Strengthening Accountable Care:

Key Changes Finalized in the 2027 Medicare Physician Fee Schedule Rule and Political Outlook for the Year Ahead

November 16, 2026

2:00pm 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.

Speakers



Aisha Pittman
Senior Vice President, Government Affairs

Nisha Bhat
Director, Performance-Based Payment Policy Group, CMS



Lisa Lentz
Senior Director, Federal Affairs



Alyssa Neumann
Director, Federal Affairs



Robert Daley
Senior Director, Legislative Affairs

Overview and Key Payment Changes

Final 2027 MPFS Rule

- Final rule released November 4
- MSSP provisions address key areas including:
  - ✓ ACPT guardrails
  - ✓ Benchmarks
  - ✓ Quality
  - ✓ CEHRT requirements
  - ✓ Assignment
  - ✓ Beneficiary notifications
- Other provisions:
  - Conversion factor decreases
  - Modifies the E/M complexity add-on to incentivize accountable care
  - Adds RPM/RTM requirements
  - Updates policies for the Ambulatory Specialty model (ASM)
  - Shifts QP determinations to the TIN/NPI level

NAACOS Resources:

- Press release
- Comments on proposed rule
- In-depth analyses available on NAACOS website
- NAACOS Spring conference on April 13-15 in Baltimore

CMS Resources:

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

Physician Payment Provisions

- Final 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
  - 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:
    - $32.95 for Qualifying APM Participants (-1.83% decrease)
    - $32.63 for other items and services (-2.31% decrease)
- New codes
  - Advance care planning furnished by clinical staff
  - Shared medical appointments

Changes to Medicare Physician Payments

CMS continued to revisit physician payment policies that it views are outdated, including targeted recalibration of payment rates

CMS' Stated Goals of Finalized Changes:

- Better align payments with the complexity and resources involved in delivering modern care
- Improve payment accuracy and address outdated payment methodologies
  - Account for efficiencies and avoid duplicative payments
  - Make physician payment calculations simpler and more transparent
- Direct Medicare resources toward prevention, coordinated primary care, and health maintenance

CY 2027 Finalized Policies:

- **Payments using Modifier ~25:** When a separately identifiable office/outpatient E/M is billed the same day as a 0-day global procedure, 100% for the most expensive service and 80% for all other services
- **Practice Expense (PE):**
  - Phase out the indirect practice cost index over two years
  - Revise indirect PE allocations
- **Changes to E/M Complexity Add-on**
- **New codes for shared medical appointments and health coaching**
- **Additional codes and flexibilities for telehealth and RHCs/FQHCs**
- **New rules for Remote Monitoring**

E/M Complexity Add-on

- Replaced the Evaluation and Management (E/M) Complexity Add-on (HCPCS code G2211) with the following modifiers, effective January 1, 2027.

Modifier	Description	Payment Impact
B1	*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
B2	*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

- B2 is available for participants in MSSP and the LEAD Model billing applicable E/M codes.
- ACO participants may bill B2 for all beneficiaries they provide care to, regardless of whether the beneficiary is assigned to an ACO.
- Claims submitted with B1 or B2 will be included in ACO beneficiary assignment calculations, historical benchmark expenditures, and performance year expenditures.
- NAACOS supported these policies and had encouraged CMS to extend modifiers to E/M code families for other longitudinal care providers such as FQHCs, RHCs, and CAHS, and the nursing facility E/M code family commonly used in LTC practice.

Telehealth

Final Policies	Key Considerations

• Made technical updates to Medicare Telehealth List effective January 1, 2027
• Updated telehealth critical care descriptors
• Added HCPCS codes for:
  ○ Advance care planning
  ○ Shared medical appointments
  ○ Pediatric speech, language voice and communication treatment
  ○ Vaccine adverse effects
• Introduced new flexibilities for virtual teaching physicians
• Added modifiers for when telehealth services furnished through virtual platforms or incident to (as required by statute)
	• NAACOS supported these policies which:
	  • Maintain alignment between the Medicare Telehealth Services List and codes newly added to the Physician Fee Schedule, ensuring continued access to services, especially for patients who face geographic, mobility, or other barriers to accessing in-person care
	  • Clarify appropriate coding and billing for telehealth critical care consultations
	  • Provide additional flexibility for virtual teaching physicians

