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Physician Fee Schedule Final Rule for 2026
Summary Part II: MSSP Requirements

Medicare and Medicaid Programs; CY 2026 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program
[CMS-1832-F]

On November 5, 2025, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* (90 FR 49266) a final rule relating to the Medicare physician fee schedule (PFS) for CY 2026[1] and other revisions to Medicare Part B policies. The policies in this final rule generally take effect on January 1, 2026.

HFMA is providing a summary of the 2026 Physician Fee Schedule final rule in three parts. Part I covers sections I through III.G (except for Section III.F: Medicare Shared Savings Program Requirements) and the Regulatory Impact Analysis. Part II covers the Medicare Shared Savings Program Requirements. Part III will cover the updates to the Quality Payment Program.

The policies related to the Medicare Shared Savings Program are designed to strengthen financial incentives for long-term participation and further Medicare's overall value-based care strategy of growth and alignment.

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[1] Henceforth in this document, a year is a calendar year (CY) unless otherwise indicated, a reference to "the Act" is a reference to the Social Security Act, and a reference to a regulatory section is a reference to that section in title 42, CFR.

1. Executive Summary and Background

Under the Medicare Shared Savings Program (MSSP), providers and suppliers that participate in an Accountable Care Organization (ACO) continue to receive traditional Medicare fee-for-service (FFS) payments under Parts A and B, and the ACO may be eligible to receive a shared savings payment if it meets specified quality and savings requirements—and in some instances may be required to share in losses if it increases health care spending.[2] CMS reviews in detail the legislative and regulatory history of the Shared Savings Program,[3] with updates regarding the number of participating providers and beneficiaries. As of January 1, 2025, over 11.2 million people with Medicare receive care from one of the over 650,000 health care providers and organizations in the 477 ACOs participating in the MSSP.

CMS summarizes the following changes to the MSSP the agency is finalizing in this rule:

- Modifying requirements for determining an ACO's eligibility for Shared Savings Program participation options, for agreement periods beginning on or after January 1, 2027, to limit participation in a one-sided model to an ACO's first agreement period under the BASIC track's glide path (if eligible), and requiring ACOs inexperienced with performance-based risk Medicare ACO initiatives (defined at §425.20) to progress more rapidly to higher levels of risk and potential reward under Level E of the BASIC track or the ENHANCED track;[4]
- Modifying Shared Savings Program eligibility requirements to require ACOs to make certain changes to their ACO participant list when an ACO participant experiences specified changes of ownership (CHOW);
- Modifying Shared Savings Program eligibility requirements and financial reconciliation requirements in connection with the statutory requirement that ACOs have at least 5,000 assigned Medicare FFS beneficiaries to:
    - Require ACOs applying to enter a new agreement period to have at least 5,000 assigned beneficiaries in benchmark year (BY) 3, while allowing the ACO to have under 5,000 assigned beneficiaries in BY1, BY2, or both;
    - Require ACOs that enter a new agreement period with less than 5,000 assigned beneficiaries in BY1, BY2, or both to enter the BASIC track;
    - Cap shared savings and shared losses at a lesser amount for ACOs with fewer than 5,000 assigned beneficiaries in any of the three BYs, to help ensure the amounts reflect the ACO's performance in the program rather than normal variation in expenditures; and
    - Exclude ACOs that fall below 5,000 assigned beneficiaries in any benchmark year from being eligible to leverage existing policies that provide certain low revenue ACOs participating in the BASIC track with increased opportunities to share in savings.
- Updating the definition of primary care services used in beneficiary assignment;

[2] In this section of the summary, all references to ACOs are to ACOs participating in the MSSP.
[3] Section 1899 of the Act contains statutory provisions of the MSSP, with regulations codified at 42 CFR part 425.
[4] See this section of the preamble for a discussion of MSSP's risk track levels.

- Revising the quality performance standard and other quality reporting requirements, including:
    - Revising the definition of a beneficiary eligible for Medicare clinical quality measures (CQMs) at §425.20 for performance year 2025 and subsequent performance years so that the population identified for reporting within the Medicare CQM collection type would have greater overlap with the beneficiaries that are assignable to an ACO;
    - Removing the health equity adjustment applied to an ACO's quality score beginning in performance year 2026 and revising the terminology used to describe the health equity adjustment and other related terms for performance years 2023 through 2025;
    - Updating the APP Plus quality measure set for Shared Savings Program ACOs including the removal of Quality ID: 487 Screening for Social Drivers of Health; and
    - Requiring CMS-approved survey vendors to administer the CAHPS for MIPS Survey via a web-mail-phone protocol beginning with 2027.
- Expanding the application of the Shared Savings Program quality and finance extreme and uncontrollable circumstances (EUC) policies to an ACO that is affected by an EUC due to a cyberattack, including ransomware/malware, as determined under the Quality Payment Program, for performance year 2025 and subsequent performance years;
- Revising the Shared Savings Program regulations for performance year 2025 and subsequent performance years to rename the "health equity benchmark adjustment" to the "population adjustment";
- Modifying the Shared Savings Program quality reporting monitoring requirements at §425.316 to specify for performance years beginning on or after January 1, 2026, requirements to monitor ACOs for failure to meet both the quality performance standard and the alternative quality performance standard; and
- Modifying §425.224(b)(1)(ii)(A) related to reviewing applications for renewing and re-entering ACOs with a demonstrated pattern of failure to meet both the quality performance standard and the alternative quality performance standard.

As a result of the MSSP policies in this final rule, CMS projects an aggregate $20 million decrease in total program spending over the 10-year period 2026 through 2035.

2. Shared Savings Program Participation Options Under the BASIC Track

a. Background on Shared Savings Program Participation Options

CMS provides a brief legislative and regulatory background on the one-sided and two-sided risk models that comprise the MSSP, and reviews the two "tracks" (the BASIC track and the ENHANCED track) through which ACOs progress through these risk models. Under the BASIC track, qualifying ACOs[5] begin the program in a one-sided risk arrangement (*i.e.*, no risk of losses), but progressively move to take on higher levels of financial risk.

Section 425.600(a)(4)(i)(C) specifies the glide path progression for agreement periods beginning on or after January 1, 2024. Under these requirements, an ACO eligible to enter the BASIC track's glide path may elect to enter its agreement period at any of the levels of risk and potential reward available. Generally, an ACO is automatically advanced to the next level of the BASIC track's glide path at the start of each subsequent performance year of its 5-year agreement period, if a higher level of risk and potential reward is available under the BASIC track, except in specific circumstances. Under current policies (codified in the 2023 PFS final rule, 87 FR 69807-69808), new ACOs inexperienced with performance-based risk Medicare ACO initiatives may participate in a BASIC track one-sided model for up to seven performance years before being required to transition to performance-based risk.

During the annual change request cycle, ACOs participating in the BASIC track's glide path have the opportunity to submit participation options change requests prior to the start of the next performance year. The timing of the annual application cycle (for new ACO applicants) and change request cycle (for existing ACOs) typically coincide and span a period from Spring through Fall in advance of the start of the upcoming performance year beginning on January 1.

b. Considerations for Timing of ACOs' Progression to Performance-Based Risk in the Shared Savings Program

CMS continues to hold that financial models under which ACOs bear a degree of financial risk have potential to induce more meaningful systematic change in providers' and suppliers' behavior towards meeting the Shared Savings Program's goals, compared to one-sided models.[6] In this final rule CMS is revising Shared Savings Program policies on the amount of time an ACO can remain under a one-sided model and the progression to performance-based risk—in particular the current policy that allows ACOs to participate for up to seven performance years under a one-sided model.

[5] *E.g.*, ACOs "inexperienced with performance-based risk." Per §425.20 "inexperienced with performance-based risk Medicare ACO initiatives" means an ACO that CMS determines meets all of the following criteria: (1) the ACO is a legal entity that has not participated in any performance-based risk Medicare ACO initiative as defined at §425.20, and has not deferred its entry into a second Shared Savings Program agreement period under a two-sided model at §425.200(e); and (2) less than 40 percent of the ACO's ACO participants participated in a performance-based risk Medicare ACO initiative, or in an ACO that deferred its entry into a second Shared Savings Program agreement period under a two-sided model at §425.200(e), in each of the five most recent performance years."

[6] See for example, 76 FR 67904-67909, 80 FR 32758-32760, and 83 FR 67967-67968.

CMS describes trends in ACO participation in the Shared Savings Program and ACO financial performance that inform the agency's consideration of policies on ACOs' progression to performance-based risk under the Shared Savings Program. In particular, CMS notes that over time, more ACOs have gravitated to two-sided risk models, as shown in Table B-G1 of the final rule (reproduced below).

