CMS plans to collect initial applications in early 2027 and targets Apr. 1, 2027 launch; future applications would be conducted in conjunction with annual MSSP applications	• ACOs may cover items/services not covered by secondary insurance (e.g., Medigap plan, Medicaid coverage) • ACOs would not be allowed to cover cost sharing for DMEPOS or prescription drugs due to high risk for FWA • Must meet 1+ defined clinical goals for each beneficiary: (1) adherence to a treatment regime, (2) adherence to a drug regime, (3) adherence to a follow-up care plan, and/or (4) management of a chronic disease or condition
***Beneficiary notifications:** • Sets a clear, May 30 deadline annually for all ACOs to furnish the standard written notice to beneficiaries rather than a rolling deadline based on primary care visits • Eliminates the follow-up communication requirement • Effective starting PY 2027	• Policies are intended to reduce administrative burden of MSSP participation • ACOs would be permitted to communicate more frequently or thoroughly with beneficiaries (e.g., sharing supplemental ACO information alongside the beneficiary notification)

** NAACOS Prior Recommendation*

Changes to Upfront Payments

Proposals	Key Issues/Comments

Discontinue prepaid shared savings (PSS) option after PY 2027 application cycle
• ACOs that are approved for PSS starting PY 2026 & 2027 will be the last participants
• CMS will cease distributing PSS payments for these ACOs beginning in 2028
	• NAACOS previously advocated for removing restrictions on allowable uses and focusing on recoupment policies
	  • CMS cites low uptake (4 participating ACOs) and burden on CMS to administer in its rationale
	  • Limited uptake is likely due to these restrictions and documentation burden, not lack of interest in the concept

Advance investment payment (AIP) policies: • Remove Area Deprivation Index (ADI) from criteria • Add rural criterion • Add a flat payment ($25) for all assigned beneficiaries not identified as rural/LIS/dual eligible • Effective starting PY 2028	• CMS notes limited overlap between beneficiaries living in a rural area and LIS/duals eligibility and it believes rurality is an appropriate proxy for access-related challenges • Intends for these changes to support ACO formation in rural areas

Primary Care Payment RFI

CMS seeks comments on 3 main topics within this RFI:

1) Reconsidering relative primary care payment in the PFS, including updates to code sets for O/O E/M, AWVs and care management services;
2) Understanding the payment implication of including technology in primary care, including impact of clinical AI;
3) * Establishing prospective primary care payment in the Medicare Shared Savings Program and potentially in the Original Medicare program broadly

- NAACOS has previously advocated for CMS to implement an optional REACH-style primary care capitation into MSSP
- CMS reflects on primary care population-based payments tested in CMMI and seeks feedback on an approach for MSSP, including:
  - ACO participant readiness for capitation (partial or full)?
  - How capitated payments would be used by the ACO?
  - Should it be limited to certain types of ACOs?
  - Need for enhanced primary care payment amount on top of base PC cap, advanced payment option

** NAACOS Prior Recommendation*

Specialty Care in Shared Savings Program RFI

Domains:	CMS seeks feedback on:
Meaningful Engagement	• How specialists meaningfully participate (data access, attribution, incentives) • PCP and specialist integration (e-consults, co-management) • Types of incentives (financial, quality, operational, sub-cap) • Types of specialists (procedural vs. chronic) • Engagement differences across high revenue and low revenue ACOs • Engagement approaches effective for high-need, high-cost populations
CMS-Delivered Tools and Support	• Use of shadow bundle data or specialty-specific data • Tools that help ACOs provide meaningful feedback to specialists • Improving specialty care data to support specialist referrals based on outcomes and quality • Specific needs of low revenue vs. high revenue ACOs
Attribution or Assignment Modifications	• Incorporating specialists into beneficiary assignment and ensuring CMS maintains strong PCP relationships • Role of NP/PA-led care in supporting beneficiary attribution • Assignment methods to recognize when specialists serve as beneficiary's principal care provider • Enabling specialists to share accountability for TCOC without serving as primary clinician • Shared accountability between PCPs and specialists for specific conditions/episodes
Benchmarking	• Specialty-specific cost benchmarks within MSSP and account for conditions that have low volumes and/or high-cost variability • Sub-populations for specialty benchmarking (chronic condition, procedure type, specialty service category, or other sub-populations that need specialty benchmarking) • Risk adjustment factors incorporated into specialty-specific benchmarks to reflect patient complexity • How specialty-specific benchmarks interact with existing TCOC benchmarks in MSSP