Remote Monitoring

Final Policies	Key Considerations
Effective CY 2027: • RTM services may only be furnished only to established patients • Practitioners reporting RPM or RTM services must furnish a separately reportable initiating visit in association with the onset of RPM or RTM services • Updates to how these services are valued under the PFS Effective CY 2029: • Payment for RPM or RTM services only when performed by clinical staff employed by the practice	• NAACOS supported the established patient requirement, which address OIG billing concerns. • NAACOS opposed the initiating visit requirement, which could create unnecessary burden and barriers to care in circumstances where a treating clinician already has an established relationship with the patient and has sufficient information to determine that remote monitoring is clinically appropriate. • NAACOS also commented the employment requirement may reduce CMS FWA concerns, but it also introduces burden, disrupts existing vendor relationships, and may limit patient access to care • Two-year delay allows time to advocate for alternative oversight approaches and watch ACCESS Model, which tests another method.

Overlaps Between Stand-Alone E/M Visits and Global Periods

Final Policies	Key Considerations

• Reduced payment when a separately identifiable office/outpatient (O/O) evaluation and management (E/M) visit is furnished by the same physician (or a physician in the same practice) on the same day as a 0-day global procedure
  • The most expensive service (either surgical or E/M visit) will be paid at 100%
  • All other surgical procedure(s) or E/M visit(s) furnished on the same day would be paid at 80%.
• Effective January 1, 2027
	• CMS had proposed this policy due to concerns about duplicative resources and payments when E/M visits and procedures occur on the same day.
	• Originally, CMS proposed paying the lower-cost service at 50% when an O/O E/M visit and a 0-, 10-, or 90-day global procedure were furnished on the same day.
	• In response to concerns about undervaluing separately identifiable care:
	  • Reduced the payment adjustment for the less expensive from 50%, as proposed, to 20% (i.e. pay at 80%)
	  • Limited the policy to 0-day global procedures, rather than also applying it to 10- and 90-day global procedures as proposed

RHCs and FQHCs

Final Policies	Key Considerations

• Added Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT) as qualified preventive services covered under RHC benefit
  ○ Stand-alone billing
  ○ Aligns to FQHC and physician office payment policies
• Codified the abeyance of the RHC/FQHC mental health visit in-person requirements through December 31, 2027
	• NAACOS supported these polices.
	• Providing appropriate payment for DSMT and MNT can better support chronic disease prevention and management and improve access for Medicare beneficiaries served by rural providers.
	• NAACOS also supported extending through CY 2027 the delay on in-person visit requirements for RHC and FQHC mental health services, thereby allowing continued flexibility for access to behavioral health services via telehealth.

Medicare Shared Savings Program (MSSP)

MSSP Financial Methodology: Finalized Policies Summary

1. Placed guardrails on the Accountable Care Prospective Trend (ACPT) component to reduce projection error and improve consistency across agreement periods.

2. Increased the shared savings rate under BASIC track Level E.

3. Risk adjusted the 5% cap on upward benchmark adjustments.
   - Increased the population scaling factor in the Prior Savings Adjustment.
   - Reduced the maximum upward regional adjustment weight for ENHANCED track ACOs that are lower spending than their region.
   - Added a new growth adjustment to incentivize new participation.

Accountable Care Prospective Trend (ACPT)

Final Policies	Key Considerations
• Established performance-year specific modified USPCC annualized growth rates to construct ACPT values • Implemented 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 • Implemented 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 • Applied beginning with the PY 2025 reconciliation, which was deferred to November 2026	• NAACOS has strongly advocated for ACPT guardrails and supported changing the ACPT calculation from an agreement period to performance period basis.