Table B-G1: Count of ACOs Participating in Basic Track Levels and Enhanced Track for PYs 2022 Through 2025

Performance Year	Total	BASIC Track			ENHANCED track
		Levels A and B	Levels C and D	Level E	
PY 2022	483	199 (41%)	40 (8%)	98 (21%)	146 (30%)
PY 2023	456	151 (33%)	19 (4%)	125 (28%)	161 (35%)
PY 2024	480	159 (33%)	10 (2%)	104 (22%)	207 (43%)
PY 2025	477	137 (29%)	5 (1%)	81 (17%)	254 (53%)

Note: Levels A and B are one-sided risk models; the others are two-sided.

CMS also points to policies adopted in the 2023, 2024, and 2025 PFS that encouraged participation in MSSP by new, low-revenue ACOs (*e.g.*, advanced investment payments, and changes to the benchmark methodology for ACOs serving medically complex, high-cost patients).

Lastly, CMS points to its analysis of ACOs' financial performance, noting that ACOs transitioning from one-sided to two-sided levels of the BASIC track, or remaining under the BASIC track's two-sided model levels, are anticipated to generate higher levels of average net savings compared to ACOs that remain in a one-sided model of the BASIC track.

c. Limiting Participation in a One-Sided Model to an ACO's First Agreement Period Under the BASIC Track's Glide Path

In light of these trends and the agency's analysis of ACOs' financial performance, CMS posits that the current participation option permitting eligible ACOs to extend participation under the BASIC track's glide path to a second agreement period, in which they can participate under a one-sided model for the first two performance years (thereby allowing eligible ACOs to remain under a one-sided model for up to seven performance years) prior to progressing to two-sided risk, may weaken the incentives for ACOs to transition to two-sided risk, and for ACOs to make more meaningful changes to health care delivery during their first 5-year agreement period, or at the start of their second agreement period.

CMS therefore proposed to limit the amount of time an ACO may participate in the Shared Savings Program under a one-sided model, and to require ACOs to more rapidly progress to higher levels of risk and potential reward under a two-sided model. Specifically, CMS proposed that for agreement periods beginning on or after January 1, 2027, an ACO that is inexperienced with performance-based risk Medicare ACO initiatives entering the BASIC track's glide path at Level A could continue to elect to remain under a one-sided model for all subsequent performance years of its first 5-year agreement period. Beyond this first agreement period, however, such an ACO would be required to enter its second or subsequent agreement period under Level E of the BASIC track or the ENHANCED track (subject to the proposed exception

prohibiting ACOs with fewer than 5,000 assigned beneficiaries in BY1, BY2, or both, from participating in the ENHANCED track).

With respect to the applicable regulatory text, CMS proposed to specify related requirements in amendments to the Shared Savings Program regulations at §425.600 and proposed technical and conforming changes elsewhere within §425.600 and at §425.605. CMS proposed to amend §425.600(g) introductory text, to limit the applicability of the current requirements in this paragraph for determining an ACO's eligibility for the Shared Savings Program participation options to agreement periods beginning on or after January 1, 2024, and before January 1, 2027.

CMS proposed to redesignate paragraph (h) of §425.600 as paragraph (i), and to add a new paragraph (h) that specifies the requirements CMS would use to determine an ACO's eligibility for Shared Savings Program participation options for agreement periods beginning on or after January 1, 2027. Additionally, §425.600(h)(3) would include a limited proposed exception for participation in the ENHANCED track by ACOs with less than 5,000 assigned beneficiaries in certain benchmark years. This limited proposed exception reflects CMS' proposal that for agreement periods beginning on or after January 1, 2027, an ACO with fewer than 5,000 assigned beneficiaries in BY 1, BY2, or both may only enter the BASIC track.

CMS proposed to specify in new §425.600(h)(1) how the agency would determine an ACO's eligibility for participation options, for agreement periods beginning on or after January 1, 2027, if an ACO is determined to be inexperienced with performance-based risk Medicare ACO initiatives. CMS proposed to specify at §425.600(h)(1) introductory text that if an ACO is determined by CMS to be inexperienced with performance-based risk Medicare ACO initiatives, the ACO may enter either the BASIC track's glide path at any of the levels of risk and potential reward, Levels A through E, or the ENHANCED track.

Lastly, CMS proposed to specify under new §425.600(h)(1)(i) that, for agreement periods beginning on or after January 1, 2027, an ACO that is inexperienced with performance-based risk Medicare ACO initiatives may participate under the BASIC track's glide path for a maximum of one agreement period, and for which the progression along the glide path is specified at §425.600(a)(4)(i)(C). Under §425.600(h)(1)(iii), CMS proposed that an ACO determined to be inexperienced with performance-based risk Medicare ACO initiatives but which is not eligible to enter the BASIC track's glide path, in accordance with the provisions of §425.600(h)(1), may enter BASIC track Level E for all performance years of the agreement period, or the ENHANCED track.[7]

In this final rule, CMS indicates that "many commenters" supported its proposal to decrease the amount of time an ACO can participate under a one-sided model under the BASIC track's glide path from 7 to 5 years, agreeing with CMS' assertion that advancement into two-sided risk tracks is essential for incentivizing care improvements and reducing health care spending. A number of commenters, however, urged various modifications of the core proposal, for example, continuing current policy for existing ACOs in BASIC Track Level in their first agreement period, or lengthening the amount of time an ACO can remain in BASIC Track Levels C or D in their

[7] Among all of these provisions, CMS would codify regulations pertaining to ACOs with fewer than 5,000 assigned beneficiaries that would generally prohibit such ACOs from participating in MSSP's ENHANCED track.

second agreement period. Such comments were motivated by concerns regarding program attrition that could be accelerated under a more rapid progression to two-sided risk. Other commenters opposed CMS' proposal to shorten the amount of time an ACO could remain in a one-sided risk arrangement, arguing that additional participation options were needed for certain types of providers and ACOs, including rural and safety net providers, community health center-led ACOs, physician-led ACOs, and federally qualified health centers (FQHCs). Interestingly, in response to these comments, CMS reviewed participation data for ACOs that began participation in the second half of calendar year 2019 with at least one FQHC, rural health clinic, or critical access hospital, identifying 15 such ACOs. CMS reports that 10 of these ACOs had moved into two-sided risk arrangements within their initial 5-year agreement period. Additionally, CMS reports that among 185 ACOs with an FQHC, rural health clinic, or critical access hospital with reconciliation in 2024, 84 percent of these ACOs earned shared savings.

After consideration of public comments received, **CMS is finalizing its proposal to reduce the maximum amount of time an ACO can remain in a one-sided risk arrangement from seven years to five years, with a limited exception for participation in the ENHANCED track by ACOs with less than 5,000 assigned beneficiaries in certain benchmark years**. This limited exception reflects the requirement that for agreement periods beginning on or after January 1, 2027, an ACO with fewer than 5,000 assigned beneficiaries in BY 1, BY2, or both may only enter the BASIC track. **CMS is also finalizing as proposed all corresponding proposed subordinate regulatory changes enumerated above**.

3. Eligibility Requirements

a. ACO Participant Change of Ownership (CHOW) Scenarios

To be eligible to participate in the Shared Savings Program, an ACO must maintain, update, and submit to CMS an accurate and complete ACO participant list. The ACO participant list identifies each ACO participant by its Medicare-enrolled Taxpayer Identification Number (TIN) and legal business name (LBN). ACO participant agreements must require an ACO participant to report changes in enrollment information to the ACO within 30 days of the change (§425.116(a)(6)) and in accordance with Shared Savings Program requirements (§425.116(a)(3)). CMS uses the certified ACO participant list to conduct critical oversight functions of the Shared Savings Program for downstream operations, such as establishing historical benchmarks, data sharing, financial performance, quality reporting, public reporting, and program eligibility.

Because of the ACO participant list's downstream effects on an ACO's participation in the Shared Savings Program, changes to the certified ACO participant list are only permitted during the annual Shared Savings Program change request cycle. All additions to the ACO participant list approved by CMS during the change request cycle are effective on January 1 of the next performance year (§425.118(b)(1)(ii)).

A change of ownership (CHOW) can occur when an ACO participant is purchased (or leased) by another organization. To notify CMS of a change of ownership, an ACO participant submits the

appropriate Medicare Enrollment Application form to their Medicare Administrative Contractor (MAC) or in the Provider Enrollment, Chain, and Ownership System (PECOS).[8]

In the 2026 PFS proposed rule, CMS noted that ACO participants may experience CHOWs and/or subsequent TIN changes during the performance year that affect their ability to continue in the Shared Savings Program. The agency noted, however, that due to the volume of data that the agency utilizes to manage the Shared Savings Program, allowing for frequent or high volumes of changes to occur to an ACO's certified participant list during a performance year can increase the risk of errors, as well as uncertainty surrounding what data is utilized to produce a report. At the same time, CMS recognizes that requiring ACOs to wait until the upcoming change request cycle each performance year to update their certified ACO participant list to reflect an ACO participant's CHOW can, in some cases, present operational difficulties for ACOs.

