The 2027 CMS PFS Proposed Rule: The Push for Accountability

written by Dave Halpert | July 23, 2026

This summer, cool off with a cold drink and the 1,592-page 2027 CMS Physician Fee Schedule Proposed Rule!

CMS has teased the elimination of Traditional MIPS and full

transition to MIPS Value Pathways (MVPs for several years), and we now have a proposed date. Starting in Performance Year 2029, MVPs will be the only option for MIPS participation. To prepare for this shakeup, CMS uses this Proposed Rule to create a two-pronged approach: first, to bolster the MVP library and address scoring concerns; second, to incentivize ACO participation, strengthening the program by enticing clinicians to abandon the MIPS ship altogether.

As you plot your Value-Based Care course, pay attention to these five key themes to ensure you're not beating the heat by being left out in the cold!

1. Specialty Care Is in the Spotlight

A whopping 80 percent of Part A and Part B charges come from specialty care. However, specialists in large multi-specialty groups have largely been shielded from MIPS quality reporting by the Group Practice Reporting Option. These groups have had the opportunity to report on a set of six quality measures, regardless of the volume of clinicians represented by their selection. By introducing the Ambulatory Specialty Model (ASM) and sunsetting Traditional MIPS, CMS aims to break down the barriers that have precluded meaningful quality reporting for specialty care providers.

ACOs and MIPS are the primary Quality Payment Program foci in these proposals. Remember that ASM presents a golden opportunity, but also carries significant risk. In the first year, providers can see a 9 percent incentive or penalty, which will eventually increase to 12 percent in the final ASM year. That's right—a 24-point swing. Even though the proposed ASM changes are limited (and are mainly explanations), there is too

much at stake to ignore the fine print.

The most important update is a clarification that, while CMS can terminate a clinician's participation on a year-to-year basis, that is not the expectation. If selected, a clinician should expect to remain in ASM for the duration of the program. Therefore, *organizations should begin planning for multi-year quality reporting at the individual level,* as required in ASM.

At least one quality measure from each cohort (back pain and heart failure) will need to be submitted, and CMS will further evaluate participants on additional cost and quality metrics. To address issues of care coordination and cost, now is the time to begin looking at collaboration agreements between your ASM participants and other clinicians, facilities, and organizations. A proposal allowing multiple entities to use the same agreement (provided that they are explicitly named) could make this process a little easier, but compliance and legal considerations ensure that this will not be an overnight process.

Of the two ASM cohorts, Low Back Pain is more complicated, and CMS has made several proposals to operationalize this track. The first is the introduction of a multi-attribution process. Because so many specialty types are flagged for Low Back Pain (and the fact that a patient may be seeing them concurrently), CMS has stated that the same patient may be attributed to multiple clinicians for the purposes of cost and quality measurement. This could include the addition of an administrative claims measure (a measure CMS calculates through claims analysis) related to the overuse of MRI utilization in early Low Back Pain treatment. CMS left the door open for the

incorporation of additional measures (including a patient-reported outcome measure) but did not explicitly propose adding them.

2. MIPS Value Pathways (MVPs) Development Is Accelerated (Take Note!)

To prepare for the end of Traditional MIPS, CMS has made several proposals to support MVP adoption and to address issues that have cropped up during the MVP phase-in.

Three new MVPs have been proposed for 2027:

- Diabetic Disease
- Hypertension
- Hospitalist

That brings the total MVP count to 30, and according to this Proposal, will cover nearly 100 percent of medical specialties.

To address certain scoring concerns, CMS has proposed axing the requirement that the 4+ measure submission must include an outcome measure. As many have discovered, some of the outcome measures in an MVP are topped out and capped at 7 points, which cuts quality scores 7.5 percent right out of the gate. CMS knows that, once MVPs are mandatory, those scoring glitches won't be tolerable. The update comes with a catch, though: while CMS does intend to phase out the "outcome" and "high priority" measure classifications, those will be replaced with a "Core Measure Designation." In the MVP quality reporting context, entities would need to include at least one "Core

Measure” in their quality submission.

