CY 2027 Physician Fee Schedule Proposed Rule: Medicare Shared Savings Program (MSSP)

On July 14, 2026, the Centers for Medicare & Medicaid Services (CMS) issued its proposed calendar year (CY) 2027 Physician Fee Schedule (PFS), which proposes policies for physician payment and other outpatient services covered under Medicare Part B. CMS released a rule overview fact sheet and an official press release outlining key proposals, along with a fact sheet on proposals related to the Medicare Shared Savings Program (MSSP). Comments on the proposed rule are due **September 14, 2026.**

The Medicare Shared Savings Program (MSSP) is a voluntary, value-based program that encourages doctors, hospitals, and other health care providers to form Accountable Care Organizations (ACOs) to deliver coordinated, high-quality care to Medicare beneficiaries.

For CY 2027, CMS outlines a series of reforms to the Medicare Shared Savings Program (MSSP) aimed at strengthening financial incentives, increasing beneficiary engagement, and reducing participation burden. Because several proposals would modify the program's financial methodology, CMS also proposes providing ACOs applying for a January 1, 2027, agreement start date a limited opportunity following the publication of the final rule to change their selection between the BASIC and ENHANCED tracks if eligible.

CHANGES TO BENEFICIARY ALIGNMENT

Pages 525-580[1]

In MSSP, "assignment" is the process CMS uses to determine whether a beneficiary has received a sufficient level of certain primary care services from providers participating in a specific ACO to be able to recognize the ACO as having primary responsibility for coordinating the beneficiary's care during a given benchmark year.

CMS proposes, beginning with the January 1, 2028 performance year, excluding allowed charges for primary care services billed by an ACO professional under a non-ACO taxpayer identification number (TIN) when determining beneficiary assignment. Under the current methodology, primary care services furnished by an ACO professional may be included in the assignment calculation even when the services are billed through a TIN that does not participate in the ACO. CMS is concerned that an ACO professional's billing patterns inside and outside the ACO for the same beneficiaries could produce assignment outcomes that advantage the ACO's financial performance. To address this issue, CMS proposes to revise the plurality competition methodology by excluding these non-ACO TIN

[1] All page numbers listed are from the unpublished proposed rule.

changes when determining whether the beneficiary received a plurality of primary care services from the ACO. This proposal would affect only beneficiary assignments and would not change the MSSP financial methodology, or the manner in which providers bill Medicare.

CMS also proposes to update the definition of primary care services used for beneficiary assignment beginning with the January 1, 2027, performance year by adding new codes for Screening, Brief Intervention, and Referral to Treatment (SBIRT), Vaccine Adverse Effects Management, and Advance Care Planning, among other services.

Finally, beginning with the January 1, 2028, performance year, CMS proposes to expand the criteria for assignment eligibility beyond the current Medicare enrollment criteria to allow beneficiaries with at least one month of concurrent Part A and Part B enrollment during the 12-month assignment window and no Medicare group health plan enrollment, including Medicare Advantage enrollment, during that same month to be assigned to an ACO.

MODIFICATIONS TO MSSP QUALITY REPORTING REQUIREMENTS

Pages 580-674

CMS Proposes Extending the Availability of MIPS CQMs Beyond PY 2026 and Extending the MIPS CQM Reporting Incentive

The MIPS Clinical Quality Measures (CQMs) are one of the collection types MSSP ACOs can use to report their quality data under the APM Performance Pathway (APP)/APP Plus framework. In the CY 2025 PFS final rule, CMS stated that MIPS CQMs would no longer be available for **MSSP** ACOs reporting the APP Plus quality measure set beginning in payment year (PY) 2027. However, in this year's proposed rule, CMS proposes to extend **the availability of** MIPS CQMs **for PY 2027 and subsequent performance years**, with the goal of reducing administrative burden **and supporting ACOs' transition to digital quality measure reporting**. **CMS also proposes to extend the associated MIPS CQM reporting incentive for PY 2027 and subsequent performance years.**

CMS is also proposing that all measures of the Medicare CQMs collection type for PY 2027 **and subsequent performance years** are scored using flat benchmarks instead of using historical benchmarks as was finalized in the CY 2025 PFS final rule. CMS proposes **that three Medicare CQMs—Diabetes: Glycemic Status Assessment Greater Than 9%, Screening for Depression and Follow-up Plan, and Controlling High Blood Pressure—be scored using flat benchmarks beginning in PY 2026**.