Thus, in the proposed rule, CMS proposed that starting January 1, 2026, ACOs that experience certain ACO participant CHOWs outside of the change request cycle must update their certified ACO participant list to reflect such ACO participant's CHOW. CMS stated that this proposal would apply in instances in which an ACO participant has undergone a CHOW resulting in a change to its Medicare enrolled TIN whereby the surviving Medicare enrolled TIN has no Medicare billing claims history; this new requirement would be codified at §425.118(b)(3). The requirement would be limited to instances where the surviving TIN is newly enrolled in PECOS with no prior Medicare billing claims history to limit program disruption such as adversely affecting quality performance.[9] CMS proposed that it would have sole discretion whether to approve the ACO participant change request for a CHOW.

Under this proposal, upon CMS approval of the change request submitted with the TIN, CMS would adjust the ACO's assignment, performance year financial calculations, and the requirement that the ACO must submit quality data as described at §§425.508 and 425.510 for the applicable performance year on behalf of eligible professionals that bill under the TIN of an ACO participant. CMS' proposal would redesignate the current §425.118(b)(3) as §425.118(b)(4) and add new paragraphs §425.118(b)(3) and §425.118(b)(4)(iii). The agency also proposed to add new §425.118(b)(3) to require an ACO to submit notice and supporting documentation to demonstrate that a CHOW resulting in a change to the Medicare enrolled TIN has taken place. This supporting documentation would include information and material currently collected by CMS during the annual change request cycle when an ACO participant has merged with or been acquired by another entity.

Interestingly, CMS indicates that *all* commenters expressed broad support—or general support with additional recommendations—for the proposal to require an ACO to submit a change request to CMS and update the ACO participant list outside of the annual change request cycle

[8] Medicare providers and suppliers can enroll using the Provider Enrollment, Chain, and Ownership System (PECOS). See https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/chain-ownership-system-pecos.

[9] CMS indicates the agency did consider an alternative proposal that would allow ACOs to submit *all* change of ownership requests outside of the change request cycle, but did not pursue such proposal out of operational concerns.

when an ACO participant undergoes a CHOW that results in a surviving Medicare enrolled TIN with no prior Medicare billing claims history. Some commenters suggested lengthening the amount of time that ACOs would have to report a specified CHOW from 30 days to 45 or 60 days, but CMS declined to act on these suggestions. After consideration of comments received, **CMS is finalizing its proposal to require that no later than 30 days after an ACO participant has undergone a CHOW that has resulted in a change to its Medicare enrolled TIN, whereby the surviving Medicare enrolled TIN has no Medicare billing claims history, the ACO must submit a change request to CMS**. CMS indicates that it will promulgate guidance on the form and manner of submission of requisite documentation, and the types of documentation that will suffice, at a later date.

b. SNF Affiliate Change of Ownership (CHOW) Scenarios

A Medicare-covered skilled nursing facility (SNF) stay requires a preceding inpatient hospital stay of at least three days (the "three-day rule") (section 1861(i) of the Act). MSSP allows ACOs to waive this hospitalization requirement for eligible beneficiaries if certain conditions are met (*e.g.*, the SNF must be a formal affiliate of the ACO). Currently, an ACO must provide CMS with a list of affiliated SNFs and copies of the applicable agreements with each affiliated SNF.

Operationally, MSSP does not provide a mechanism by which an ACO can add a new TIN to its SNF affiliate list outside of the annual change request cycle, including in situations where a SNF affiliate experiences a CHOW resulting in a change to the Medicare-enrolled TIN. Thus, if a SNF affiliate experiences a CHOW resulting in a change to its Medicare-enrolled TIN, it can no longer admit eligible beneficiaries without a prior 3-day inpatient hospitalization due to the change in Medicare enrollment and CMS' operational processes for receiving and reviewing SNF affiliate list modifications on an annual basis.

In recognition of this problem, and in response to requests from ACOs, in the proposed rule CMS proposed to amend §425.612(a)(1)(i)(B) by moving the text to §425.612(a)(1)(i)(B)(1) and revising it to specify that the list of SNFs must include the Medicare enrolled TIN and the CCN of each SNF. CMS also proposed to add new §425.612(a)(1)(i)(B)(2) to require ACOs to notify CMS no later than 30 days after the change of ownership of a SNF affiliate.

CMS indicates that most commenters supported these proposals, but as with the proposed (now finalized) general CHOW reporting requirements, some commenters wanted a longer period of time to report specified changes in ownership. One commenter opposed the proposals. **CMS is finalizing its proposals related to ACOs' reporting of changes in ownership of affiliated SNFs**. CMS will specify the form and manner of submitting the requisite documentation of a CHOW at a later date.

4. <u>ACO Eligibility and Related Financial Reconciliation Requirements</u>

Under MSSP regulations (CMS provides an extensive regulatory history in this rule's preamble), CMS deems an ACO to have initially satisfied the statutory requirement to have at least 5,000 assigned Medicare FFS beneficiaries (section 1899(b)(2)(D) of the Act), if 5,000 or more

beneficiaries are historically assigned to the ACO participants in each of the three historical benchmark years as defined at §425.110(a)(2). This policy was established to align with the statutory requirement and to ensure CMS is able to reliably and accurately assess ACOs' financial and quality performance.

CMS notes that while most ACOs are able to meet the 5,000-beneficiary threshold, it does preclude some potential applicants from participating in MSSP. The agency states that its experience managing MSSP suggests that it would be possible for some ACOs to successfully participate in the program with fewer than 5,000 assigned beneficiaries. Thus, CMS in July proposed changes to the MSSP eligibility requirements to allow for participation by ACOs with a minimum of 5,000 assigned beneficiaries in their third benchmark year, even if the ACO has fewer than 5,000 assigned beneficiaries in BY 1, BY2, or both. Under this proposal, such ACOs would be limited to participating in the MSSP BASIC track, and they would be subject to alternative performance payment limit and loss recoupment limits.

In the proposed rule for 2026 CMS proposed to amend the requirements at §425.110(a)(2) to specify that, for agreement periods beginning on or after, January 1, 2027, ACOs applying to enter a new agreement period would be required to have at least 5,000 assigned beneficiaries in the ACO's BY3 but could be under 5,000 assigned beneficiaries in BY1, BY2, or both. Such applicants (historically around 2 percent of MSSP applicants) would be denied under the existing policy at the time of the proposed rule, which would expire December 31, 2026.

CMS contended that this proposal would provide greater flexibility on the requirement to have 5,000 assigned beneficiaries in each benchmark year, but the agency acknowledges that it also could introduce risk for both the ACO and the MSSP. Thus, concurrent with the proposed eligibility change, CMS proposed as a safeguard that if an ACO, when entering a new agreement period, is under the 5,000-beneficiary minimum in BY1, BY2, or both, but meets this requirement in BY3, the ACO would only be able to enter an agreement period in the BASIC track, to reduce the potential risk to the ACO and to the Shared Savings Program.

As an additional safeguard given the potential performance volatility associated with smaller ACOs, CMS proposed alternative performance payment limit and loss recoupment limits for ACOs that would be admitted to MSSP under its proposed revisions to the eligibility policy (90 FR 32664 through 32671).

Currently, the performance payment limit (which is the maximum amount of earned shared savings an ACO can receive in a performance year) is calculated by first calculating an ACO's per capita updated benchmark expenditures for the performance year and then multiplying this value by the ACO's assigned beneficiary person years for the performance year; this result is the ACO's total benchmark expenditures. CMS then calculates the performance payment limit as a percentage of total benchmark expenditures, with the applicable percentage dependent on the ACO's track / level of participation (either 10 percent for the BASIC track, or 20 percent for the ENHANCED track). An ACO's earned shared savings payment is capped at the ACO's

performance payment limit amount (see §§425.600(a)(3)-(4), 425.605, and 425.610. CMS undertakes a similar process for calculating the applicable recoupment limit.[10]

In this year's proposed rule, CMS proposed that for ACOs with fewer than 5,000 assigned beneficiaries in any benchmark year, an alternative limit to performance payments and loss recoupment would apply for these ACOs in agreement periods beginning on or after January 1, 2027. CMS proposed that this policy would apply during financial reconciliation for any performance year in an agreement period for which the ACO was assigned fewer than 5,000 beneficiaries in any benchmark year. The proposed timing of applicability for this policy would be consistent with the timing of applicability for the agency's proposed approach to allow participation by ACOs with 5,000 assigned beneficiaries in BY3, and fewer than 5,000 assigned beneficiaries in BY1, BY2, or both, described in section III.F.4.b.(2) of the proposed rule.

