# Little changes can mean big dollars for Shared Savings ACOs

by: Roy Edroso

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A series of seemingly small technical changes to the Medicare Shared Savings Program (MSSP) can lead to major advantages for some participants, experts tell *Part B News*.

In the 2027 proposed Medicare physician fee schedule, CMS praised the 14-year-old MSSP for reaching 12.6 million assigned beneficiaries via 511 accountable care organizations (ACO) and saving the Medicare program $12 billion between 2017 and 2024. With its proposed changes, CMS says, the program is "projected to reduce Trust Fund expenditures by $5.5 billion in total through the end of the 10-year period 2027 through 2036."

The biggest story for current or prospective ACO participants, says Thomas Kim, M.D., CEO of Sound Long Term Care Management ACO in Richmond, Va., is "CMS' clear effort to accelerate movement into two-sided risk."

The most impactful change in this regard would probably be a proposed 10-point increase in the shared-savings rate for BASIC Track Level E participants. The BASIC track is usually the starting point for ACOs; it has five levels, the first two of which (A and B) are reward-only, with others adding and increasing both risk and reward, culminating at Level E, in which ACOs risk first dollar losses at a rate (currently) of 30%.

The current shared-savings rate of 50% for Level E would be lifted to 60% under this proposal. Jenn Toms, managing director for health care technology consultancy Innsena in Boston, says that this narrows the gap with the next-step-up ENHANCED Track, which has a 75% shared-savings rate, and "makes Level E a more attractive middle ground for practices willing to take on downside risk but not ready for ENHANCED's higher stakes."

Also, Toms adds, a change in the double-sided-risk ENHANCED track proposed in the proposed rule would further narrow the gap: ENHANCED currently enjoys a 50% regional-adjustment benefit — but CMS proposes to cut this to 35%.

That adjustment "was intended to capture the fact that different parts of the country have distinct costs of care, and some ACOs may be achieving relative reductions in spending even if the absolute numbers were still high," says Neal D. Shah, shareholder in the Polsinelli law firm in Chicago. "CMS believes certain ENHANCED ACOs may be earning 'passive' shared savings due to this adjustment."

In the proposed rule, CMS explains that the "lower spending ACOs" in the ENHANCED track overperform due to both their "higher shared savings rate and larger regional adjustments" on average, which may "incentivize selection into the ENHANCED track independent of an ACO's capacity to achieve genuine cost savings to Medicare" — that is, do more good for the successful ACOs in ENHANCED than it does the Shared Savings program.

These proposed changes are "designed to rebalance financial incentives across tracks and encourage ACOs to select their tracks based on their actual capacity to reduce costs rather than differences in financial advantages embedded in track design, thereby potentially improving Trust Funds net savings," CMS says.

If this is finalized, Toms says, "for physicians on the fence about joining an ACO, the improved Level E economics and rural-friendly advance payments are worth a second look." Also, Toms adds, physicians already in an ACO should be asking their leadership "how the Level E/ENHANCED math changes for their organization and whether the benchmark changes affect their specific patient population."

"A financial incentive tends to drive participation," says Dave Halpert, chief of the client team of Roji Health Intelligence in Chicago. "Although Level E participants don't represent the majority in the two-sided track, increasing its potential savings — and losses, of course — provides a better stepping stone for those on the BASIC Track to make the move to the ENHANCED Track, which is CMS' ultimate goal."

**Rolling back the ratchet**

CMS proposes to make other changes that could change ACOs' decisions.

For example, the rule says CMS is mindful of the "negative ratchet effects of benchmark rebasing" that are brought on its current formulae, like the "scaling factor" for prior savings adjustment. For example, the rule says, "savings an ACO achieves in one agreement period can reduce its rebased benchmark for a subsequent agreement period by lowering the

historical spending that forms the basis for that benchmark" — a situation that, CMS says in its Strengthening Original Medicare release on July 16, 2026, "makes it harder for previously successful ACOs to continue to earn shared savings."

To remedy this, CMS proposes to increase the prior savings adjustment scaling factor from 50% to 75%.

Thus "the benchmark 'ratchet effect' would be softened, and benchmarks would better account for how sick your patients are," Toms says. "Physicians often feel punished for succeeding — they hit the savings target one year, and then the bar gets harder to clear the next year. CMS is proposing more protection against that."

Also, in response to "ACOs serving medically complex populations with higher CMS-HCC risk scores" that had expressed concern over a 5% cap on positive adjustments, which they found "restrictive" and which they felt made treating sicker patients a "financial liability," CMS proposed that the cap would be adjusted. The new cap will be determined by a complex formula that takes into account the ACO's weighted average CMS-HCC risk score and preliminary regional adjustment for the enrollment type.

**Hello to Medicare eCQMs**

In addition to the electronic clinical quality measures (eCQM), MIPS CQMs and Medicare CQMs used currently to report in this program, CMS proposes to add Medicare eCQMs.

These are similar to regular eCQMs, Halpert explains, "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."

Like the other methods, Medicare eCQMs require data aggregation from each practice to ensure that reporting occurs at the patient level, "so from a technical perspective, the additional limit on the population makes these more complex than regular eCQMs," Halpert says, "and would preclude ACOs from receiving a population adjustment" (previously known as the "health equity benchmark adjustment"). However, Halpert adds, "if an ACO wanted to limit quality reporting strictly to its attributed population, these would be an option."