Even though (in theory) all specialties have an available MVP, large, multi-specialty groups have been reticent to report MVPs via subgroups. The reason is simple: it is much more work. Rather than building workflows and monitoring performance on a set of 6 measures, a comprehensive practice may need to create 20+ subgroups, reporting a minimum of 4 measures apiece. The result is that groups would need to track performance on at least 80 metrics—more than 13 times what’s required today. CMS does state that they will monitor subgroup reporting burden to see if additional support is required, but do not propose any specific dispensations for those in this situation.

The other notable MIPS changes are updates to the Promoting Interoperability category (like Core Measures, these will also apply to Traditional MIPS until it sunsets). CMS proposes adding a pair of electronic prior authorization measures to facilitate quicker turnaround for certain drugs and care. Other metrics are on the chopping block, including attestations that ONC or an ONC-Authorized Certification Body can conduct a direct review to confirm CEHRT requirements, as well as the Security Risk Assessment measure.

The justification for these removals is that providers are already bound by language in HIPAA and in CEHRT, and so these attestations are extraneous. Your group may be relieved of the administrative and reporting “burden” of answering “yes” to these three questions, but know that in 2025, more than 61.5 million patients were affected by large healthcare data breaches, so do not be lulled into cybersecurity complacency. Since submission of these measures will not occur until 2027,

these removals could go live in 2026; but remember, these are only proposed actions and will not be finalized until November.

3. ACO Growth Is a Key Priority

To fulfill its goal of having all patients in an Accountable Care relationship by 2030, CMS needs to expand the ACO program. They propose several policies they hope will bring more providers into existing ACOs and encourage new ACO development.

Their most direct approach is to increase the shared savings opportunity for those at the highest level of the ACO BASIC Track (Level E). As proposed, the savings rate would increase from 50 percent to 60 percent. The rationale is that, in order for the ACO to be self-sustaining, the savings must outweigh the costs and efforts associated with its creation and maintenance. Of course, there is the potential for shared losses, and so it's critical to strike a risk/reward balance. At present, there is a substantial gap between maximum savings/losses rates in the ENHANCED Track and Level E of the BASIC Track. By increasing the stakes for the Level E ACOs, CMS hopes to lessen the divide between the two, and provide a better steppingstone from the BASIC Track to the ENHANCED Track.

To increase participation in existing ACOs, CMS is proposing a "Growth Adjustment" of up to 5 percent for ACOs who can bring in new providers. Shifting these providers from Traditional Medicare FFS arrangements into ACOs gets CMS that much closer to its 2030 enrollment goals. In addition to the carrot, they also use a stick, saying that APM incentive payments will be calculated at the TIN/NPI level, and not the NPI alone. In other words, a provider billing out of multiple practices could

only receive APM compensation when billing from the TIN in the APM's participant list.

Recognizing that Medicare patients have freedom of choice, CMS makes proposals that incentivize patients to seek care from ACOs, particularly those without Medigap, Medicaid, or employer-sponsored plans. In ACO REACH, CMS piloted a Part B cost-sharing support arrangement between ACOs and patients that limited patients' out-of-pocket costs. Given the success of ACO REACH, CMS has proposed that ACOs can enter those same types of Part B cost-sharing support arrangements with participants. These would eliminate cost-sharing for all Original Part B items except DME, Prosthetics, Orthotics and Supplies (DMEPOS) and prescription drugs. CMS uses this as a reason to cut prepaid shared savings, saying that cost-sharing eliminates the need. Nevertheless, there is fantastic potential for ACOs to more effectively care for patients in high-needs populations.

4. CMS Wants ACOs to Produce Continuous Savings

Since ACOs are judged each year against a set of benchmarks, generating savings creates an unanticipated consequence: the Ratcheting Effect. Reducing an ACO's spending also cuts its regional and historical spending trends, meaning that the ACO becomes a victim of its own success. By reducing the spending trends used to calculate benchmarks, ACOs lower the limit on what CMS believes they should spend. This limbo dance makes it more challenging for ACOs to limit spending without compromising quality and can disenfranchise ACO participants. To ensure that ACOs have predictable targets and continued incentives to generate yearly savings, CMS has proposed several changes to its benchmarking methodology.