Historical Benchmark Adjustment Cap

Final Policies	Key Considerations
• Risk adjusted the 5% cap on upward adjustments to the historical benchmark, which include the positive regional adjustment, prior savings adjustment, and population adjustment, beginning with agreement periods starting on or after January 1, 2027 • No downward risk adjustments	• NAACOS supported this change. • Upward risk adjustment is a positive step toward expanding accountable care to complex populations. • However, this policy does not resolve the overall existing constraints of the cap, since successful ACOs often reach it, limiting their upside savings potential.

BASIC Level E Risk Track: Shared Savings Rate

Final Policies	Key Considerations
Increased the shared savings rate for Level E of the BASIC track from 50% to 60% to more properly balance this participation option relative to the ENHANCED track, beginning with agreement periods starting on or after January 1, 2027	• NAACOS supported this change, which is intended to increase the participation and long-term success of ACOs, particularly those with less experience, unique populations, low revenue, and/or that are small, rural, or physician-only. • The increased shared savings rate provides ACOs an incentive to take more time in the BASIC track before taking on higher risk, before they are truly ready, in the ENHANCED track.

ENHANCED Risk Track: Regional Adjustment

Final Policies	Key Considerations
Reduced the maximum weight for calculating the positive regional adjustment for ACOs participating under the ENHANCED track, spending lower than their region from 50% to 35% to mitigate concern that gross savings may be a product of the adjustment structure rather than true cost reduction based on ACO efficiency, beginning with agreement periods starting on or after January 1, 2027	• NAACOS strongly opposed this policy, which disproportionately impacts longer standing, successful ACOs, who have achieved efficiencies over multiple agreement periods. • In turn, the policy may disincentivize high-performing ACOs by reducing incentives to grow, consolidate, and maintain existing efficiencies. • This change creates inconsistency with LEAD model incentives and may drive participation decisions. • Additionally, CMS made this change based descriptive analyses and observation rather than on rigorous analysis with statistically significant results. • NAACOS will continue to advocate for stronger benchmark policies that address the benchmark ratchet.

Prior Savings Adjustment

Final Policies	Key Considerations
Increased the prior savings adjustment's scaling factor from 50% to 75%, which intends to mitigate the rebasing "ratchet effect," in which the savings an ACO achieves in one agreement period can reduce its rebased benchmark.	• NAACOS supported this change. • CMS acknowledges only a small number of ACOs are expected to benefit in the short-term. • CMS believes long-term this will increase 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) and could incentivize ACOs to generate more savings in their initial agreement period and encourage long-term participation in the Shared Savings Program.

New Growth Adjustment

Final Policies	Key Considerations
Added a new growth adjustment, to the highest of the positive regional adjustment, prior savings adjustment, and population adjustment, or no adjustment, and the total amount cannot exceed the 5% risk-adjusted cap on upward benchmark adjustments, beginning with agreement periods starting on or after January 1, 2027	• NAACOS supported this explicit signal from CMS that it wants ACOs to expand its reach. • However, the number of ACOs that benefit from the adjustment may be limited due to restrictive calculation rules and many ACOs already reaching the 5% upward benchmark adjustment cap.

Claims-Based Assignment Methodology

Final Policies	Key Considerations

• Finalized **modifications to claims-based assignment methodology** to exclude from plurality calculations allowed charges for primary care services delivered by an ACO professional billed through a non-ACO TIN/CCN
  • Effective beginning Jan. 1, 2028
  • Applies to all 3 steps of the claims-based assignment methodology
	• Does not affect expenditure calculations under financial methodologies
	• Does not affect assignment when an ACO professional participates in multiple ACOs
	• More heavily weights assignment towards ACO TINs vs. non-ACO TINs
	  • 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
	• NAACOS encouraged CMS to conduct further analysis on how certain types of ACOs are affected before finalizing

Beneficiary Assignment Eligibility

Final Policies	Key Considerations

• Finalized as proposed **expanded assignment eligibility criteria**, which mirrors the "assignable beneficiary" definition
  • New criteria will include beneficiaries with <12 months of Parts A&B enrollment; must have at least 1 month of both Parts A & B enrollment and no Medicare group enrollment during that same month during the assignment window
  • Applies to both claims-based and voluntary assignment eligibility criteria and to prospective assignment exclusion criteria
  • Effective beginning Jan. 1, 2028
	• 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
	• NAACOS encouraged CMS to conduct further analysis on how certain types of ACOs are affected before finalizing