MIPS CQMs had been slated for extinction, but CMS has agreed to extend them another year, which Leigh Poland, vice president, coding services, clinical quality and education, AGS Health in West Monroe, La., expects will please a lot of ACOs.

"MIPS CQMs [reporting] lets ACOs report electronic clinical quality measures based only on their assigned Medicare beneficiaries rather than their full all-payer, all-patient population," Poland explains. "The all-payer requirement has been one of ACOs' loudest complaints about eCQM reporting, since practices with large commercial or Medicaid panels had to pull and validate data well beyond their ACO population."

**More changes to note**

Other proposed adjustments include:

**Some ACOs reduce or eliminate Part B cost sharing for beneficiarie**s. As soon as April 2027, per the MSSP fact sheet, CMS proposes that eligible ACOs will be allowed to "enter Part B cost-sharing support arrangements with ACO participants to reduce or eliminate cost sharing for certain categories of Part B items and services" for eligible beneficiaries. Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) and prescription drugs would be excluded. CMS says it's inspired by the example of the ACO REACH (now ACO LEAD) program aimed at ACOs with high-needs patients (PBN 2/26/26).

"ACOs — and providers — are sometimes reluctant to provide or bill for some of the Medicare-covered care coordination and health promotion services for fear that patients will be assessed a potentially substantial coinsurance obligation," Shah explains. "This also provides a clear pathway to support beneficiary engagement without worrying about some of the potential compliance risk in waiving co-pays."

"This is a real tool for improving follow-through on chronic disease management and preventive care as patients would be less likely to skip care they need over copay costs," Toms says.

"These proposals are especially important for ACOs who manage large populations of patients without Medigap, Medicaid or an employer-sponsored plan," Halpert says. "These groups face higher out-of-pocket costs for care and, because of that, they are more likely to limit in-person visits." Since deferred upfront care tends to cause more serious illness and interventions, he adds, "from a financial perspective, ACOs can save the difference between the cost of an office visit and a hospitalization."

At the same time, CMS proposes to abandon the prepaid shared savings payment option, which since 2025 has authorized upfront payment to certain MSSP participants, due to "low uptake."

**Upfront "advance investment payments" (AIP) for new ACOs**. This refers to the AIPs available to certain low-revenue/rural ACOs in MSSP. Previously these were calculated for beneficiaries based on their Area Deprivation Index (ADI) national percentile rank, but due to "methodological issues identified with the ADI metric" these are proposed to be dispensed to rural beneficiaries as a flat payment amount — $45 for Part D low-income-subsidy enrolled, dually eligible, or rural beneficiaries and $25 for everyone else, capped at 10,000 beneficiaries per ACOs.

"For rural and safety-net practices weighing whether ACO participation is worth it, this is a direct answer," Toms says. Poland says it "gives a prospective ACO a number [that] it can pencil into a business case with confidence before it ever

applies, which matters a lot for smaller or physician-led organizations weighing whether the upfront investment is worth the risk."

**New standard for judging ACOs' "experience with risk."** For purposes of assignment and payment, CMS has been calculating participating ACOs' "experience with risk" based on prior participation by taxpayer dentification number (TIN). But in this proposal, if the TIN didn't have a written agreement with a CMS ACO program previously, it "would not be considered to have participated in such an initiative" — even if by other standards (e.g., involvement in a "legacy TIN," or failed practice) it might have been involved.

This "would tighten how billing under multiple TINs affects patient assignment and 'risk experience status,'" Toms says. "If billing is split between a hospital-employed TIN and an ACO-participant TIN, or a physician has moved between organizations, this could affect whether or not patients get assigned to an ACO and whether or not a new ACO qualifies for the BASIC Track glide path."

**G2211 modifier impact**. The proposed PFS includes a proposal to replace the E/M visit complexity add-on code G2211 with a modifier, MOD2. Halpert says this will affect MSSP ACOs especially "as it offers a more direct and timely compensation for the effort necessary to manage patients with complex health histories, particularly as it relates to coordination between primary care and specialty providers."

But Jeff Wurzburg, partner with Norton Rose Fulbright US LLP in San Antonio, notes that CMS also proposes that claims billed with MOD2 "would be included in ACO expenditure calculations for benchmarking and performance year expenditures." As a result, the higher payment flows both ways. Therefore, MOD2 has the potential to increase reimbursement amounts sufficiently to increase an ACO's "spend" and lower its shared savings.

"At the end of the day, this provides an additional incentive in the fee-for-service system for providers to participate in MSSP and LEAD ACOs," Shah says. But "CMS does caution that it expects that providers will need to provide additional work to reflect the additional reimbursement for this code; it will be interesting to see how that plays out from a compliance perspective."

CMS also proposes alterations to beneficiary eligibility standards, which determines how patients' care factors into an ACO's shared savings, including new screening methods and coding for beneficiary assignment via primary care services, including "vaccine adverse effects."

**Resources**

- CMS, "Calendar Year (CY) 2027 Medicare Physician Fee Schedule Proposed Rule (CMS-1848-P) — Medicare Shared Savings Program Proposals," July 14, 2026: www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2027-medicare-physician-fee-schedule-proposed-rule-cms-1848-p-medicare-shared
- CMS, "Strengthening Original Medicare," July 16, 2026: www.cms.gov/newsroom/blog/strengthening-original-medicare

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