The 2026 CMS PFS Final Rule: The 5 Ways CMS Aims to Control Total Cost of Care

written by Dave Halpert | November 3, 2025



The CMS PFS Final Rule is out . . . early? If you're wondering how, in the midst of the Shutdown, a 2,375-page Rule could be released, the answer is simple: most of the proposals from this summer were finalized as is.

There are always exceptions, but the big takeaway is that this Rule solidifies CMS's proposals to control the Total Cost of Care. Through a variety of finalized proposals, we've identified five themes that illustrate how they intend to accomplish this, and what it means for you.

1. Bit by Bit, Everyone Will be Shunted into Two-Sided Risk

The key tenet in CMS's push to save money through accountable care relationships is that providers must be at financial risk. A program that will pay providers a bonus but not recoup high costs will not reduce CMS expenditures. Through a new and mandatory program, the Ambulatory Specialty Model (ASM), and a change to the Medicare Shared Savings (MSSP) ACO model, the theme of two-sided risk will have an extremely broad impact across organizations and providers.

The Ambulatory Surgical Model (ASM) was finalized as a mandatory model for providers treating patients with heart failure or low back pain. The program is set to begin in 2027 and run for seven years (including post-reporting payment years).

Not everyone will be included, but providers in certain Core Based Statistical Areas (CSBAs) and using a specific specialty code on the plurality of Part B claims will be required to participate. For heart failure, the specialty code is cardiology. Low back pain cuts across a broader set, including anesthesiology, interventional pain management, neurosurgery, orthopedic surgery, pain management, or physical medicine and rehabilitation. For either group, there is also a requirement that at least 20 attributable episodes occurred in the calendar year two years prior.

ASM mirrors MVPs, including use of the Episode Based Cost Measures (ECBMs) in the heart failure and low back pain MVPs. However, there is a critical difference. In ASM, Quality and Cost each contribute 50 percent of the final score. A failure

to submit Improvement Activities and Promoting Interoperability categories can detract from a provider's score, but completing them will not add to it.

The other major difference between ASM and an MVP is the methodology behind the payment adjustment. MIPS is budget neutral; those who do not meet a performance threshold are penalized, and those that do will receive an incentive payment based on the size of the penalty pool. In ASM, adjustments come from an ASM incentive pool, which is a fixed rate of total Part B claims paid to ASM participants. Since there is no performance threshold, the adjustment is exclusively based on comparison against peers. The risk level starts at 9 percent in 2027, and will increase to 12 percent by the end of the program. There will definitely be winners and losers.

On the MSSP front, CMS is finalizing its proposal to limit ACOs to a 5-year period in the one-sided BASIC Track. Following that, those ACOs will need to either move to BASIC Track Level E, or to the higher-risk/higher-reward ENHANCED Track. However, this will not go into effect until 2027, as the 2026 application cycle had already started when the Proposed Rule was published in the Federal Register.

That change will be felt by a newly allowed contingent of ACOs who were formerly precluded from participation based on attributable beneficiary volume. Previously, ACOs must have had at least 5,000 attributable beneficiaries to be approved as an ACO. Now, by finalizing the proposed change that an ACO may have fewer than 5,000 attributed beneficiaries in years 1 and 2 (provided they hit 5,000 by year 3), these smaller groups can be brought into the MSSP fold. They will only be able to

participate in the BASIC Track (not ENHANCED), and will have a cap on savings/losses. Like the previously described policy, this will also not take effect until 2027

2. Consistency in MIPS is Temporary

CMS has previously expressed its intention to phase out Traditional MIPS and replace it with MIPS Value Pathways (MVPs). This Final Rule does not list an official date for sunsetting Traditional MIPS, but there is a mention that they expect to be ready by 2029. To ensure that providers have a stable ground from which to jump from Transitional MIPS to MVPs, they have finalized a multitude of proposals aimed at keeping Traditional MIPS stable while enhancing the MVP library:

- Creation of six new MVPs in underrepresented specialties;
- Updating the scoring of the Total Per Capita Cost measure and administrative claims Quality measures, adopting the more favorable scoring method using the median and standard deviation method currently employed in episode-based cost measures;
- Adding a two-year “informational-only” period for new Cost measures;
- Moving additional measures into the alternate performance calculation for topped out measures in specialties with limited choice;
- Updating the security-related requirements of Promoting Interoperability requirements, but minimizing other changes;
- Maintaining the 75-point performance threshold through 2028.

While Traditional MIPS remains stable, there are changes coming for MVP participants. The most important is that 2025 is the last year multispecialty groups can report an MVP as a single group, rather than a subgroup. This has been the deadline for years, but unlike some prior deadlines, this one was not undone by the Final Rule. Undoubtedly, although Subgroup reporting is mandatory in 2026 and beyond for multispecialty groups, the decision not to undo the deadline is partially because these multispecialty groups are only impacted if they chose to report an MVP. They still have the opportunity to report at the group level in Traditional MIPS.

An additional change to subgroup reporting was finalized. CMS has learned that they cannot use claims to determine how to accurately break a multispecialty practice into subgroups. Mid-year acquisitions, provider turnover, and NPs in specialty settings are just a few of the variables that preclude claims data from being the “source of truth” with regards to the composition of a multispecialty group. CMS has released an RFI to determine methods to determine ways to preemptively establish subgroups, but for 2026, practices must attest to their composition.

