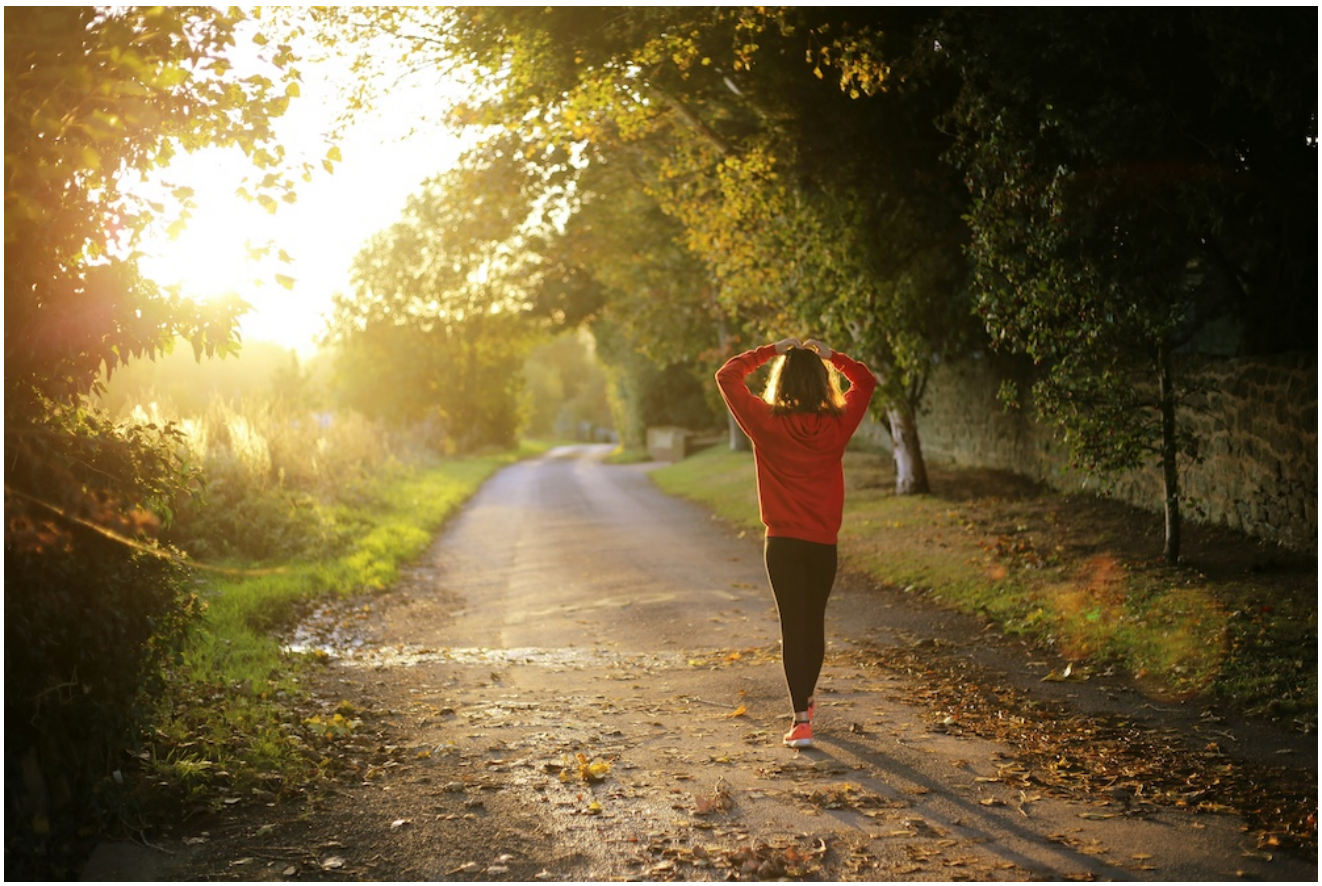
2027 Physician Fee Schedule Final Rule: 5 Themes Shaping the Future of Value-Based Care

written by Theresa Hush | November 12, 2026



That rustling you hear isn't falling leaves—it's the 2,468 pages in the 2027 CMS Physician Fee Schedule Final Rule. While the Rule deals with many reimbursement and rate issues, this annual rule also covers the latest direction of the CMS Value-Based Care program. This year they have pushed the envelope.

Proposed policies have largely sailed through, and we've covered these thoroughly in a prior blog. The notable exception is the timeline for Traditional MIPS. Still, its days are numbered, and it will sunset following the 2030 performance year.

Regulatory surprises are in short supply, but the impact of these finalized policies on Value-Based Care is staggering. The vision is taking shape, and these five themes should guide your transition from volume to value.