Beneficiary Assignment

Final Policies	Key Considerations

• **Added codes to definition of primary care services used in claims-based assignment**:
  • Screening, Brief Intervention, Referral to Treatment (G2011, G0369, G0397)
  • Vaccine Adverse Effects Management (G0576)
  • Add-on payment for diagnosis and management of suspected vaccine adverse reaction in conjunction with an E/M visit
  • Advance Care Planning (G0572, G0573)
  • ACP services furnished by clinical staff under direct supervision of billing practitioner
  • Existing ACP codes already included in definition
• Effective beginning Jan. 1, 2027
	• NAACOS supported these additions
	• These are similar to codes already included in the definition of primary care services used in assignment

Application and Participation Policies

Final Policies	Key Considerations
• Allows current MSSP applicants for PY 2027 start a time-limited opportunity to change their final selection between the BASIC and ENHANCED tracks	• Eligible ACOs will have until November 17 at 12:00pm ET to update their final selection in the ACO-MS • Only for ACOs that had already applied for a new agreement beginning PY 2027, not ACOs in current agreement periods that are not renewing
• Modifies 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 beginning Jan. 1, 2027	• Legacy TIN/CCN policies for CMMI models mean that there may be legacy TINs/CCNs currently included in the experience determination threshold for MSSP despite the TIN/CCN not having a written agreement to participate in an ACO • NAACOS supported; will make it easier to qualify for inexperienced definition for some orgs

Beneficiary Engagement Policies

Final Policies	Key Considerations

***Part B Cost Sharing Waiver**
• Creates a tailored, Part B cost sharing waiver similar to the one in ACO REACH
• CMS plans to collect initial applications in early 2027 and targets Apr. 1, 2027 launch
  • Future applications will be held in conjunction with annual MSSP application and change request cycle
	• NAACOS has advocated for this waiver in MSSP
	• ACOs could define a subset of ACO beneficiaries and/or a subset of services for which to cover cost sharing (funded by the ACO)
	  • 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
	  • May not include services covered by secondary insurance (e.g., Medigap, Medicaid)
	  • ACOs would not be allowed to cover cost sharing for DMEPOS or prescription drugs due to high risk for FWA

***Beneficiary Notification Requirements** • Sets a deadline of May 30 annually for all ACOs to furnish the written beneficiary notice • Eliminates the requirements to send a follow-up communication • Effective beginning Jan. 1, 2027	• Both policies recommended by NAACOS to reduce burden • CMS clarified that for ACOs under retrospective assignment, they should use the list of assignable beneficiaries included in the initial assignment report package received at the start of the PY • Beneficiaries added after that date would need to be notified by May 30 of the following PY if they remain on the list of "assignable beneficiaries" included in the Q4 report package

** NAACOS Prior Recommendation*

Changes to Upfront Payments

Final Policies	Key Considerations

Prepaid Shared Savings (PSS)
• Discontinues 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 after Dec. 31, 2027
	• CMS cited low uptake and burden to administer
	• NAACOS opposed and recommended CMS instead modify PSS policies to increase uptake by removing restrictions on allowable uses and focusing on recoupment policies

Advance Investment Payment (AIP)
• Modifies AIP policies to:
  • Remove Area Deprivation Index (ADI) from criteria
  • Add a new rural criterion
  • Add a flat ($25) payment for all assigned beneficiaries not identified as rural/LIS/dual eligible
• Effective beginning Jan. 1, 2028
	• CMS intends for these changes to support ACO formation in rural areas
	• NAACOS supported

MSSP Quality Proposals

Quality changes 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), outlining a potential timeline that implements voluntary reporting beginning in PY 2028 and mandatory reporting beginning in PY 2030.

- NAACOS provided detailed feedback in response to the RFI on this topic and will continue to engage with members, vendor partners, and CMS to ensure a smooth transition for ACOs.