Additionally, CMS anticipates sunsetting the MIPS CQMs collection type and scoring using flat benchmarks beginning in PY 2030, when Fast Healthcare Interoperability Resources (FHIR)-based reporting becomes mandatory.

Proposals for the MIPS Data Reporting Requirements

ACOs reporting quality measures must meet MIPS data completeness requirements, which generally involves reporting data for a specific percentage of patients in each measure. This requirement is

intended to ensure that reported quality data accurately reflects an ACO's performance. However, CMS has heard from stakeholders and ACO participants that meeting these data completeness requirements can be challenging. Therefore, CMS includes several proposals to address these challenges:

- **Add Medicare eCQM as a New Reporting Option**: For PY 2027 and subsequent performance years, CMS proposes establishing Medicare eCQMs as a new reporting option. This option will operate similarly to eCQMs, but will only include the ACO's assigned beneficiaries, instead of the ACO's all payer/all patient population. CMS additionally proposes that Medicare eCQMs will be scored using flat benchmarks, and ACOs that choose to report this type will not be eligible for the eCQM/MIPS reporting incentive or the Complex Organization Adjustment. Finally, ACOs would have the option to report the five Medicare eCQMs, or a combination of eCQMs/MIPS CQMs/Medicare CQMs/Medicare eCQMs, to meet the quality reporting requirement and quality performance standard for PY 2027 and subsequent performance years.

- **Revise Quality Reporting Requirements**: Beginning in PY 2026, CMS proposes allowing ACOs to exclude one or more TINs from quality reporting in certain circumstances as long as TINs included still represent at least 95 percent of beneficiaries assigned to the ACO. These exclusions include unforeseen circumstances beyond the ACO's control; an ACO participant TIN using specialty-focused CEHRT that does not support measures in the APP Plus quality measure set; or other circumstances identified by CMS. ACOs would additionally still need to meet the 75 percent data completeness requirement for each submitted measure.

- **Revise the Definition of a "Beneficiary Eligible for Medicare CQMs"**: CMS proposes to revise the definition of a "beneficiary eligible for Medicare CQMs" for PY 2027 and subsequent performance years to align with the population of beneficiaries assigned to the ACO.

Updating the APP Plus Quality Measure Set

For PY 2027, and subsequent performance years, MSSP ACOs would be required to report on eight measures in the APP Plus quality measure set: five eCQMs/MIPS CQMs/Medicare CQMs/Medicare eCQMs, the CAHPS for MIPS survey, and two administrative claims-based measures that would be calculated by CMS.

Additionally, CMS is proposing to remove two measures from the quality measure set: the Initiation and Engagement of Substance Use Disorder Treatment (Quality ID: 305) and Adult Immunization Status (Quality ID: 493).[2]

Revising Scoring Policy for Excluded APP Plus Measures

CMS is proposing to revise the scoring policy at § 425.512(a)(7) for measures included in the APP Plus quality measure set that are excluded from MIPS and for APP Plus measures that lack a benchmark. For PY 2027 and subsequent performance years, the current scoring policy would only apply if the

[2] Table B-G5 on page 638 of the unpublished proposed rule includes the quality measure set for SSP ACOs for PY 2027

ACO's MIPS quality performance category score is calculated on fewer than five measures for a PY, which generally would occur if four or more measures are excluded from MIPS. The current policy would also no longer apply merely because one or more required APP Plus measures lack a benchmark.

Under the alternative proposed scoring policy, each measure included in the five-measure minimum used to calculate the ACO's MIPS quality performance category score would receive equal weight. For example, if the score is calculated using five measures, each measure would contribute 20 percent of the score.

PROPOSALS TO UPDATE MSSP CEHRT USE REQUIREMENTS

Pages 639-673

To be considered an Advanced APM through which eligible clinicians may attain Qualifying participant (QPs) status and be exempt from MIPS, an APM must require participants to meaningfully use CEHRT that meets specific requirements.