Specifically, CMS proposed to use an alternative calculation for the benchmark-based performance payment limits and loss recoupment limits, under which the agency would compute an ACO's total benchmark expenditures as the product of an ACO's per capita updated benchmark expenditures and the ACO's assigned beneficiary person years *from the benchmark year with the lowest number of assigned beneficiaries* (see 90 FR 32668 through 32671). CMS would only use this alternative calculation if an ACO has fewer than 5,000 historically assigned beneficiaries in a benchmark year; otherwise, the agency would use its current performance payment limit calculation that uses the ACO's assigned beneficiary person years from BY3. CMS proposed to compare the alternative benchmark-based performance payment limit or loss recoupment limit (calculated using assigned beneficiary person years from the benchmark year with the lowest number of assigned beneficiaries) with the benchmark-based performance payment limit or loss recoupment limit calculated with assigned beneficiary person years for the performance year (current policy). CMS would apply the lesser of these two in determining the final performance payment limit or loss recoupment limit. This approach would be codified at new §425.605(i) (BASIC track) and new §425.610(l) (ENHANCED track).

In parallel with the proposal to allow certain ACOs with fewer than 5,000 assigned beneficiaries to participate in MSSP (and the proposed alternative calculation for payment limits and loss recoupment limits), CMS also proposed to exclude ACOs that fall below 5,000 assigned beneficiaries in any BY from being eligible to benefit from the policies at §425.605(h) that provide certain low-revenue ACOs participating in the BASIC track with additional opportunities to share in savings (see §425.605(h) for a description of this policy). CMS proposed to amend §425.605(h)(1) by adding new paragraph (v) that specifies: "For agreement periods beginning on or after January 1, 2027, the ACO has at least 5,000 assigned beneficiaries in each of the ACO's benchmark years."

CMS indicates that commenters generally supported its proposal, noting that the change would facilitate broader participation in MSSP through easier entry and by granting flexibility to existing MSSP ACOs (especially those operating in rural areas). On the other hand (and interestingly, given some commenters' opposition to CMS' proposal to shorten the amount of time an ACO can remain in a one-sided risk arrangement, discussed above), some commenters

[10] The applicable percentage dependent on the ACO's track / level of participation: either 1 percent for Level C, 2 percent for Level D, or 4 percent for Level E of the BASIC track, or 15 percent for the ENHANCED track.

expressed concerns about requiring ACOs whose assigned population dipped below 5,000 beneficiaries to participate in the BASIC (rather than the ENHANCED) track, arguing that this requirement would dampen these ACOs' return on investment. Some commenters urged CMS to implement a six-month "grace period" to allow an ACO to reach the 5,000 beneficiary minimum.

After consideration of comments received, **CMS is finalizing the addition of a new paragraph (3) to §425.110(a) specifying that for agreement periods beginning on or after January 1, 2027, CMS will determine whether an ACO has 5,000 or more beneficiaries historically assigned to the ACO participants in each of the three benchmark years, as calculated using the assignment methodology set forth in existing subpart E of Part 425. CMS is also finalizing with minor modification for consistency with existing regulation text at §425.110(a)(2) the provision under new §425.110(a)(3) that states, in the case of the third benchmark year, CMS uses the most recent data available to estimate the number of assigned beneficiaries. Lastly, CMS is finalizing at §425.110(a)(3)(i) through (ii) the proposed provisions in connection with the agency's determination of whether an ACO has 5,000 or more assigned beneficiaries in its benchmark years**.

With respect to the proposed alternative performance payment limit and loss recoupment limit for ACOs with fewer than 5,000 assigned beneficiaries in the benchmark years, CMS indicates that "many" commenters supported the agency's proposals. CMS did not give merit to "one commenter" who suggested that capping potential shared savings via the alternative limits would discourage participation; CMS argued that "the proposal to apply alternative performance payment and loss recoupment limits for ACOs with less than 5,000 assigned beneficiaries in any BY is one of several safeguards we believe is necessary to address risk to the program that result from the proposed changes to the eligibility requirements to allow for participation by ACOs that have fewer than 5,000 assigned beneficiaries in BY1, BY2, or both" (which the agency is finalizing in this final rule). Thus, **CMS is finalizing the application of an alternative performance payment limit and loss recoupment limit during financial reconciliation for ACOs that fall below 5,000 assigned beneficiaries in any benchmark year as proposed at new §425.605(i) (BASIC track) and new §425.610(l) (ENHANCED track)**.

At new §425.605(i), CMS will codify the existing approach to calculating the performance payment limit under new paragraph (i)(1)(i), and the loss recoupment limit under new paragraph (i)(2)(i). CMS is finalizing in new paragraphs (i)(1)(ii) and (i)(2)(ii) of §425.605 provisions for how the agency determines whether to apply an alternative performance payment limit or loss recoupment limit (respectively), if an ACO has fewer than 5,000 assigned beneficiaries in BY1, BY2, or BY3, in conducting financial reconciliation for each performance year, for agreement periods beginning on or after January 1, 2027. At new §425.610(l)(1) to (2), CMS will codify the existing approach to calculating the performance payment limit and the loss recoupment limit. **The agency is also finalizing, with a minor modification for consistency and clarity, its proposal to specify under new paragraph (l)(3) of §425.610 provisions for how it will determine whether to apply an alternative performance payment limit or loss recoupment limit if an ACO has fewer than 5,000 assigned beneficiaries in BY1, BY2, or BY3, in conducting financial reconciliation for each performance year, for agreement periods beginning on or after January 1, 2027**.

As noted above, CMS also proposed (90 FR 32671) to exclude ACOs that fall below 5,000 assigned beneficiaries in any BY from being eligible to benefit from the policies at §425.605(h) that provide certain low-revenue ACOs participating in the BASIC track with additional opportunities to share in savings. In this final rule CMS is finalizing a policy to allow ACOs with fewer than 5,000 assigned beneficiaries in BY1 or BY2 or both years to participate in MSSP. In doing so, however, CMS acknowledges that the Shared Savings Program will be more vulnerable to making shared savings payments to ACOs that would not reward true cost savings, but instead would pay for normal or random expenditure fluctuations when smaller populations of assigned beneficiaries are used to establish the ACO's historical benchmark as a result of the ACO having fewer than 5,000 assigned beneficiaries in a benchmark year. CMS asserts that this concern is further increased under the policy at §425.605(h), under which certain low revenue, BASIC track ACOs may qualify for a shared savings payment when they have not met the MSR requirement. Therefore, **CMS is finalizing its proposal to amend §425.605(h)(1) to include an additional criterion, applicable for agreement periods beginning on or after January 1, 2027, under which Medicare will require an ACO to have at least 5,000 assigned beneficiaries in each of its BYs to be eligible for the increased opportunities to share in savings, under the policy established at § 425.605(h)**.

5. Revisions to the Definition of Primary Care Services used in Medicare Shared Savings Program (MSSP) Beneficiary Assignment

a. Background

Section 1899(c)(1) of the Act specifies that beneficiaries are assigned to ACOs based on their utilization of primary care services provided by a physician who is an ACO professional and of all services furnished by rural health clinics (RHCs) and federally qualified health centers (FQHCs). However, a list of services considered primary care services for purposes of beneficiary assignment is not specified in statute.[11]

b. Finalized Revisions

In order to remain consistent with billing and coding under the PFS, CMS is finalizing, with modifications, at §425.400(c)(1)(x) a revised list of codes to be included as primary care services used in the MSSP assignment methodology for performance years beginning on or after January 1, 2026.

As finalized, the revised list includes the list of HCPCS and CPT codes currently specified in §425.400(c)(1)(ix) and adds to that list Enhanced Care Model Management Services (HCPCS codes GPCM1, GPCM2, and GPCM3, which are add-on HCPCS codes being finalized in the PFS payment policy in the rule as G0568, G0569, and G0570, respectively). In the 2026 PFS proposed rule, CMS had proposed that the revised list not include Social Determinants of Health Risk Assessment Services (HCPCS code G0136), if the proposed deletion of such HCPCS code were to be finalized under the FFS payment policy. Since CMS is *not* finalizing deletion of

[11] For the performance year beginning on January 1, 2025 and subsequent performance years, primary care services are defined for purposes of assigning beneficiaries to ACOs in §425.402 as the set of services identified by the listed HCPCS/CPT codes at §425.400(c)(1)(ix).

HCPCS code G0136 from the HCPCS code set (but is instead modifying the code descriptor) and it remains a payable service under the PFS, CMS is *not* finalizing its proposal to remove the code from the list of codes included as primary care services used for purposes of MSSP assignment. Instead, CMS is revising the code descriptor to describe physical activity and nutrition assessment services consistent with the G0136 code descriptor revisions in section II.I of the rule.