MIPS CQMs

Final Policies	Key Considerations

• * Retains 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 did not include an end date in the rule
• * Extends the MIPS CQM reporting incentive (i.e., the 10/40 rule) 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 did not include an end date in the rule
	• Both policies strongly recommended by NAACOS
	• CMS anticipates sunsetting these in relation to the transition to FHIR dQMs, but does not currently set an end date
	• Reporting incentive continues to encourage all-payer reporting

** NAACOS Prior Recommendation*

Medicare CQMs

Final Policies	Key Considerations

• *Applies flat benchmarks to PY 2026 scores for the Medicare CQMs:
  • Controlling High Blood Pressure
  • Depression Screening & F/U
  • A1c Poor Control
• *Extends the use of flat benchmarks to all Medicare CQMs for PY 2027 and subsequent years
	• Under prior policies, Breast Cancer Screening and Colorectal Cancer Screening Medicare CQMs 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

• *Revises the definition of a beneficiary eligible for Medicare CQMs to include only beneficiaries assigned to the ACO • Effective beginning in PY 2027	• NAACOS had recommended CMS implement this change beginning PY 2026, but CMS finalized as proposed

** NAACOS Prior Recommendation*

Data Completeness for ACOs

Final Policies	Key Considerations

• *Creates new data completeness requirements for ACOs that allow the exclusion of one or more TINs from the quality submission only when:
  • Unforeseen circumstances outside the ACO's control arise (e.g., practice closing unexpectedly mid-year), or
  • TIN uses a CEHRT product designed for specialty use that does not support a given measure, or
  • Other circumstances as determined by CMS (i.e., widespread issues that arise during the PY)
  • AND: the TINs included in the ACO's quality submission must represent 95% of an ACO's assigned population (prior to application of measure specs)
• MIPS data completeness requirement (75%) will apply based on the resulting denominator (after TIN exclusions and application of measure specifications)
• Applies to all four reporting options
• Available beginning PY 2026 (reporting that occurs in early 2027)
	• Exclusions apply on a measure-by-level basis
	• CMS will provide ACOs with beneficiary-TIN level data to determine that included TINs represent at least 95% of assigned beneficiaries
	• Only beneficiaries w/an eligible primary care claim in the PY count toward 95% threshold, but all assigned beneficiaries count toward denominator
	  • Creates challenges for ACOs under prospective assignment or those w/ more voluntarily aligned
	• NAACOS supported and recommended that CMS:
	  • Expand the criteria to include CEHRT products that are not designed for specialty use and do not support a given measure in the APP Plus set,
	  • Allow ACOs to submit for other circumstances, and
	  • Modify numerator calculation of 95% threshold to not disadvantage ACOs under prospective assignment (CMS declined modifications)

** NAACOS Prior Recommendation*

Medicare eCQMs

Final Policies	Key Considerations
• Creates new "Medicare eCQMs" reporting option which uses eCQM specifications applied only to ACO-assigned beneficiaries, beginning PY 2027 • Applies flat benchmarks to Medicare eCQMs for PY 2027 and subsequent years	• NAACOS has raised concerns with assessing ACOs on patients not managed by the ACO for purposes of determining shared savings • NAACOS previously recommended the use of flat benchmarks for measures only reported by ACOs • eCQM reporting incentive will only apply to all payer/all patient eCQMs • Complex Organization Adjustment will apply

** NAACOS Prior Recommendation*

Measure Suppression Policy

Final Policies	Key Considerations

• Modifies scoring policy for measures that are excluded so that ACOs will only receive the higher of their score or the QPS when 4 or more measures are excluded for a given PY
  • i.e., Only applies when the ACO's quality score is calculated on less than 5 measures for a given PY
  • Policy would no longer apply when measures lack a benchmark
  • Effective beginning Jan. 1, 2027
	• Previously, measure suppression policy awarded an ACO the higher of its score or the MSSP quality performance standard if any measures were excluded or the total measure achievement points were reduced
	• CMS notes this change is due to the increase in ACO-reported measures since the initial measure suppression policy was created
	• NAACOS recommended that CMS modify to apply the policy when 3 or more of the ACO-reported measures are excluded to avoid putting heavier weight on administrative claims and CAHPS measures that ACOs have less ability to act on during the PY (CMS declined modifications)