Specialty Care in Shared Savings Program RFI

Domains:	CMS seeks feedback on:
Specialist Performance Measurement	• Assessing specialist performance within ACOs and how it should differ from how ACOs are currently assessed • Specialty-specific performance profiles or feedback mechanism that drive improvement • Performance measures that support prevention and upstream management by specialists • Quality performance info needed for care coordination, outcomes, cost management • Incentivizing specialists or ACOs to report on specialist quality performance • ACOs to align financial and non-financial incentives to reflect specialists' contributions to cost and quality • Barriers and burden to data collection from specialists • Tie ACO performance to system-level metrics • Leveraging MVPs to support specialist engagement – least or most effective when applied to high-low revenue ACOs or different specialty types
Waiver Flexibilities	• Types of waivers most effective in supporting specialty integration (SNF 3-day, telehealth) – barriers to limit adoption • Expanding existing waiver flexibilities to support specialist-driven care pathways • Additional waivers needed to enable specialists' participation in ACOs • Waiver differences by high-low revenue participants
ACO and Provider Burden	• Burden reduction with specialty-specific quality reporting (aligning measures across programs, leveraging claims-based measures) while maintaining accountability • Burden reduction with data-sharing requirements (interoperability) • Operational/compliance requirements that burden smaller, rural specialty practices • Flexibilities to encourage specialist participation in ACOs over current FFS requirements

MSSP Quality Proposals

Quality proposals are a huge win for ACOs, with many proposals directly responsive to NAACOS member asks, including:

- ✓ *Extension of MIPS CQM reporting option and MIPS CQM reporting incentive*
- ✓ *Allowing ACOs to report only on ACO-assigned beneficiaries*
- ✓ *Solutions on data completeness challenges for ACOs*
- ✓ *Retaining the existing APP Plus quality measure set without introducing new measures*

- NAACOS hosted ACO listening sessions with CMS to explain challenges with existing reporting requirements for ACOs and highlight the need for flexibilities

Transition to FHIR-based dQMs

CMS continues to build on its plan to transition quality reporting programs to digital quality measures (dQMs) leveraging Fast Healthcare Interoperability Resources (FHIR)

- Outlines, but does not propose, a 2-year transition to FHIR-based reporting, starting with optional reporting in PY 2028 and required reporting beginning PY 2030
- Requests feedback on:
  - Structure of transition period and scoring implications
  - Factors affecting readiness for FHIR-based reporting and how to address technology barriers
  - Specific considerations for MSSP, in recognition of organizational complexity that may require a longer lead time
  - Technical assistance needed for the transition

Respond to NAACOS' ACO Quality Survey by 8/14

MIPS CQMs

Proposals	Key Issues/Comments

• * Retain the MIPS CQM reporting option for ACOs for PY 2027 and subsequent years
  • CMS anticipates sunsetting MIPS CQMs as an option for MSSP beginning in PY 2030, but does not propose an end date in the rule
• * Extend the MIPS CQM reporting incentive through PY 2027 and subsequent years
  • CMS anticipates sunsetting this reporting incentive at the start of the transition to FHIR-based reporting, potentially as soon at PY 2028, but does not propose an end date
	• NAACOS has recommended retaining all current reporting options through this transition
	• Proposals are tied to CMS' intended timeline for transitioning ACOs to FHIR-based quality reporting (PY 2028-2030)

** NAACOS Prior Recommendation*

Flat Benchmarks for Medicare CQMs

Proposals	Key Issues/Comments

• * Apply flat benchmarks to PY 2026 scores for the Medicare CQMs:
  • Controlling High Blood Pressure
  • Depression Screening and Follow-up
  • A1c Poor Control
• * Extend the use of flat benchmarks to all Medicare CQMs for PY 2027 and subsequent years
	• Under current policies, Breast Cancer Screening and Colorectal Cancer Screening Medicare CQMs will already use flat benchmarks for PY 2026
	• NAACOS previously recommended the use of flat benchmarks for Medicare CQMs:
	  • Decile-based benchmark policies under MIPS could be skewed due to ACO-only reporting and higher performance data, which CMS acknowledges in its rationale
	  • Provides more predictable, transparent benchmarks

** NAACOS Prior Recommendation*

Data Completeness for ACOs

Proposals	Key Issues/Comments

• * Addresses ACOs' challenges with meeting MIPS data completeness requirements by:
  • Allowing exclusion of TIN(s) from an ACO's quality submission beginning PY 2026
  • After application of TIN exclusions, the ACO's submission must include 95% of assigned beneficiaries prior to the application of measure specifications
  • MIPS data completeness for ACOs would be calculated based on the denominator determined after application of TIN exclusions and measure specifications
	• Exclusions cover unforeseen circumstances outside the ACO's control, EHRs that do not support a given measure, or other circumstances determined by CMS
	• Policies are directly responsive to situations NAACOS has raised in which data cannot be accessed by the ACO, thus jeopardizing the ACO's quality reporting