The three add-on HCPCS codes finalized under the PFS payment policy allow for payment under the PFS when behavioral health integration services (BHI) or psychiatric collaborative care management services (CoCM) are furnished in conjunction with Advanced Primary Care Management (APCM) services for practitioners who meet the requirements to furnish both services. For payment under the PFS:

- *Finalized HCPCS code G0568* is an add-on code that mirrors 99492 (CoCM initial month).
- *Finalized HCPCS code G0569* is an add-on code that mirrors 99493 (subsequent months) for CoCM services delivered to patients also receiving APCM services.
- *Finalized HCPCS code G0570* is an add-on code for general behavioral health integration services that mirrors CPT code 99484 (20 minutes or more of BHI services) for BHI services delivered to patients also receiving APCM services.

The codes are optional add-ons for APCM services and remove the time-based requirements and reduce documentation requirements of the previous BHI and CoCM CPT codes, which CMS believes could make PCPs more likely to offer BHI and CoCM services. The new HCPCS codes are to allow for the payment of services that, when reported as standalone services, are currently included in the definition of primary care services used for purposes of assignment when furnished in conjunction with APCM services.

6. Quality Performance Standard and Other Reporting Requirements

a. Background

The MSSP's quality performance standard is used to determine whether an ACO is eligible to receive shared savings for a performance year (PY). Determination of whether the standard has been met takes into account the number and type of measures for which an ACO reports data and its measure scores. Beginning with PY 2025, ACOs must report (i) the three electronic clinical quality measures (eCQMs) or clinical quality measures (CQMs) of the APM Performance Pathway (APP) of the Merit-based Incentive Payment System (MIPS) (MIPS CQMs) and (ii) the CAHPS for MIPS survey through the APP. Also, in the 2024 PFS final rule, CMS established the Medicare Clinical Quality Measures for ACOs Participating in the MSSP (Medicare CQMs), which are MIPS CQMs but are reported on an ACO's eligible Medicare FFS beneficiaries (rather than all payer/all patients), as another optional collection type beginning for performance year 2024. Medicare CQMs are intended to serve as a transition collection type to help some ACOs build the infrastructure and expertise to report all payer/all patient eCQMs/MIPS CQMs.

b. Revisions to the Definition of Beneficiary Eligible for Medicare CQMs

CMS describes how Medicare CQMs were designed to address the concern that for ACOs with a higher proportion of specialty practices, the broader all payer/all patient eligible population would capture beneficiaries with no primary care relationship to the ACO. Since Medicare CQMs are an all-beneficiary Medicare measure (not just ACO assigned beneficiaries) they were also designed to help ACOs aggregate patient data.

A beneficiary eligible for Medicare CQMs is defined under §425.20 as a beneficiary identified for purposes of reporting Medicare CQMs for ACOs participating in the MSSP who satisfies either of the following descriptions:

(1) A Medicare FFS beneficiary who meets the criteria for a beneficiary to be assigned to an ACO (described at §425.401(a)) and had at least one claim with a date of service during the measurement period from an ACO professional who (i) is a primary care physician (PCP) or has one of the specialty designations included in §425.402(c) or (ii) is a physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS).
(2) A Medicare FFS beneficiary who is assigned to an ACO in accordance with §425.420(e) because the beneficiary designated an ACO professional participating in the ACO as responsible for coordinating their overall care.

In the 2024 PFS final rule, CMS specified that it would provide each ACO with a list of beneficiaries eligible for Medicare CQMs each quarter of the performance year as part of the ACO's quarterly informational reports packages. The list is to assist ACOs in identifying the denominator eligible population for each measure to the extent that the data can be identified through claims and Medicare administrative systems. CMS now explains that since the list does not apply measure-specific eligibility criteria it may include FFS beneficiaries who are not eligible for inclusion in any of the Medicare CQMs in the APP quality measure set. CMS has learned that the complexity of the current definition of beneficiary eligible for Medicare CQMs has created much confusion, specifically because the methodology used to generate the list of beneficiaries eligible for Medicare CQMs (which follows more closely to all payer/all patient MIPS CQM specifications) is different from that used to generate the list of beneficiaries assignable to an ACO.

CMS is finalizing, as proposed, to therefore revise the definition at §425.20 of beneficiary eligible for Medicare CQMs effective January 1, 2025 (retroactive to apply for performance year 2025 as well as for subsequent performance years) so that the definition will have greater overlap with the list of beneficiaries who are assignable to an ACO. The revised definition will require at least one primary care service with a date of service during the applicable performance year from an ACO professional who is a PCP or who has one of the specialty designations included at §425.402(c), or who is a PA, NP, or CNS. Specifically, under the definition, description #1 (above) of an individual qualifying as a beneficiary eligible for Medicare CQMs will be changed to instead describe:

- A Medicare FFS beneficiary who meets the criteria for a beneficiary to be assigned to an ACO (described at §425.401(a) and had at least one primary care service with a date of service during the applicable performance year [*instead of the previous description: claim with a date of service during the measurement period*] from an ACO professional who is a PCP or has one of the specialty designations included in §425.402(c), or is a PA, NP, or CNS.

CMS will continue to provide the quarterly list and will add an additional variable to the quarterly list to flag each beneficiary who had a primary care service visit beginning with the performance year 2025 quarter 2 list to identify beneficiaries eligible for Medicare CQMs under the revised definition. Starting with the performance year 2025 quarter 4 list, the list will be based on the finalized definition. CMS believes it is in the public interest to apply these changes retroactively beginning in performance year 2025 (and thus believes it falls under the public interest exception to the section 1871(e)(1)(A) prohibition on retroactive substantive regulatory changes) because if the previous definition (applied prior to this rule) were applied any further it would be an ongoing contributor to ACOs' confusion on which beneficiaries to use for quality data reporting.

c. Removal of the Health Equity Adjustment (HEA)

Background. CMS finalized in the 2023 PFS final rule[12] the HEA, which had been available starting for performance year 2023 to an ACO that reports the three eCQMs/MIPS CQMs in the APP quality measure set (meeting the data completeness requirement for all three) and administers the CAHPs for MIPS survey. The level of the HEA was based on the ACO's performance on quality measures and the proportion of beneficiaries served by the ACO who are from underserved neighborhoods or are eligible for the Medicare part D low-income subsidy (LIS) or dually eligible for Medicare and Medicaid. Up to 10 additional points could be added to an eligible ACO's MIPS quality performance category score.

Since the adoption of the HEA, CMS has adopted or extended other scoring adjustments. In the 2025 PFS final rule, the complex organization adjustment was adopted beginning for the 2025 performance period/2027 MIPS payment year to account for organizational complexities encountered by virtual groups and APM entities, including MSSP ACOs when reporting eCQMs.[13] An ACO receives one measure achievement point for each submitted eCQM that meets the case minimum requirement and data completeness requirement. The complex organization adjustment may be up to 10 percent of the total available measure achievement points in the quality performance category. CMS describes how if the number of eCQMs that ACOs are required to report in the APP Plus quality set grows, the relative value of the complex organization adjustment will increase.

In addition, CMS adopted an incentive for ACOs to transition to eCQM/MIPS CQM reporting (the eCQM/MIPS CQM reporting incentive), which was extended in the 2025 PFS final rule to support ACOs in the transition to eCQMs. If the eCQM/MIPS CQM reporting incentive criteria are satisfied the ACO may meet the quality performance standard and be eligible to receive

[12] 87 FR 69838-69857.
[13] 89 FR 98116-98117.

maximum shared savings and avoid maximum shared losses. As extended, for performance year 2025 and subsequent performance years for ACOs reporting eCQMs, and for performance years 2025 and 2026 for ACOs reporting MIPS CQMs, an ACO will satisfy the quality performance standard if the ACO (i) reports all of the eCQMs/MIPS CQMs in the APP Plus quality measure, as applicable for the performance year (meeting data completeness requirements); (ii) achieves a quality performance score equal to or more than the 10th percentile of the benchmark on at least one of the outcome measures in the APP Plus quality measure set; and (iii) achieves a quality performance score equal to or more than the 40th percentile of the benchmark on at least one of the remaining measures in the APP Plus quality measure set.

Finalized HEA Removal. CMS believes that the eCQM/MIPS reporting incentive and the Complex Organization Adjustment are duplicative of the incentives provided by the HEA and serve a similar function – specifically, the agency observes they both ultimately increase an ACO's MIPS quality performance category score and improve the ACO's ability to meet the quality performance standard. The agency believes that the eCQM/MIPS CQM reporting incentive and the complex organization adjustment accomplish the purpose of supporting ACOs to address challenges of reporting all payer/all patient measures as well as supporting ACOs that serve high proportions of dually eligible beneficiaries and LIS beneficiaries, and both have broader applicability than the HEA. In addition, as finalized in the 2025 PFS final rule, measures of the Medicare CQM collection type will be scored using flat benchmarks for the measure's first two performance periods in MIPS. The agency believes these flat benchmarks will also provide benefits that are duplicative of the HEA.