APP Plus Measure Set Changes

Final Policies	Key Considerations

• Removes two measures prior to their addition (previously scheduled to be added in PY 2027):
  • Initiation and Engagement of SUD Treatment
  • Adult Immunization Status
• Updates measure specifications beginning PY 2027:
  • Creates Medicare eCQM version for all reported measures
  • Updates measure logic for A1c Poor Control eCQM to improve logic
  • Depression Screening & F/U measure: updates measure description, definition of active interventions, guidance, and numerator for eCQM collection type; updates numerator and denominator exception for MIPS CQM/Medicare CQM collection types
  • Hospital-wide Readmissions (claims measure): removes denominator exclusion for COVID diagnoses
	• NAACOS supported; had recommended not adding any measures to the set until after ACOs transition to FHIR dQMs

** NAACOS Prior Recommendation*

CEHRT Requirements for ACOs

Final Policies	Key Considerations
• Effective beginning Jan. 1, 2027 • *Sunsets requirements for MSSP ACOs to report MIPS Promoting Interoperability (PI) category • Creates new options for MSSP ACOs to demonstrate CEHRT use (select 1 of 3): 1. Report at least one measure in the APP Plus set as an eCQM or Medicare eCQM (no attestation/additional reporting required) 2. Attest to ACO's use of FHIR capabilities to support reporting (e.g., for data collection) of at least one measure in the APP Plus set as MIPS CQM or Medicare CQM 3. Select and attest to (not report) one of the MSSP CEHRT use metrics: 1. Electronic Prescribing 2. HIE Bi-Directional Exchange 3. Provide Patient Electronic Access to Their Health Information	• Options 1&2 allow use of new data completeness exclusions • Option 2 is an ACO-level (not TIN-level) attestation • Option 3 allows standard MIPS PI exclusions/exceptions EXCEPT small practice exclusion • Option 3 requires at least one ACO provider at each eligible ACO TIN (not all eligible providers within the TIN) to attest "Yes" • These are only for MSSP-specific CEHRT use policies, do not affect MIPS PI obligations for those in a MIPS APM Track • CMS will not enforce the MSSP PI requirement for PY 2026 • NAACOS supported and has recommended eliminating the requirement for all ACOs to report MIPS PI since it was implemented

** NAACOS Prior Recommendation*

Requests for Information

- NAACOS responded to several RFIs included in the proposed rule
- Typically, CMS does not respond to RFI comments in the final rule, but will consider this feedback in future rulemaking
- See NAACOS' comments for our responses on:
  - Developing Prospective Payment Within MSSP (p. 6)
  - Transitioning to FHIR-Based Digital Quality Measurement in CMS Quality Programs (p. 20)
  - Applying Electronic Prior Authorization Measures to MSSP ACOs (p. 26)
  - Integrating Specialty Care in MSSP (see p. 33)

Quality Payment Program (QPP)

Ambulatory Specialty Model (ASM)

Final Policies	Key Considerations
Definitions and Eligibility • Clarifies that a clinician who is selected to participate for at least one ASM performance year will be considered an "ASM participant" for the duration of the model (unless terminated by CMS) • Clarifies circumstances under which ASM participants may be excepted from ASM requirements for a given PY; CMS will evaluate administrative data to determine participant exceptions and notify affected participants • Allows certain cardiac subspecialists to redesignate their specialty type and be excepted from the ASM HF cohort for the duration of the model; CMS will validate redesignations through PECOS and notify participants • Establishes a process for CMS to terminate ASM participants under specified circumstances	• NAACOS raised concerns w/participation status changing year to year • NAACOS supported cardiac redesignation policies • CMS may terminate ASM participants due to noncompliance, threats to patient safety, false data, or program integrity risks; participants may not terminate their own participation

Ambulatory Specialty Model (ASM)