3. Accountable Care Must Enable Clinician-Level Comparisons

CMS’s stated goal is to have all Traditional Medicare beneficiaries into an accountable care relationship with a provider by 2030. Here, “provider” is the key term. Even in an ACO, patients are attributed based on encounters with a specific provider. CMS uses this Rule to advance accountable care at the clinician-level.

In the ASM, the key detail is that the accountable party is a specific provider, defined using the combination of individual NPI and practice Tax ID Number. This is in stark contrast to TEAM, which is a hospital-based program. Nevertheless, many of the strategies for success in TEAM and opportunity for collaboration agreements are applicable to ASM, and can be adopted widely. This ensures that your value-based care strategy isn't duplicating your team's efforts, and can produce maximum impact with your available resources.

ASM participant eligibility is determined yearly, and so some years, a provider will be in ASM, and others, that provider will need to fulfill QPP requirements through MIPS. CMS will notify providers annually whether they fulfill inclusion criteria, and has stated that they will provide a preliminary 2027 list based on 2024 data.

In the Quality Payment Program, CMS has finalized its proposal to make Qualified APM Participant (QP) determinations at the individual level, not just at the entity level. Previously, by looking only at the entity level, providers that may be eligible for an APM could be incorrectly seen as not having met the required patient and payment amounts, despite the fact that they would have met QP thresholds on their own (e.g. a nephrologist that would qualify for a Comprehensive Kidney Care Contracting APM, but was overlooked due to the specialty composition of the practice as a whole).

Furthermore, CMS is finalizing QP determinations using Encounter and Management services and covered professional services. Since primary care providers will have a higher proportion of E/M services compared to specialty providers,

this will advise CMS on instances in which a beneficiary had not been attributed to an Advanced APM even though they were receiving specialty care within an Advanced APM (e.g. the nephrologist in the prior example).

4. In One Form or Another, Health Equity Will Always Play a Role

For MSSPs, one of the biggest (and most unwelcome) proposals was the removal of the Health Equity Adjustment, particularly since it was proposed to take effect this year, rather than 2026. Its removal was finalized, but ACOs can breathe a temporary sigh of relief, as this policy will not begin until 2026. CMS had previously stated that this bonus was duplicative of the Complex Payment Adjustment, which rewarded practices who reported quality measures on all patients using either MIPS CQMs or Electronic Clinical Quality Measures (eCQMs).

However, those reporting using Medicare CQMs do not receive the Complex Organization Bonus, meaning that the Health Equity Adjustment was not duplicative. Nevertheless, CMS is removing it for all ACOs, stating that those reporting Medicare CQMs do not need the adjustment, as Medicare CQMs already have flat benchmarks.

The Health Equity Benchmark Adjustment (HEBA) will not be removed, but CMS will be renaming it the “Population Adjustment.” This adjustment was seen as critical to CMS’s mission of having all patients in an accountable care relationship by 2030, as it incentivized ACO creation and expansion in communities that may have been seen as too risky, based on the proportion of patients with Dual Eligible status or receiving the Part D Low Income Subsidy (LIS).

In the ASM, CMS has stated that there will be scoring adjustments for providers with greater rates of medically complex patients or “socially complex” patients. References to equity and social determinants of health (including the removal of a quality measure previously included in most MVPs) may be gone, but in theory, these factors will be considered.

In a pan-program move, CMS has finalized Advanced Primary Care Management (APCM) codes that reimburse behavioral health management in conjunction with primary care services. Their aim is to improve outcomes for patients with both behavioral health and other chronic conditions. The administration has been critical of perceived “over-medication,” and has slotted space for these codes in the hope that behavioral health is addressed through other means in the primary care setting.

5. Quality Reporting Is Here to Stay

Each year, CMS updates quality reporting requirements for existing programs and creates them for new ones. Many of these updates are intended to align program requirements, and this year is no exception. In ASM, quality measures will mirror CQMs in MIPS and the Alternative Performance Model Pathway (APP Plus), requiring that 75 percent of the eligible denominator is tagged with an applicable response. Performance for these reported cases are compared to a to benchmark, and the participant is awarded achievement points. Again, just like MIPS and in the APP, zero points are awarded if the data completion threshold is not met.

For ACOs, the Quality performance standard calculation remains steady. To meet the standard and be eligible to earn its full share of savings, an ACO must report through the APP and, at

minimum, achieve the 40th percentile for the APP Plus Measure Set. However, ACOs can still share in some savings if they meet the 10th percentile in one of the APP Plus outcome measures, provided at they perform at or above the 40th decile in another APP Plus measure. The only difference is in 2026 is that there will be an additional claims measure and additional CQM.

In MIPS and APMs (including ASM, TEAM and ACOs) CMS has defined strict rules for quality reporting. The requirements are complex, often requiring data aggregation and the ability to look at results at TIN, Practice, Site, and Provider levels. For that reason, CMS has allowed "Third Party Intermediaries" (like Clinical Data Registries) to submit data on behalf of providers and entities participating in these programs.

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