CMS Commits to Control Total Cost of Care: 6 Volleys in the 2026 CMS PFS Proposed Rule

written by Dave Halpert | July 18, 2025

Summer is here, and the heat is on: barbeques, beaches, and the 2026 CMS Physician Fee Schedule Proposed Rule. Throughout 1,803 pages, CMS is going after the total cost of care in the MIPS and APM tracks of the Quality Payment Program (QPP).

These proposed updates and the creation of a surprise new (and mandatory!) Alternate Payment Model (APM), share themes that you need to recognize to ensure that your Value-Based Care strategy has long-term viability.

1. Two-sided risk will come for everybody, and it will be mandatory.

The biggest news to come out of this Proposed Rule is the creation of a new and mandatory two-sided risk model named the "Ambulatory Specialty Model" or "ASM". As we've predicted, CMS has taken another step toward mandatory, two-sided risk models.

Required participation eliminates the selection bias that can corrupt the data from voluntary models and furthers CMS's goal of having all Medicare patients in accountable care relationships by 2030.

We will cover the ASM in more detail in a future blog, but in broad strokes, the goal is to reduce costs and improve care coordination in specialty care, starting with two chronic conditions: heart failure and low back pain. Aside from diabetes, these are the conditions that account for the highest Medicare Part A and Part B spending (diabetes was not included because it is frequently managed solely by primary care providers, rather than primary care providers in conjunction with specialty providers). The process will be very similar to a MIPS Value Pathway (MVP), and, in fact, it will utilize the Heart Failure and Low Back Pain Episode Based Cost Measures (ECBMs) found in MIPS.

On the ACO side, the Proposed Rule condenses the period in which ACOs that are "Inexperienced" with two-sided risk can remain in a one-sided arrangement. Rather than seven years, CMS proposes five, the length of the initial agreement period. In the ACO's second agreement period, the entire five years would need to be two-sided, in either the highest level (E) of the BASIC Track or by advancing to the ENHANCED Track.

In the ACO environment, those in two-sided models consistently outperform their non-risk counterparts, and in order for the ACO model to remain cost-effective, "Inexperienced" ACOs must be brought more rapidly into the fold. The "Experienced" ACOs have gradually moved in the same direction, with 2025 marking the first year in which participation in the ENHANCED Track has

eclipsed participation in the BASIC Track.

2. Effective care coordination can reduce costs by slowing disease progression.

Proposals related to managing chronic condition costs apply to all facets of the Quality Payment Program. In the ASM, participants are incentivized to ensure patients are aligned with PCPs who can screen and identify symptoms of chronic disease earlier for proactive intervention. Scoring on quality and cost measures reflect the progression of existing disease.

In MIPS Value Pathways (MVPs), the approach to care coordination is tailored to encourage enhanced participation. Since there is no proposed timeline to sunset Traditional MIPS, MVP participation is still optional. With mandatory subgroup reporting on the horizon, many multispecialty practices have chosen to remain in Traditional MIPS.

This has created an unintended consequence for practices that employ multiple specialty providers, but are aligned on a single, clinical focus. For example, a cancer care center may consist of radiologists, oncologists, NPs and PAs, and potentially even a primary care physician. Forcing these types of practices to report as subgroups actually detracts from their mission and will increase reporting burden while producing less meaningful results.

To alleviate this issue, these groups will be able to self-attest to being a “single specialty” group and report a single MVP, rather than breaking the larger group into subgroups. This was a concern raised when specialty composition within a practice was defined by CMS through claims.

3. Health equity by any other name will always play a role in Value-Based Care.

Although not surprising when taken in context of the current administration's priorities, there is a significant purge of Health Equity terminology and provisions within this proposal. However, the removal of the Health Equity Adjustment for ACOs this year (as opposed to 2026) was unexpected. The claim is that the Complex Organization Adjustment and the extension of the all-patient reporting incentive render the Health Equity Adjustment duplicative. Unfortunately, these incentives do not apply to those utilizing Medicare CQMs, and those ACOs stand to lose the most from the loss of the Health Equity Adjustment.