Final Policies	Key Considerations
Quality Measurement, Scoring, Reporting, and Data Submission • Allows ASM participants to submit Improvement Activities data at the group or individual level • Assigns the group-level score to all individual ASM participants in a small practice when data are submitted at both the individual and group levels • Updates quality measures for LBP cohort; adds modified claims measure for MRI lumbar spine, replaces Functional Status PRO with Functional Outcome Assessment measure • Revises benchmarking and scoring methodologies for claims measures • Did not finalize voluntary submission of PRO data and incentive • Updates ASM PI to align with MIPS PI changes; finalizes a 1-year transition policy for the ASM PI category • Creates a scoring adjustment (+5 points) for ASM participants in rural areas	• NAACOS encouraged CMS to allow all categories to be submitted at group or individual level • Opposed MRI lumbar spine measure • Supported replacing functional status measure • Recommended testing and validation before using PRO measures for performance • Supported, but recommended excluding rural clinicians from ASM

Ambulatory Specialty Model (ASM)

Final Policies	Key Considerations
Payment Adjustments and Financial Policies • Clarifies how payment adjustments apply when a participant reassigns billing rights to a new TIN during the payment year • E.g., an ASM participant that was eligible in 2027 but is no longer eligible in 2029 would still be subject to ASM payment adjustment in 2029	• Payment year occurs 2 years after relevant performance year; participants may cycle in and out of performance

Compliance and Waivers
• Revises Collaborative Care Arrangement (CCA) to clarify:
  • CCA must be exclusively between ASM participant(s), under the same TIN if multiple, and primary care practice
  • CCA parties must share a patient who is an ASM beneficiary
  • Renumeration must relate to CCA purpose, be capped based on ASM performance adjustment
  • Applicable compliance obligations and documentation requirements
• Clarifies that model safe harbor and waivers only apply when ASM participant is actively performing under the model (e.g., not available during a PY the participant is excepted from ASM requirements)
	• NAACOS supported allowing multiple ASM participants in the same TIN to enter a CCA with the same PCP
	• Encouraged CMS to provide more clarity and guidance

Quality Payment Program

Final Policies	Issues/Comments
Merit-based Incentive Payment System (MIPS) • Finalized mandatory MIPS Value Pathways (MVPs) for all MIPS reporters beginning in CY 2031 • Sunsets traditional MIPS reporting after CY 2030	• Delayed 2 years from proposal • MIPS APMs can continue to report the APP • NAACOS has opposed mandatory MVPs
Advanced APMs • Finalized proposals implementing CAA (lowered QP thresholds for PY 2026 and extension of APM bonus at 3.1% for PY 2026 (paid in 2028)) • Finalized applying QP and partial QP determinations at the TIN/NPI level (rather than at the NPI level across all TINs), beginning with the 2027 QP performance period	• NAACOS opposed the QP changes citing 1)administrative complexity; 2)lower financial incentives for APMs; 3)Inconsistency w statute

Mid-Term Election

Election Results: What they mean for Accountable Care

A change in the congressional audience, not in the bipartisan case for accountable care

2026 CONGRESSIONAL OUTLOOK

Democrats win control of both chambers

HOUSE

D 256 — R 170

9 uncalled

SENATE

D 55 — R 44

1 uncalled

Results remain incomplete. Counts reflect races called as of 5:00PM ET on Nov. 15.

Implications for accountable care

1. **Re-engage and educate**

   Committee leadership and staff will shift. Resume Hill briefings and events, positioning accountable care around affordability, Medicare sustainability, and better care for patients.

2. **Expect a limited lame duck**

   Republicans may try to advance remaining priorities through reconciliation, but many NAACOS priorities are likely to move to the next Congress.

3. **APM incentives remain viable**

   Advanced APM incentives retain a strong path forward, with Democrats consistently linking them to broader physician payment fixes and bipartisan MACRA reform.

4. **Prepare for CMS oversight**

   Congressional scrutiny of CMS and CMMI will increase. Focus on Medicaid, Exchanges, MA. VBC oversight focused on WISER and mandatory models

BOTTOM LINE **The election changes who we engage, not the underlying opportunity for accountable care.**

Questions?



Registration Is Open!

Spring 2027 Conference

Register Today!

April 13-15

Hilton Baltimore Inner Harbor

Thank you!

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