To prevent the Ratcheting Effect, CMS aims proposals at the Prior Savings Adjustment and the Accountable Care Prospective Trend (ACPT). The Prior Savings Adjustment increases benchmarks to account for previous success (savings). To incentivize ACOs to sustain their efforts and prevent ratcheting, CMS proposes to increase its scaling factor from 50 percent to 75 percent. This would lessen the decrease in target prices that resulted in savings (as opposed to other regional trends), thus incentivizing ACOs to sustain their efforts and protect against the Ratcheting Effect. For the same reason, CMS has added a guardrail based on US Per Capita Cost (average costs for Part A and Part B per beneficiary) so that projected growth does not penalize prior savings.

CMS has also proposed limiting the weight that the Regional Adjustment has on ENHANCED Track ACO benchmarks, from 50 percent to 35 percent. ENHANCED Track ACOs have more at stake than those in the BASIC Track, but can also earn more savings. One reason is that, when spending is lower than the region average, ENHANCED Track ACOs are rewarded at a higher rate than their BASIC Track counterparts.

The issue is, according to CMS, regional adjustment dollars are on the rise, but the share of those that see the benefits have remained steady. Since only the impact (and not the breadth) of these adjustments has increased, CMS questions whether ENHANCED Track ACOs are saving more because they’re performing better or, rather, because they receive more favorable benchmarks. Reducing the impact of the Regional Adjustment would eliminate this issue and, combined with the increased savings potential for BASIC Track Level E participants, would further bridge the gap between BASIC and ENHANCED Track ACOs.

To ensure ACOs are not penalized for caring for high-risk patients, CMS has proposed modifying the 5 percent cap on increases to the Historical, Prior Savings, and Population (formerly Health Equity) adjustments. Since 5 percent may not be enough to cover the expenditures needed to manage complex populations, CMS has proposed increasing the 5 percent cap via risk adjustment.

In addition to financial benchmarks, APP reporting also impacts Shared Savings. To maximize Shared Savings, ACOs must meet the Quality Standard through APP reporting, and CMS has proposed a new method: Medicare eCQMs. These are similar to eCQMs, but rather than covering an all-patient population, this version is limited to the ACO's attributed patients, similar to the current Medicare CQM collection type. To further bolster participation options, CMS has walked back its decision to eliminate the MIPS CQM collection type, proposing it as a permanent option.

To alleviate Medicare CQM and eCQM scoring concerns, CMS has proposed that each measure receive a "flat" benchmark—e.g. 90-100 percent equals 10 points, 80-88.99 percent = 9 points, etc. This provides ACOs a more predictable and understandable scoring scale, and eliminates questions about the validity of applying historical benchmarks to recently devised measures. If finalized, since PY2026 data submission does not occur until 2027, these benchmarks would be applied retrospectively to 2026 APP scores. To reduce reporting burden (and align with priorities of the current administration), CMS will not add the planned adult immunization status and substance use disorder treatment measures to the 2027 APP measure set.

5. You Have a Voice

These proposals are far-reaching, but key details are still to be determined, and you can have a voice in the discussion. Along with your ability to comment on the rule, there are several Requests for Information that solicit suggestions for planning, implementing, and evaluating a value-based care transformation:

> How to integrate FHIR APIs into quality reporting, from a 2028 pilot stage through full implementation in 2030;
> Suggestions for improving MVP scoring, including normalization by MVP, rather than relying solely on CMS measure benchmarks. This would eliminate issues in which one MVP has more topped-out measures than others;
> Best practices for bringing specialist providers into ACOs, including MVPs, CMS data sets, and sub-capitation arrangements, similar to the risk arrangement agreements we see in TEAM and ASM.

To comment on the Proposed Rule and/or provide feedback on its included RFIs, you can do so electronically, referencing CMS-1848-P. Comments are due by September 14—make your voice heard!

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