In response to feedback on the 2025 deregulation RFI, CMS proposes to sunset the current MSSP CEHRT use requirement that all ACOs report all MIPS Promoting Interoperability measures and activities. Instead of the existing requirements, CMS proposes that, beginning in PY 2027, to meet the CEHRT use requirement, ACOs would be required to perform one of the following and publicly report which option they choose:

- Completely report one of the five ACO-reported APP Plus quality measures through eCQMs or Medicare eCQMs,
- Use CEHRT to support complete reporting of at least one of the five ACO-reported APP Plus measures and attest that data collected through an HL7 FHIR-based application programming interface using a certified health IT module supported quality measurement; or
- Attest to one of the proposed MSSP CEHRT use metrics, which are based on a subset of MIPS Promoting Interoperability performance category measures that may be updated annually.

CMS proposes allowing ACOs to apply certain TIN-level exclusions without submitting a request to CMS. Specifically, an ACO could attest that it performed the activity required by the metric even if one or more ACO participant TINs lacked a provider that performed the activity, provided that the TIN qualifies for a "special status"[3] exception or faces hardship circumstances that would qualify for a MIPS hardship exception. ACOs would be required to maintain documentation on excluded TINs and produce the documentation in the event of a CMS audit.

[3] The qualifications for "special status" begin on page 665 of the unpublished proposed rule.

PROPOSED CHANGES TO THE MSSP FINANCIAL METHODOLOGY

Pages 674-786

CMS proposes several changes to the financial methodology of MSSP to increase participation in the program and increase savings for the Medicare Trust Funds. CMS proposes several changes to balance incentives and mitigate selection issues between Level E of the BASIC track and the ENHANCED track. These include:

- **Increasing the sharing rate for Level E of the BASIC track from 50 percent to 60 percent**. CMS believes the difference in sharing rates may have led ACOs to assume the maximum allowed risk before they were prepared for the added demands of a higher-risk track, which could contribute to lower MSSP retention rates. Both BASIC Level E and the ENHANCED track are two-sided risk participation options that may satisfy the financial-risk requirements for Advanced APM status.

- **Reducing the maximum weight on regional adjustment for lower-spending ACOs in the ENHANCED track from 50 percent to 35 percent**. CMS notes that data show ENHANCED track ACOs generally achieve greater savings and receive larger positive regional adjustments than BASIC Level E ACOs. CMS believes these incentives may encourage ACOs with spending below their regional average to choose the ENHANCED track over BASIC Level E. The proposal aims to reduce the regional adjustment so ACOs choose a track based on their actual ability to generate Medicare savings. Regional adjustment weights for ACOs with a higher spending than the regional average remain unchanged.

CMS offers several other changes to the financial methodology, including:

- Increase the prior savings adjustment scaling factor from 50 percent to 75 percent. CMS believes a 50 percent scaling factor may not provide enough incentive for ACOs to remain in the program when their benchmarks are rebased to reflect their own prior spending reductions.

- Risk-adjust the 5 percent cap on upward adjustments (regional adjustment, prior savings adjustment, and population adjustment) to the historical benchmark to better reflect beneficiary clinical complexity. This proposal may result in potentially higher upward adjustments to the benchmark for ACOs with a high-risk population, which could encourage ACOs to enter and remain in MSSP.

- Establish a growth adjustment to the historical benchmark to reward ACOs for recruiting clinicians who are inexperienced with value-based care and serving beneficiaries who are new to value-based care. The growth adjustment would be applied on top of the highest existing benchmark adjustment for which the ACO is eligible—either the positive regional, prior savings, or population adjustment—and would remain subject to the proposed risk-adjusted 5% cap. CMS also proposes incorporating the growth incentive into the prior savings adjustment for a subsequent agreement period, if applicable, when the ACO maintains or increases the growth achieved during the prior agreement period.

- Reform the Accountable Care Prospective Trend (ACPT) component by calculating annualized growth rates separately for each performance year, rather than on an agreement-period basis, and applying guardrails that generally prevent the ACPT from falling more than 1 percentage point below or rising more than 1.5 percentage points above observed national expenditure growth. For ACOs with agreement periods beginning January 1, 2027, or later, both guardrails would apply. CMS also proposes retroactively applying the lower guardrail to ACOs with 2024, 2025, and 2026 agreement start dates beginning with PY 2025 reconciliation. CMS is delaying PY 2025 financial reconciliation until November 2026 so the proposal can be implemented if finalized.

