Shared Savings pushes risk, but experts debate the impact

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Most of the significant changes to the Medicare Shared Savings Program (MSSP) have been confirmed in the final 2026 Medicare physician fee schedule, with a major emphasis on making it easier for new and slow-to-advance entrants to take on risk. However, experts aren't sure it'll work.

CMS will reduce the length of time an ACO can participate in a one-sided model of the BASIC track from a maximum of seven performance years over two performance periods to five performance years with the first year starting in 2027.

After that, the neophyte ACO must sign up for Level E of the BASIC MSSP track for all performance years of the agreement period, or for the ENHANCED track. (Both tracks make the ACO eligible for Advanced APM status.)

Also, CMS will "increase flexibility" for these entrants regarding the minimum patient population of 5,000 assigned Medicare fee-for-service (FFS) beneficiaries required in MSSP benchmark years: Starting in 2027, the ACOs can have fewer than 5,000 in their first two performance years.

However, ACO entrants with fewer than 5,000 beneficiaries have to stay in the BASIC track during that time, and their shared savings and shared losses will be capped at a lesser amount. They'll also be excluded during that time from certain opportunities available to "low revenue ACOs participating in the BASIC track," such as advance investment payments and exemption from minimum savings requirement (MSR) requirements.

Experts see risk glass half full

Will this do the job of drawing new MSSP entrants to risk? Some experts are lukewarm.

Leigh Poland, vice president of the coding service line at AGS Health in Washington, D.C., thinks the changes will "probably" help some entrants, particularly smaller or rural ACOs who were previously excluded by their modest size. And she expects the shorter risk-free periods, not to mention the "higher shared savings rates for early risk-takers," might get some slow-moving ACOs to jump in.

Daniel B. Frier, Esq., co-founder of the Frier Levitt law firm and chair of its health care group, believes these change "should modestly accelerate migration to two-sided risk," though he feels "the caps and BASIC-only constraint for ACOs below 5,000 in any benchmark year may dampen the upside."

While he has no quarrel with the concepts, Darryl Drevna, senior director of regulatory affairs for the American Medical Group Association (AMGA) in Washington, D.C., feels that the constant tinkering to get members to take on risk makes MSSP feel riskier and less attractive.

"It's really hard for our members to continue to make investments in MSSP when they keep changing the methodology," Drevna says. "There's always going to be tweaks. But when your staff and technology costs go up, and there's only a modest update on the conversion factor, and the APM bonuses are expiring and they need to be reauthorized — there's just a whole lot of uncertainty in what the overall system is going to look like even two weeks from now, let alone two or three years from now."

Drevna acknowledges the larger, more established ACOs will probably roll with the changes, but "if you're new to the program or if you're a smaller ACO, that beneficiary threshold requirement, for example, is going to create a barrier to entry."

The real motivators for new ACOs, in Frier's view, "remain the policies CMS locked in last year" — that is, the health equity benchmark (renamed "population adjustment" this year by the equity-averse new administration), and the prepaid shared savings for entrants looking for advanceable shared savings for reinvestment (PBN 7/22/24).

BHI, CoCM now attributable

Risk-shy ACOs may gain encouragement from a revised definition of primary care services used for purposes of beneficiary assignment: Starting in 2026, behavioral health integration (BHI) and psychiatric collaborative care management (CoCM) add-on services will be included in the definition of primary care services.

It may be confusing for some observers who assume recipients of BHI and CoCM are already getting assignment attribution for other primary care services. But David Halpert, chief of client team at Roji Health Intelligence in Chicago, points out the "plurality of primary care services" language in CMS attribution methodology "considers allowed charges when determining whether a patient should be attributed to one ACO or another. Since the behavioral health codes are add-ons — and can only be used with advanced primary care codes — they are counted as separate primary care services, with separate allowed charges, and can play a role in beneficiary attribution."

CMS also offers stakeholders a related request for information (RFI): "Should CMS consider new payments to Shared Savings Program ACOs for prospective monthly APCM payments to be delivered to primary care practices that satisfy the APCM billing requirements, with the payments reconciled under the ACO benchmark?"

Poland believes this will swell the assignment ranks of ACOs that have established behavioral health teams and currently see patients who primarily interact with them via those teams.

Frier likes the change. "It makes it easier for primary care practices using BHI/CoCM to reach and maintain assignment thresholds; recognizes more holistic care patterns that increasingly drive visit volume; and improves attribution fidelity for integrated practices, which in turn improves benchmark accuracy and confidence in financial results."

SDOH kept, equity cut

Also, in a change from the proposed rule, CMS won't pull the social determinants of health (SDOH) risk assessment code **G0136** from its definition of "primary care services" used for the purposes of assignment. The code's description, however, will be revised to focus on "physical activity and nutrition" (*PBN 11/17/25*).

The health equity adjustment to the ACO quality score, however, will be removed retroactive to 2025. This code adjusts an ACO's historical benchmark based on the share of beneficiaries who are low-income subsidy (LIS) and/or dual eligibles and can currently increase the MIPS quality score of an ACO by a maximum of 10 points.

CMS says this adjustment is duplicative of the Complex Organization Adjustment, which "upwardly adjusts an ACO's MIPS Quality performance category score when an ACO reports quality data via eCQMs [electronic clinical quality measures]," and of the eCQM/MIPS CQM reporting incentive, and these "have made it unnecessary to continue applying the health equity adjustment to an ACO's quality score."

Note other changes

Also, the Alternative Payment Model (APM) Performance Pathway (APP) Plus quality measure set for Shared Savings Program ACOs will lose the Screening for Social Drivers of Health, and its Consumer Assessment of Healthcare Providers and Systems (CAHPS) for Merit-based Incentive Payment System (MIPS) Survey will change from a mail-phone administration protocol to a web-mail-phone administration protocol in 2027.

Speaking of scoring, while Medicare CQMs seemed to be going away as a reporting method, now CMS is making them easier to use, e.g., with the "change in beneficiary eligibility for Medicare CQMs" to promote "greater overlap with the ACO's assignable beneficiary population."

"A lot of our members had used those successfully, and phasing them out had created some measurement gaps and challenges for ACOs," Drevna says. "This will make it a little bit easier for groups to continue to use their robust data collection and reporting that is already in place rather than forcing a quick transition. I think this is an instance where CMS heard from the provider community and adjusted accordingly."

CMS will allow ACOs to use Medicare CQMs if they have "at least one primary care service with a date of service during the applicable performance year" from the eligible provider, which the agency says "reduces ACOs' burden in the patient matching necessary to report Medicare CQMs because the list of beneficiaries eligible for Medicare CQMs will have greater overlap with the list of beneficiaries that are assignable to an ACO."

And the Shared Savings Program extreme and uncontrollable circumstances (EUC) policies will now be extended to any ACO that is affected by an EUC "due to a cyberattack, including ransomware/malware," in performance year 2025 and subsequent performance years.

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