On the other hand, CMS is not removing the Health Equity Benchmark Adjustment related to Part D low-income subsidy (LIS) and Dual Eligible patients, but they are renaming it "Population Adjustment." The decision to preserve (but rename) the "Health Equity Benchmark Adjustment" and remove the "Health Equity Adjustment" comes down to CMS's goal to have all Traditional Medicare beneficiaries in an accountable care relationship by 2030. The Health Equity Benchmark Adjustment was shown to bring ACOs into communities that would have been seen as too risky.

The eradication of health equity references also applies to MIPS. On the quality side, they have proposed removing measures related to Screening for Social Drivers of Health (measure 487) and Connection to Community Service Provider (measure 498), stating that they were no longer considered "high priority" measures and were therefore "non-relevant process measures." Similarly, the "Advancing Health Equity" Improvement Activities

have also been proposed for removal, to be replaced with "Advancing Health Wellness" activities.

The rule indicates that CMS is not attempting to take focus away from access, but that they're intending to do so through nutrition, "well-being," and patient engagement. No evidence was provided to indicate that the affected quality measures and IAs were irrelevant, and time will tell what impact this will have on patient outcomes and the intermediate outcome-based quality measures. It will definitely affect MVP participation, though—the Screening for Social Drivers of Health measure was broadly included in MVPs and was prioritized by many health systems for workflow development, as it would cross all subgroups in a multi-specialty practice. Its removal will mean fewer options for participating providers.

4. CMS has its eye on specialty care, down to the clinician level.

The newly announced Ambulatory Specialty Model is mandatory, and when viewed in the context of the previously finalized (and mandatory) Transforming Episode Accountability Model (TEAM), it is clear that CMS is exploring options to control specialty-driven costs. Although ASM is an APM built on an MVP chassis, there is a significant difference: ASM will be scored at the clinician level, rather than at the group or sub-group level. This will enable an "apples to apples" comparison and may yield interesting results, especially when providers are in the same large organization, like an Academic Medical Center.

For MIPS participants, CMS uses this Proposed Rule to encourage specialists' engagement in MIPS Value Pathways (MVPs), rather than Traditional MIPS. To that end, they have released six new

MVPs, opening the MVP environment up to:

- Diagnostic Radiology
- Interventional Radiology
- Neuropsychology
- Pathology
- Podiatry
- Vascular Surgery

Although nothing was proposed, CMS does discuss considerations for ensuring that providers are reporting the most relevant MVPs, creating a true and comparable profile to other clinicians in the same field. Specifically, the Proposed Rule suggests the future use of procedures and diagnoses on claims to dictate which MVP a provider would need to report, similar to how the ASM is configured. Additionally, CMS considers making certain MVP measures (designated as Core Elements) mandatory, ensuring provider comparability and streamlining reporting options, particularly in MVPs with abundant measures.

Finally, CMS is adding a proposal to add an individual QP (Qualified Participant in an APM) determination. Currently, by looking only at the APM Entity's status, a provider could be excluded if an APM Entity did meet payment amount and patient count requirements, even if that provider would meet those criteria individually (e.g. a minority of surgeons participating in a BPCI practice). By utilizing individual and APM Entity determinations to advise QP status, specialty practitioners are more likely to remain participants in advanced APMs, furthering CMS's goals.

5. The unbreakable bond between data security and Value-Based Care is essential.

In the wake of the biggest U.S. Healthcare data breach of all time, it behooves you to ensure that your system is protected from bad actors. Although the Proposed Rule does make allotments in program participation in the form of Extreme and Uncontrollable Circumstance (EUC) exemptions for cyberattacks and ransomware, the bulk of the security proposals are added responsibilities for providers, practices, and health systems.

