

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

CMS is going after the total cost of care in all facets of the Quality Payment Program (QPP). Proposed updates and the creation of a surprise new (and mandatory!) Alternate Payment Model (APM) share themes that you must 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.

- CMS has created a new, mandatory two-sided risk model: The “Ambulatory Specialty Model” (ASM), aiming to reduce costs and improve care coordination using an MVP framework.
- The Proposed Rule condenses the period in which ACOs that are “Inexperienced” with two-sided risk can remain in a one-sided arrangement.

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

- ASM participants are incentivized to ensure patients are aligned with PCPs who can diagnose and proactively treat chronic disease; quality/cost measures will reflect disease management.
- In MIPS Value Pathways (MVPs), groups with a single focus (but comprised of different specialties) will be able to self-attest to being a “single specialty” group and report a single MVP.

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

- The Health Equity Adjustment for ACOs will be removed in 2025 (as opposed to 2026) for ACOs. All-patient reporting bonuses offset this loss, but do not go to Medicare CQM reporters.
- CMS is renaming, but not removing, the Health Equity Benchmark Adjustment, now calling it “Population Adjustment.” This will preserve ACO development in rural and underserved areas.
- MIPS measures and activities related to “health equity” have been proposed for removal.

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

- ASM will be scored at the clinician level, rather than at the group or sub-group level.
- There are six new proposed MVPs for specialties that were previously unrepresented.
- An individual QP (Qualified Participant in an APM) Determination was proposed, which would promote specialty participation in advanced APMs.

5. The unbreakable bond between data security and Value-Based Care remains intact.

- The bulk of the security proposals are added responsibilities for providers, practices, and health systems, focusing on enhanced Security Analyses and steps taken to close security gaps.
- EHR interference delays care and drives poor outcomes and downstream costs.

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

- CMS requested information on Fast Healthcare Interoperability Resources (FHIR). FHIR would streamline quality reporting and accelerate CMS’s transition to Digital Quality Measures (dQMs).
- A proposed scoring update would align MIPS provider-level outcome and cost measures.
- Several specialty MIPS measures’ scoring provisions were relaxed to facilitate MVP participation.