** NAACOS Prior Recommendation*

Reporting on Assigned Patients

Proposals	Key Issues/Comments

• * Create a new reporting option "Medicare eCQMs" which use eCQM specifications limited to the ACO's assigned beneficiary population
  • Available beginning PY 2027
  • Medicare eCQMs will be scored using flat benchmarks
  • ACOs will continue to have the option to report all payer/all patient eCQMs
• * Revise the definition of a beneficiary eligible for Medicare CQMs to include only beneficiaries assigned to the ACO
  • Effective beginning in PY 2027
	• NAACOS has raised concerns with assessing ACOs on patients not managed by the ACO for purposes of determining shared savings
	  • These proposals are directly responsive to ACOs' concerns
	• eCQM reporting incentive will only apply to all payer/all patient eCQMs

** NAACOS Prior Recommendation*

Measure Suppression Policy

Proposals	Key Issues/Comments

• Modify the existing scoring policy for measures that are excluded or that lack a benchmark
  • Would only apply when the ACO's quality category score is calculated on less than five measures for a given PY (e.g., when 4 or more measures are excluded)
  • Effective PY 2027
	• Current measure suppression policy awards ACO the higher of its score or the MSSP quality performance standard if any measures are excluded or the total measure achievement points are reduced
	• CMS notes this change is due to the increase in ACO-reported measures since the initial measure suppression policy was created

APP Plus Measure Set Changes

Proposals	Key Issues/Comments
• * **Remove two measures** from the APP measure set: 1. *Initiation and Engagement of SUD Treatment* measure 2. *Adult Immunization Status* measure • Both measures previously scheduled to be added beginning PY 2027 • **Update measure specifications** for following measures: 1. *Diabetes: Glycemic Statue Assessment Greater Than 9%* (eCQM only) measure to improve logic and create the Medicare eCQM version 2. *Screening for Depression and Follow-up Plan* measure to expand the numerator, add a new denominator exclusion for pervious screening, and create the Medicare eCQM version 3. *Hospital-Wide 30-day All-cause Unplanned Readmission* (claims measure) to remove the denominator exclusion for COVID diagnoses	• NAACS has recommended retaining the existing measure set without additions through the transition to digital quality reporting

** NAACOS Prior Recommendation*

CEHRT Requirements for ACOs

Proposals	Key Issues/Comments
• * Eliminate requirement for MSSP ACOs to report MIPS Promoting Interoperability (PI) beginning PY 2027 • Replace PI with requirement to demonstrate CEHRT use via at least one of 3 options: 1. Completely report at least 1 quality measure as eCQM or Medicare eCQM 2. Attest to ACO's use of FHIR capabilities to support reporting of at least 1 reported measure using CEHRT 3. Select and attest to one of the MSSP CEHRT use metrics, a subset of PI measures • Revise public reporting requirements for CEHRT use; ACOs will report on which of the 3 allowable CEHRT options above they elected for a given PY	• NAACOS strongly opposed the application of MIPS PI requirements to all MSSP ACOs regardless of Advanced APM status • These proposals reflect NAACOS' recommendations for a more flexible, attestation-based approach • These proposals only affect MSSP-specific requirements and do not alter MIPS obligations for participants in MIPS APM tracks or not meeting QP status • In 7/15 ACO Spotlight, CMS announced it will exercise enforcement discretion for MSSP PI requirements for PY 2026 • Similar to PY 2025, MSSP-specific requirement will not be enforced

** NAACOS Prior Recommendation*

Quality Payment Program (QPP)

MIPS Value Pathways (MVPs)

Proposals	Key Issues/Comments
• Beginning in CY 2029, all MIPS eligible clinicians must report-through MVPs unless eligible to report through the APM Performance Pathway (APP) • Virtual groups would be able to report MVPs • Modifying all 27 MVPs and adding 3 New MVPs 1) Diabetic Disease 2) Hospitalist 3) Hypertension	• MIPS APMs could continue to report the APP

QPP Requests for Information seek feedback on:

- Scoring methodology that more fairly compares clinician performance within the same MVP
- Whether to normalize scores within each MVP to improve fairness across MVPs
- Implementation timing for transition and if CMS should pilot test prior to 2029 performance period

Advanced APMs

Proposals	Key Issues/Comments
Implements provisions from the Consolidated Appropriations Act of 2026	• Lowers Qualifying APM Participant (QP) thresholds for Performance Year 2026 to: ▪ 50% for Medicare payment amount ▪ 35% for Medicare patient count ▪ Under current law, thresholds increase in 2027 to 75%/ 50% • Extends a **3.1% advanced APM incentive** for Performance Year 2026/ Payment Year 2028 • NAACOS advocating for extension of APM incentives and modifications to QP thresholds • House Doctors Caucus introduced proposal to permanently modify thresholds

Advanced APMs (AAPMs)