These proposals impact the Promoting Interoperability (PI) performance category, which is now required by ACOs, MIPS participants, and is also scored in ASM. However, as configurations vary by Certified EHR Technology (CEHRT) implementation instance, assessment by CMS is not feasible, and certain components must be handled through provider attestation.

CMS has the ability to audit any data submitted by a provider or on a provider's behalf, and this includes Promoting Interoperability. Giving the rubber stamp treatment to attestations can have severe consequences, including payment recoupments, fines, and potentially prison. Therefore, the additional attestations required for PI should not be glossed over, particularly related to the Security Analysis.

In addition to confirming whether a Security Risk Analysis was performed, a second attestation must be made to indicate whether security risk management activities have been conducted. In other words, whether the Risk Analysis was carefully reviewed, and whether steps were taken to close security gaps. It is certainly conceivable that, in the future,

the fate of a provider's cyberattack-related EUC could hinge on evidence that these tasks were performed.

Security is paramount in Value-Based Care. If your system is attacked and you are locked out, the information you need to make informed clinical decisions will suffer. The results will mean poorer outcomes and higher downstream costs.

6. Quality measurement is essential for controlling costs and swings back to per-provider.

Do not mistake the emphasis on controlling total cost of care for a withdrawal from quality measurement. Even before this proposal, CMS has solicited feedback on the Health Technology Ecosystem, including input on how quality measurement should look in the future, what should contribute to quality measure scoring, and how it can be less of a burdensome process. A notable element of quality measurement in the proposed ASM is quality and cost measurement of individual providers. Based on the language of the rule, we may see more of that in the future, especially for specialists.

The Proposed Rule continues this discussion with several Requests for Information (RFIs) intended to guide future rules and development. Of particular importance, there is an RFI on the development of Fast Healthcare Interoperability Resources (FHIR). FHIR would allow different healthcare software—and not just EHRs—to achieve a standard of interoperability that will make quality reporting more robust and more efficient in the future. Bulk data (populations of individual patients) FHIR exchanges would substantially accelerate CMS's transition to

Digital Quality Measures (dQMs), and they would like your feedback on how it should work, and your current challenges.

In the short-term, CMS has made several proposals to enhance quality measurement, including updates to scoring mechanisms that unfairly penalize providers for average—and in some cases, high—performance. The Final 2025 Rule addressed two major pain points, and this proposal follows suit.

The first issue was that MIPS Cost measures disproportionately punished those with average scores. Therefore, rather than using a bell-curve approach that gave 5 points out of 10 to average performers, CMS designed a method using the median and weighted standard deviations, meaning that providers in the middle of the pack scored in the 7-point range, rather than 5. In other words, “average” earns a “C”, rather than an “F.”

This approach was well received, and has been proposed in scoring the quality measures that CMS calculates using its claims data (e.g. readmission rates, admission rates for patients with chronic conditions). Aligning the scoring for claims-based quality measures with the existing claims-based cost measures is anticipated to produce similar results, meaning that an average score will no longer mean a failing grade.

The second concern was that many specialty providers still have limited measures to choose from, with a significant percentage hindered by “extremely topped out” status. These measures have such stringent benchmarks applied that providers who perform well in 99 percent of cases will only earn 2 out of 10 points.

Not surprisingly, this has scared many providers away from MVPs, as they can see that these limited selections put them at greater risk than reporting more peripheral measures using Traditional MIPS. That directly conflicts with CMS's goal of moving providers into MVPs and sunsetting Traditional MIPS. To alleviate this concern, additional measures have been proposed to receive the coveted "Alternative Benchmarking Methodology." While this proposal is still stringent, providers would still earn a score high enough to clear the MIPS Performance Threshold (proposed to remain at 75 points through the 2028 performance year), even if participating in an MVP.

These proposals and RFIs can bring significant changes to future care delivery and reimbursement, so we encourage you to participate in rulemaking. Before the 60-day comment period ends on September 12, go to http://www.regulations.gov/ and reference "CMS-1832-P" to make your voice heard.

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