1. Specialty Care in the Spotlight

The Ambulatory Specialty Model (ASM) is rolling out as planned, beginning on January 1, 2027. As proposed, specialty care physicians treating heart failure and low back pain will be evaluated on the quality and costs associated with each condition.

By making ASM mandatory, CMS pulls back the curtain on quality and costs on chronic conditions managed by specialist providers. It's hard to understate the impact that publicly reported data will have on patient choice and marketplace competition. In addition, this model has teeth—payment adjustments start at plus/minus 9 percent and grow.

Monitoring ongoing ASM performance will be a challenge—for some. Quality measure benchmarks and patient attribution will not be completed until after the performance year, when it's too late to adjust. To maximize ASM performance, ASM participants will need tools to proactively identify patients at risk for high-cost events, spotlight drivers of costs, and slow disease progression.

ASM has arrived on the heels of other recent efforts to curtail excess specialty care spending. The Transforming Episode Accountability Model (TEAM) started this year and is focused on five types of surgeries accounting for the highest cost and volume in Medicare. While TEAM holds hospitals at risk, the use of collaboration agreements allows them to align incentives with clinical and surgical teams. Comprehensive Joint Replacement Expanded (CJR-X), which includes all hospitals lower extremity joint replacements not covered by TEAM, will begin in 2028. And finally, the LEAD ACO Model enables ACOs in

the model to use CMS shadow bundles to negotiate costs with specialists for the first time. Taken together, these four initiatives dramatically change the structure for evaluating value and paying for specialty care.

2. Investment in Accountable Care Organizations

CMS sees ACOs as the key to ensuring all Original Medicare (OM) patients are in accountable care relationship by 2030. Buy-in from patients and providers is critical. This Rule finalizes proposals intended to drive new ACO formation and augment volume in existing ACOs.

To incentivize ACOs to form or expand into high-needs populations, CMS will risk-adjust benchmarks and provide opportunities to earn greater savings. Additional ACO concerns about accepting risk in that area are assuaged through benchmarking corrections that protect ACOs against inadvertent ratcheting issues stemming from year-over-year savings.

Driving existing ACO growth is a two-part operation that requires recruiting new providers and new patients. ACOs efforts to attract both groups must address financial benefits and losses. The modifications to the ACO reimbursement formula go a long way to address provider concerns. To benefit patients, CMS is allowing ACOs to reduce or eliminate beneficiaries' out-of-pocket costs for patients through "Cost Sharing." This up-front investment can offset deferred care and translate into a greater magnitude of savings down the road. It also helps put ACOs on a more even footing with Medicare Advantage (MA), which could help ACOs strategically in their ownership or negotiating positions with MA plans.

3. Options for Independents, but Risk Remains

Traditional MIPS does get a slight extension before it is dismantled, but ignore the warning signs at your peril! The extension is only to accommodate the planned introduction of Digital Quality Measures, or dQMs. These next-generation quality measures are built on the Fast Healthcare Interoperability Resources (FHIR), utilizing vastly more comprehensive data without (in theory) adding administrative burden.

Beginning in 2031, MIPS Value Pathways (MVPs) will become mandatory for all MIPS participants, shifting clinicians into disease-, procedure-, or practice-based measurement profiles. The intent is to shine a light on care delivered by specialists, as their specific contributions to an organization's cost and quality have been obfuscated by group-level data submissions.

Since CMS uses MIPS results to guide new program development, expect the MVP rollout to produce new, mandatory specialty payment models. ASM may be the first to highlight quality reporting for specialty providers, but don't be surprised to see more specialty payment models in future rules.

4. Reduced Administrative Burden Shifts Attention to Performance

To launch ASM and promote ACO adoption, CMS has alleviated several administrative burdens. CMS will handle ASM specialty designation issues using PECOS, so make sure your information is accurate! Meanwhile, Promoting Interoperability has been converted to an attestation, with Improvement Activities now

allowed at the group level. Promoting Interoperability dispensations have also been granted to ACOs.

The catch is that, by offloading administrative burden, CMS puts the spotlight squarely on ACO and ASM participants' quality and cost results. That transparency will enable CMS and patients to differentiate high quality performers from their competition.

5. Putting the Whole Patient First

An underreported highlight of this rule is the attention given to the window between traditional office visits. Policies include new billing codes for Medicare payment of patients' health coaching, shared medical appointments to receive group guidance and peer support, and the addition of services to the ACO attribution methodology to reflect the importance of patient lifestyle and decision-making. This marks a shift from CMS relying solely on payment models to encourage providers to develop specific patient programs, and the willingness to insert new ideas to facilitate patient accountability into the programs.

Far more than in previous years, this rule recognizes that each patient/provider relationship will vary, but that each patient can benefit from an accountable care relationship—IF the clinician has the technology and support that facilitates engagement, actionable intelligence, and improvement pathways.

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