CMS reviews simulations it conducted based on performance year 2024 ACO quality data (which had not yet been available prior to publication of the 2026 PFS proposed rule) to analyze how the removal of the HEA and the application of the eCQM/MIPS CQM reporting incentive, Complex Organization Adjustment, and flat benchmarking policies for Medicare CQMs would impact ACOs' quality scores. Based on the simulations, CMS continues to believe that the HEA is duplicative with the other adjustments.

Therefore, CMS is finalizing, with modification, its proposal to remove the HEA. The modification is that the removal will apply beginning with performance year 2026 (instead of beginning retroactively with performance year 2025, as had been proposed).

Selected Comments/Responses. A few commenters supported the removal of the HEA as a means of simplifying and streamlining quality scoring. However, many other commenters did not support removal of the HEA and pointed out various reasons why they believe the HEA is not duplicative with the other adjustments as described by the agency. CMS, however, disagrees and points to its previously stated reasoning, including by pointing to the performance year 2024 ACO quality results that became available after the publication of the 2026 PFS proposed rule. Based on those results the agency found that all 26 ACOs that earned HEA bonus points and reported eCQMs/MIPS CQMs also met the criteria for the eCQM/MIPS CQM reporting incentive and also based on an internal CMS simulation of the 2024 quality results, that the 13 ACOs that earned HEA bonus points in that performance year and reported Medicare CQMs would have benefited from the flat benchmarks for Medicare CQMs to a greater degree than the

HEA, had that flat benchmark policy been applicable in performance year 2024. CMS believes this data helps demonstrate that the benefit of flat benchmarks for Medicare CQMs, together with the eCQM/MIPS CQM reporting incentive and the Complex Organization Adjustment, collectively provide sufficient support to ACOs to support removing the HEA.

Section 1871(e)(1)(A)(ii) prohibits retroactive application of substantive changes in Medicare regulations unless the Secretary determines that failure to apply the change retroactively would be contrary to the public interest. In the 2026 PFS proposed rule, CMS asserted this is a case where it would be contrary to the public interest if the proposal were not applied retroactively. The agency pointed to the complexity and confusion of having multiple duplicative incentives for ACOs to meet the quality performance standard.

Some commenters were concerned that removing the HEA retroactively would increase uncertainty and financial risk. Other commenters noted that some ACOs have already made financial decisions based on the understanding that the HEA would be available for performance year 2025 and retroactively removing it would affect ongoing investments. CMS acknowledges these concerns and is finalizing the policy with modification to remove the HEA beginning with performance year 2026 (instead of performance year 2025, as proposed). The agency believes the prospective removal of the HEA will also allow ACOs to better understand (before the HEA is removed) the impacts of the extension of the eCQM/MIPS CQM reporting incentive, the Complex Organization Adjustment, and flat benchmarks for Medicare CQMs.

Revising Terminology in MSSP Regulations Used to Describe the HEA and Other Related Terms. CMS finalizes (with modifications to align with the finalized removal of the HEA in performance year 2026, instead of performance year 2025, as proposed) revisions to terminology used to describe the HEA and other related terms in the MSSP regulations, including to consistently clarify that "impermissible features, such as race and ethnicity" are not included in MSSP policies. The HEA is being renamed the "population and income adjustment." In revising these terms, CMS determined that the terms "quality score" and "quality performance score" could be confusing, so it is also revising the term "quality score" to consistently mean an ACO-level quality score and to revise quality performance score to consistently mean a measure-level score. CMS lists its finalized revisions in terminology and references used in the specific paragraphs of the MSSP regulations, including removing references related to the HEA, underserved populations, and the underserved multiplier and instead referring more generally to the quality score or multiplier under §425.512. These changes are to terminology and are *not* changes in the methodology used to calculate the HEA bonus points or the HEA quality performance score for performance years 2023 through 2025.

d. Updates to the APP Plus Quality Measure Set

In the 2025 PFS final rule (89 FR 98105), CMS finalized that MSSP ACOs are required to report the APP Plus quality measure set beginning for performance year 2025 and are required to report on (and will be scored on) all applicable quality measures in the measure set according to a phase-in schedule for incorporating measures progressively into the measure set. As finalized under the 2025 PFS final rule, the phase-in of the quality measures in the APP Plus quality measure set for MSSP ACOs was as follows:

- For performance year 2025: Six measures (four eCQMs/MIPS CQMs/Medicare CQMs, one administrative claims measure, and the CAHPS for MIPS survey measure).
- For performance year 2026: Eight measures (five eCQMs/MIPS CQMs/Medicare CQMs, two administrative claims measures, and the CAPS for MIPS survey measure).
- For performance year 2027: Nine measures (six eCQMs/Medicare CQMs, two administrative claims measures, and the CAPS for MIPS survey measure).
- Beginning for (i) performance year 2028 or (ii) the performance year that is one year after the eCQM specifications become available for Quality ID: 487 Screening Social Drivers of Health and Quality ID: 493 Adult Immunization Status, whichever is later: Eleven measures (eight eCQMs/Medicare CQMs, two administrative claims measures, and the CAHPS for MIPS Survey measure). For Quality ID: 487 Screening for Social Drivers of Health or Quality ID: 493 Adult Immunization Status to be incorporated into the APP Plus quality measure set in performance year 2028, the eCQM specification for the measure must be published on the eCQI resource center by May 2027, and the measure would then be required to be reported by ACOs in early 2029.

CMS is now finalizing substantive changes (shown in Table Groups D and DD of Appendix A of the final rule) of the following measures, which are also included in the APP Plus quality measure set for MSSP ACOs:

- Breast Cancer Screening (Quality ID: 112)
- Colorectal Cancer Screening (Quality ID: 113)
- Preventive Care and Screening: Screening for Depression and Follow-up Plan (Quality ID: 134) (eCQM collection type only)
- Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (Quality ID: 484)

CMS is finalizing removal of the Screening for SDOH (Quality ID: 487), as shown in Table Group C of Appendix A of the final rule. With the removal of the Screening for SDOH measure, the measure would no longer be available for inclusion in the phase-in of the APP Plus Quality measure set. CMS is, therefore, finalizing its proposal to modify the phased-in required reporting such that beginning with performance year 2028 (or the performance year that is 1 year after the eCQM specification becomes available for Quality ID 493, if later) the APP Plus quality measure set for MSSP ACOs will include 10 (instead of 11) measures.

Table B-G5 in the rule shows the finalized APP Plus quality measure set for MSSP ACOs for performance year 2028 or the performance year that is 1 year after the eCQM specification becomes available for Quality ID 493, whichever is later. The following table shows the phased-in measure set as previously and newly finalized (including the changes shown in Table B-G5 beginning for performance year 2028).

Measures Included in APP Plus Quality Measure Set for MSSP ACOs				
Measure ID #	**Measure Title**	**Measure Type**	**Collection Type**	**Performance Years (PYs)**
321	CAHPS for MIPS Survey	Patient Engagement /Experience	CAHPS for MIPS Survey	PY 2025 and Subsequent PYs
479	Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups	Outcome	Administrative Claims	PY 2025 and Subsequent PYs
001	Diabetes: Glycemic Status Assessment Greater than 9%	Intermediate Outcome	eCQM /Medicare CQM (and, for 2025 and 2026, MIPS CQM)	PY 2025 and Subsequent PYs
134	Preventive Care and Screening: Screening for Depression and Follow-up Plan	Process	eCQM /Medicare CQM (and, for 2025 and 2026, MIPS CQM)	PY 2025 and Subsequent PYs
236	Controlling High Blood Pressure	Intermediate Outcome	eCQM /Medicare CQM (and, for 2025 and 2026, MIPS CQM)	PY 2025 and Subsequent PYs
112	Breast Cancer Screening	Process	eCQM /Medicare CQM (and, for 2025 and 2026, MIPS CQM)	PY 2025 and Subsequent PYs
113	Colorectal Cancer Screening	Process	eCQM /Medicare CQM (and, for 2026, MIPS CQM)	PY 2026 and Subsequent PYs
484	Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	Outcome	Administrative Claims	PY 2026 and Subsequent PYs
305	Initiation and Engagement of Substance Use Disorder Treatment	Process	eCQM/Medicare CQM	PY 2027 and Subsequent PYs
493	Adult Immunization Status	Process	eCQM/Medicare CQM	PY 2028 (or the performance year that is 1 year after the eCQM specification becomes available for Quality ID 493, if later) and Subsequent PYs

e. Adding Web-Based Survey Mode to CAHPS for MIPS Survey

Background. The CAHPS for MIPS Survey is an annual survey used for traditional MIPS, MVPs, and APMs. The survey is a quality measure in the APP Plus quality measure set and, as such, MSSP ACOs are required to administer the survey (except if the ACO does not meet the

required sample size)[14] to meet the quality reporting requirements under the MSSP for performance years beginning on or after January 1, 2025. The survey must be administered by CMS-approved survey vendors. Data is currently collected using a mail-phone survey administration protocol in English and Spanish, with additional translations available. In response to the RFI issued in the 2025 PFS proposed rule on the potential expansion to a web-mail-phone protocol,[15] comments received expressed wide support for such expansion and noted that the expansion could help increase response rates.