PROPOSALS TO INCREASE BENEFICIARY ENGAGEMENT

Pages 786-808

For CY 2027, CMS proposes two changes to expand ACOs' ability to support beneficiary engagement in their care. First, CMS proposes to discontinue the prepaid shared savings option. Under the proposal, no new cohorts could apply after the application cycle for the January 1, 2027, start date, although participating ACOs could continue receiving prepaid shared savings payments through December 31, 2027.

Second, following the flexibilities available under the ACO REACH Model, CMS proposes to allow MSSP ACOs to enter into Part B cost-sharing support agreements beginning April 1, 2027. Under the proposal, eligible ACOs with a CMS-approved implementation plan could enter into arrangements with ACO participants to reduce or eliminate all or part of a beneficiary's Medicare fee-for-service (FFS) Part B deductible and/or coinsurance for specified categories of services and eligible beneficiaries identified by the ACO. Cost-sharing support could apply to Original Medicare Part B items and services other than durable medical equipment, prosthetics, orthotics and supplies and prescription drugs.

MODIFICATIONS TO THE ADVANCE INVESTMENT PAYMENTS

Pages 808-819

For PY 2028 and subsequent performance years, CMS proposes to modify the methodology used to calculate quarterly advance investment payments. Currently, payment amounts are based on a risk-factor score that includes, among other factors, an Area Deprivation Index (ADI) score. CMS proposes removing the ADI due to methodological concerns and replacing the current methodology with quarterly payments of $45 for each beneficiary who receives the Part D low-income subsidy, is dually eligible for Medicare and Medicaid, or resides in a qualifying rural county, and $25 for each remaining beneficiary. Payments would continue to be capped at 10,000 beneficiaries.

CLARIFICATION OF AN EXPERIENCED VS. INEXPERIENCED ACO

Pages 819-826

As part of determining MSSP eligibility, CMS classifies ACOs as experienced or inexperienced with financial responsibility based, in part, on prior participation in Medicare ACO initiatives. For CY 2027,

CMS proposes to revise the treatment of a "legacy" TIN so that an ACO participant TIN that appears in claims history solely because its claims were included in financial reconciliation, but that did not have a written agreement to participate in a performance-based risk Medicare ACO initiative, would not be considered to have participated in that initiative for purposes of determining the applicant ACO's experience with risk beginning January 1, 2027.

CHANGE TO BENEFICIARY NOTIFICATION

Pages 826-832

CMS proposes replacing the requirement to provide beneficiary notice **before or at a beneficiary's first primary care service visit during the applicable performance** year with a requirement to provide a CMS-developed written notice at least once during an agreement period. The notice generally would be required by May 30 of the applicable performance year, unless CMS specifies a later date. CMS also proposes eliminating the requirement to provide follow-up verbal or written communication after the initial notice. CMS notes these changes would align MSSP with CMS Innovation Center ACO models. The changes would take effect January 1, 2027.

REQUESTS FOR INFORMATION

Pages 275-284, 673-674, and 832-851

CMS includes several Requests for Information to inform potential future policy development for MSSP:

- **Applying Electronic Prior Authorization Measures**: CMS seeks feedback on how MSSP ACOs use electronic prior authorization, including FHIR-enabled health IT modules; whether to create an ACO-specific measure requiring completion of at least one FHIR-based prior authorization request during a performance period; and other factors CMS should consider when developing prior authorization measures.

- **Expanding Specialty Care Participation**: CMS recognizes that while primary care remains crucial to coordinating care, Medicare spend on specialty care has continued to grow. ACOs have historically had limited ability to influence any specialty care furnished to beneficiaries assigned to their ACO. Therefore, CMS is seeking stakeholder feedback on policy changes and resources that could improve clinical outcomes while reducing inappropriate Medicare spending through accountable care programs and models. Specifically, CMS requests input on meaningful engagement, CMS-delivered tools and support, attribution or assignment modifications, benchmarking, specialist performance measurement, waiver flexibilities, and ACO and provider burden.

- **Primary Care-Focused Capitated Payment Model**: CMS is seeking stakeholder feedback regarding potential primary care capitated payment agreements in MSSP. Specifically, CMS requests input on ACO and ACO participant readiness, eligibility for participation, payment design and structure, and care delivery requirements. CMS provides specific questions on these topics from pages 276-282 of the unpublished proposed rule.