Proposals	Key Issues/Comments
Apply QP and Partial QP determinations at the TIN/NPI level, beginning with the 2027 QP performance period	***Current Policy:*** QP determinations are made at the NPI level and QP status (and MIPS exemptions) applies across all an NPI's TINs • APM incentive payments are calculated based on total billing across all an NPI's TINs, including those not participating in any AAPM, and generally paid as a lump sum to the TIN associated with the AAPM through which QP status was attained ***Proposed Policy:*** Financial incentives will be calculated based only on NPI's claims associated with TINs participating in AAPMs • Clinicians would **only be exempt** from MIPS at the TIN (or TINs) in which they achieved QP status ▪ A clinician who bills under multiple TINs may have differing payment updates/ MIPS reporting obligations for each TIN ▪ CMS highlights that this would not impact most clinicians in AAPMs because they already participate in an APM with all their TIN reassignments and QP status would apply under each of those TINS with this proposal • CMS estimates that this approach will prevent about $2.38 billion from flowing to TINs that are not actively participating in an AAPM

Other RFIs/ Comments

Requests for Information seek feedback on:

- Applying electronic prior authorization measures/CEHRT requirements to ACOs
- Impact of duplicate testing, imaging and results sharing and interoperability
- Community-based palliative care and evolving current care management services to support beneficiaries in future medical decisions
- Lifestyle interventions for Alzheimer's disease
- Improvements and alternative options to the current star rating assignment methodology for quality measure scores collected under the administrative claims collection type

Ambulatory Specialty Model (ASM)

Proposals	Key Issues/Comments
Definitions and Eligibility • Revise and expand ASM definitions • TIN change exceptions • Heart failure specialty redesignation exception • Participant termination policy	• Updates existing terminology and adds new definitions to improve clarity and administration of ASM • Clarifies when ASM participants may be exempted from certain model requirements if their TIN changes before or during a performance year • Establishes an exceptions process for certain cardiac subspecialities that may have been unintentionally pulled into the HF cohort • Establishes a process allowing CMS to terminate ASM participants under specified circumstances

Ambulatory Specialty Model (ASM)

Proposals	Key Issues/Comments
Quality Measurement and Scoring • Quality scoring for small practices • Changes to low back pain quality measures • Benchmarking and scoring updates • PRO data incentive • Rural scoring adjustment	• Clarifies how CMS scores multiple quality-measure submissions from small-practice ASM participants • Adds an administrative claims-based imaging measure for LBP and replaces the current PRO measure with a functional-status outcome process measure • Revises quality measure benchmarking and scoring methodologies for administrative claims-based measures • Creates a quality scoring incentive for voluntary submission of PRO data to support future development of PRO performance measures • Establishes a scoring adjustment for ASM participants practicing in rural areas

Ambulatory Specialty Model (ASM)

Proposals	Key Issues/Comments
Reporting and Data Submission • Improvement Activities reporting flexibility • Promoting Interoperability alignment • Enhanced performance reports **Payment Adjustments and Financial Policies** • Payment adjustment clarification after TIN reassignment	• Builds on policy finalized last year requiring IA to be reported at TIN level; proposed changes allow participants flexibility to submit IA data at either the individual clinician level or group level • Aligns ASM Promoting Interoperability requirements with proposed MIPS Promoting Interoperability changes and adds a measure suppression policy • Expands ASM performance reports to show additional information related to scoring and performance calculations • Clarifies how ASM payment adjustments apply when a participant reassigns billing rights to a new TIN during a payment year

Ambulatory Specialty Model (ASM)

Proposals	Key Issues/Comments
Compliance and Waivers • Safe harbor and waiver clarification • Collaborative Care Arrangement (CCA) revisions • Technical and organizational edits	• Clarifies that CMS model arrangements, patient incentive safe harbors, and program waivers apply only when a participant is actively performing in ASM, not when the participant is ineligible or excepted from requirements • Updates CCA rules to improve clarity regarding eligible parties, payment/remuneration conditions, documentation requirements, and compliance obligations • Reorganizes and clarifies regulatory text to improve readability and usability of the ASMA regulations

Questions?

2026 Excellence Awards

Submissions will be accepted until July 30

Excellence Awards recognize high-performing organizations who have demonstrated an outstanding commitment to and accomplishments in accountable care across three key areas (below). Awardees will be recognized at the Fall 2026 Conference.

Performance

- Improved quality and outcomes across multiple populations and areas of care; and
- Implemented value-based payment arrangements with reductions in total cost of care across lines of business.

Data and Technology

- Reduced provider burden or support practice-level care delivery improvements; and
- Fostered patient engagement or deploy patient-level care solutions.

Partnerships

- Engaged external providers and collaborated with other elements of the care delivery continuum; and
- Fostered engagement with the broader community, such as by partnering with community-based organizations.

Registration Is Open!

Fall 2026 Conference

Register Today!

October 14-16

Marriott Marquis Washington, D.C.

APPENDIX

Thank you!

Please email advocacy@naacos.com with additional feedback or questions.