Final Action. CMS finalizes that, beginning with 2027, CMS-approved survey vendors are required to administer the survey through a web-mail-phone protocol.

f. Summary of Final Policies

Tables B-G6 and B-G7 of the rule (combined and represented with organizational and noted changes below) summarize the APP quality reporting requirements and quality performance standard policies, including as newly finalized, for performance year (PY) 2025 and subsequent PYs. These finalized tables are the same as Tables 52 and 53 in the proposed rule.

APP Plus Quality Measure Set Reporting Requirements and Quality Performance Standard for PY 2025 and Subsequent PYs				
	PY 2025[16]	**PY 2026**	**PY 2027**	**Beginning PY 2028**[17]
Quality Reporting Requirements	Report 4 eCQMs/ Medicare CQMs/MIPS CQMs in the APP Plus quality measure set; and administer CAHPS for MIPS survey. CMS calculates 1 claims-based measure.	Report 5 eCQMs/ Medicare CQMs/MIPS CQMs in the APP Plus quality measure set; and administer CAHPS for MIPS survey. CMS calculates 2 claims-based measures.	Report 6 eCQMs/ Medicare CQMs in the APP Plus quality measure set; and administer CAHPS for MIPS survey. CMS calculates 2 claims-based measures.	Report 7 eCQMs/ Medicare CQM in the APP Plus quality measure set; and administer CAHPS for MIPS survey. CMS calculates 2 claims-based measures.
Quality Performance Standard used to determine eligibility for maximum shared savings and to avoid maximum	Achieve a *health equity adjusted* quality score that is ≥ the 40th percentile across all MIPS Quality performance category scores (excludes those eligible for facility-based scoring*) - OR - Report the 4 eCQMs/MIPS CQMs	Achieve a quality score that is ≥ the 40th percentile across all MIPS Quality performance category scores (excludes those eligible for facility-based scoring*) - OR - Report the 5 eCQMs/MIPS CQMs in the APP Plus	Achieve a quality score that is ≥ the 40th percentile across all MIPS Quality performance category scores (excludes those eligible for facility-based scoring*) - OR - Report the 6 eCQMs in the APP Plus quality measure set	Achieve a quality score that is ≥ the 40th percentile across all MIPS Quality performance category scores (excludes those eligible for facility-based scoring*) - OR - Report the 7 eCQMs in the APP Plus

[14] The required sample size is specified under §414.1380(b)(1)(vii)(B).
[15] 89 FR 61869, 62042, and 62043.
[16] The final rule states that Tables B-G6 and B-G7 are the same as Tables 52 and 53 in the proposed rule. However, the removal of the HEA, as finalized, applies beginning for performance year 2026. To reflect that finalized policy, the performance year 2025 column in this table shows (in italics) the HEA being applied for performance year 2025.
[17] PY 2028 or the performance year that is one year after the eCQM specifications become available for Quality ID: 493, whichever is later.

APP Plus Quality Measure Set Reporting Requirements and Quality Performance Standard for PY 2025 and Subsequent PYs				
	PY 2025[16]	**PY 2026**	**PY 2027**	**Beginning PY 2028**[17]
shared losses, if applicable	in the APP Plus quality measure set (for each, meet completeness requirement); achieve quality performance score that is ≥ 10th percentile of performance benchmark on ≥ 1 (of 3) APP Plus quality measure set outcome measures and a score ≥ the 40th percentile of performance benchmark on ≥ 1 of 5 remaining APP Plus quality measure set measures	quality measure set (for each, meet completeness requirement); achieve quality performance score that is ≥ 10th percentile of performance benchmark on ≥ 1 (of 4) APP Plus quality measure set outcome measures and a score ≥ the 40th percentile of performance benchmark on ≥ 1 of 7 remaining APP Plus quality measure set measures	(for each, meet completeness requirement); achieve quality performance score that is ≥ 10th percentile of performance benchmark on ≥ 1 (of 4) APP Plus quality measure set outcome measures and a score ≥ the 40th percentile of performance benchmark on ≥ 1 of 8 remaining APP Plus quality measure set measures	quality measure set (for each, meet completeness requirement); achieve quality performance score that is ≥ 10th percentile of performance benchmark on ≥ 1 (of 4) APP Plus quality measure set outcome measures and a score ≥ the 40th percentile of performance benchmark on ≥ 1 of 9 remaining APP Plus quality measure set measures
Alternative Quality Performance Standard	Fails to meet criteria above but a quality performance score that is ≥ than 10th percentile of performance benchmark on ≥ 1 (of 3) APP Plus quality measure set outcome measures would allow shared savings (if otherwise eligible) at a lower rate that is scaled by the ACO's *health equity adjusted* quality performance score	Fails to meet criteria above but a quality performance score that is ≥ than 10th percentile of performance benchmark on ≥ 1 (of 4) APP Plus quality measure set outcome measures would allow shared savings (if otherwise eligible) at a lower rate that is scaled by the ACO's quality performance score	Fails to meet criteria above but a quality performance score that is ≥ than 10th percentile of performance benchmark on ≥ 1 (of 4) APP Plus quality measure set outcome measures would allow shared savings (if otherwise eligible) at a lower rate that is scaled by the ACO's quality performance score	Fails to meet criteria above but a quality performance score that is ≥ than 10th percentile of performance benchmark on ≥ 1 (of 4) APP Plus quality measure set outcome measures would allow shared savings (if otherwise eligible) at a lower rate that is scaled by the ACO's quality performance score
Quality Performance Standard is NOT Met	If an ACO (1) does not report any of the 4 eCQMs/MIPS CQMs/Medicare CQMs in the APP Plus quality measure set and (2) does not administer a CAHPS for MIPS survey, the ACO will not meet the quality performance standard or the alternative quality performance standard. The ACO will be ineligible to share	If an ACO (1) does not report any of the 5 eCQMs/MIPS CQMs/Medicare CQMs in the APP Plus quality measure set and (2) does not administer a CAHPS for MIPS survey, the ACO will not meet the quality performance standard or the alternative quality performance standard. The ACO will be ineligible to share	If an ACO (1) does not report any of the 6 eCQMs/ Medicare CQMs in the APP Plus quality measure set and (2) does not administer a CAHPS for MIPS survey, the ACO will not meet the quality performance standard or the alternative quality performance standard. The ACO will be ineligible to share savings and will owe	If an ACO (1) does not report any of the 7 eCQMs/ Medicare CQMs in the APP Plus quality measure set and (2) does not administer a CAHPS for MIPS survey, the ACO will not meet the quality performance standard or the alternative quality performance standard. The ACO will be ineligible to share savings and

APP Plus Quality Measure Set Reporting Requirements and Quality Performance Standard for PY 2025 and Subsequent PYs				
	PY 2025[16]	**PY 2026**	**PY 2027**	**Beginning PY 2028**[17]
	savings and will owe maximum shared losses, if applicable.	savings and will owe maximum shared losses, if applicable.	maximum shared losses, if applicable.	will owe maximum shared losses, if applicable.
* Facility-based scoring allows certain clinicians (e.g., pathologists) to be scored using their facilities' Hospital Value Based Purchasing Program results.				

g. RFI: Toward Digital Quality Measurement in CMS Quality Programs

CMS describes its goal to fully transition to digital quality measurement (dQM) in quality reporting and value-based purchasing programs. The agency refers readers to section IV.A.4.c of the rule, which references the RFI in the 2026 PFS proposed rule that sought comment on the transition to dQM, including as related to FHIR-based eCQMs for MSSP and the MIPS quality performance category. CMS does not in the final rule address comments received but states that it will take those comments into consideration to help it consider future rulemaking on the topic.

7. Revisions to Extreme and Uncontrollable Circumstances (EUC) Policies to Determine Quality and Financial Performance

Background. CMS describes its current MSSP quality and finance EUC policies,[18] which have been used for ACOs affected by natural disasters or PHEs but which do not necessarily address ACOs affected by a cyberattack, including ransomware/malware, which can similarly be outside of the control of the ACO and could affect the agency's ability to accurately measure the ACO's quality performance. Under the current EUC policy, for ACOs affected by an EUC, CMS uses an alternative approach to calculate the quality score by setting the ACO's minimum quality performance score to the equivalent of the 40th percentile MIPS quality performance category score across all MIPS quality performance scores, excluding entities/providers eligible for facility-based scoring. If the affected ACO reports quality data, then CMS calculates the ACO's quality score by using the higher of the ACO's quality performance score or the equivalent of the 40th percentile MIPS quality performance category (excluding facility-based scoring eligible entities/providers). An ACO is considered affected by an EUC if (i) at least 20 percent of the ACO's beneficiaries reside in an area identified under the QPP as affected by an EUC; or (ii) the ACO's legal entity is located in an area identified under the QPP as affected by an EUC.[19]

Quality Performance. CMS is finalizing, as proposed, for performance year 2025 and subsequent years, to expand the application of the quality and finance EUC policies to an ACO that is affected by an EUC due to a cyberattack, including ransomware/malware, as determined under the QPP. If the ACO is affected at the legal entity level by an EUC due to a cyberattack, the ACO will need to submit a MIPS EUC exception application to the QPP *as an APM entity* for the affected performance year. If approved, then the MSSP quality and finance EUC policies at §§425.512(c), 425.605(f), and 425.610(i) will apply to provide relief from quality reporting requirements and mitigate shared losses. The MSSP will *not* apply the quality and finance EUC

[18] The MSSP quality EUC policies are codified at §425.512(c).
[19] See requirements under §425.512(c)(1).

policies to an ACO that submits the exception application as an individual, group, or virtual group. Specifically, beginning in performance year 2025:

- Consistent with §425.512(c)(3)(iv), if an ACO with an approved MIPS EUC exception application for a cyberattack reports the APP Plus quality measure set, meets the data completeness requirements and receives a MIPS quality performance category score, then CMS will use the higher of (i) the ACO's quality score or (ii) the equivalent of the 40th percentile MIPS quality performance category score across all MIPS quality performance categories, excluding facility-based scoring eligible entities/providers.
- Consistent with §425.512(c)(2)(ii), if CMS determines the ACO is affected by the EUC (as determined by meeting the requirements of §425.512(c)(1)), the ACO's minimum quality performance score will be the equivalent of the 40th percentile MIPS quality performance category score, excluding facility-based scoring eligible entities/providers.

CMS acknowledges that section 1871(e)(1)(A)(ii) of the Act prohibits retroactive application of substantive changes to regulations except where the Secretary determines that failure to apply the change retroactively would be contrary to the public interest. CMS believes this is such an instance that satisfies that exception. The agency believes that it is in the public interest to provide relief from the MSSP quality reporting requirements and mitigate shared losses to ACOs that have an approved MIPS EUC exception application due to a cyberattack occurring during performance year 2025 or a subsequent year. In support CMS points to a 2024 survey conducted by the American Medical Association, which demonstrates the impacts of the Change Healthcare cyberattack on clinical practices.[20]

Selected Comments/Responses. Most commenters supported the changes to the quality EUC policy, noting how the availability of relief to ACOs affected by a cyberattack is critical to maintaining continuity of care and protecting beneficiaries. In response to a request for guidance on documentation requirements and timelines for the MIPS EUC exception applications, CMS notes that updated information for performance year 2025 will be available on the Quality Payment Program Exception Application website.[21]

Determining Financial Performance. Under current policies at §§425.605(f) and 425.610(i), if CMS determines an ACO has been affected by an EUC, the ACO will have its shared losses (if applicable) reduced by an amount that is proportional to the percentage of the year (determined by total months) affected by the EUC and the percentage of the ACO's performance year-assigned beneficiaries residing in the EUC-affected areas.

CMS finalizes that it will apply the MSSP finance EUC policies to an ACO whose MIPS EUC exception application (submitted as an APM entity) has been approved for a cyberattack. In the case of a cyberattack, however, the agency notes it will be unable to determine the percentage of the ACO's performance year-assigned beneficiaries residing in an EUC-affected area based on the ACO's submission of the EUC application to the QPP. Therefore, it is finalizing, as proposed, to apply the finance EUC policies at §§425.605(f) and 425.610(i) to 100 percent of the

[20] American Medical Association (2024). *Change Healthcare cyberattack impact: Key takeaways from informal AMA follow-up survey,* available at https://www.ama-assn.org/system/files/change-healthcare-follow-up-survey-results.pdf.

[21] https://qpp.cms.gov/mips/exception-applications?py=2025

ACO's assigned beneficiaries. The MIPS EUC exception application requires a start date for the EUC to be provided but allows the option to include or not include an end date (in case the EUC is still continuing). CMS finalizes that if an ACO does not provide an end date (either through the application or by contacting the QPP service center), the agency will apply a 90-day default duration for purposes of mitigating shared losses. This is consistent with the timeframe used for determining a PHE declaration (the duration of the PHE or 90 days with the Secretary able to extend). An ACO will be required to submit a MIPS EUC exception application for each affected performance year. The agency lists the specific finalized revisions to the MSSP EUC regulatory text that it will make to effectuate this finalized policy and notes that it made some corrections to the descriptions of the amendments (from what had been in the 2026 PFS proposed rule) for clarity.

Scenarios for the Start and End Dates. CMS finalizes, as proposed, several scenarios to illustrate the determination of the start and end dates of an EUC for the finalized quality and finance EUC policies. Those scenarios are presented in the table below.

Scenario	Quality EUC Policy Would Apply to ACO for…	Finance EUC Policy Would Apply for …
ACO provides start and end dates for the EUC in the application or contacts QPP service center to provide the end date prior to the end of the application submission period	The entire performance year, where CMS would use the higher of the ACO's quality score (if the ACO reports quality data) or the equivalent of the 40th percentile MIPS quality performance category score	The provided start and end dates for the EUC; and the policy would apply to 100 percent of the ACO's assigned beneficiaries for that period
ACO provides start date (ex, Mar 1) in the application but no end date and does not contact QPP service center with end date before end of application submission period	The entire performance year, where CMS would use the higher of the ACO's quality score (if the ACO reports quality data) or the equivalent of the 40th percentile MIPS quality performance category score	The provided start date (Mar 1) and an end date that would be 90 days from that start date; and the policy would apply to 100 percent of the ACO's assigned beneficiaries for that period
ACO provides in the application a start date that is within last 90 days of end of performance year (ex. Nov 1) but no end date and does not contact QPP service center with end date before end of application submission period	The entire performance year, where CMS would use the higher of the ACO's quality score (if the ACO reports quality data) or the equivalent of the 40th percentile MIPS quality performance category score	The provided started date (Nov 1) and an end date of December 31 (last day of the performance year); and the policy would apply to 100 percent of the ACO's assigned beneficiaries for that period

8. Population Adjustment – Financial Benchmarking Methodology

CMS reviews that the Health Equity Benchmark Adjustment (HEBA) was adopted in the 2025 PFS final rule[22] to increase participation in the MSSP by ACOs that serve a high proportion of Medicare part D LIS enrollees or dually eligible beneficiaries and to incentivize ACOs to provide coordinated care to these populations. Based on updated 2025 final benchmark data available since publication of the 2026 PFS proposed rule, the agency notes that 50 percent of ACOs estimated to receive the HEBA are new ACOs participating in their first agreement period

[22] 89 FR 98574-98576.

and therefore would not have otherwise qualified for the prior savings adjustment or positive regional adjustments and would have therefore had a less favorable benchmark. The Regulatory Impact Analysis of the HEBA from the 2025 PFS final rule (89 FR 98523 and 98524) estimated that total net savings is projected to grow over ten years by approximately $260 million as a result of the HEBA attracting additional high-cost ACOs to join the program and creating savings for the Medicare program.

However, CMS believes the HEBA terminology does not accurately reflect the specific data inputs and population focus of the adjustment. The agency is therefore finalizing, beginning for performance year 2025, to rename the HEBA to instead be the "population adjustment" and to rename the HEBA scaler to instead be the "scaler". The policy will revise only the terminology used; the methodology used to calculate the adjustment will be unchanged. CMS describes the regulatory text that would be amended to effectuate this terminology change.

9. Shared Savings Program Quality Reporting Monitoring Provisions

The alternative quality performance standard was finalized in the 2023 PFS final rule.[23] To meet the alternative standard for performance year 2025 and subsequent years, an ACO must report quality data on the APP Plus quality measure set and achieve a quality performance score equal to or higher than the 10th percentile of the performance benchmark on at least one of the outcome measures in the measure set. An ACO that meets the alternative standard (but not the quality performance standard) is eligible to share in savings on a sliding scale.

CMS explains that the agency monitors and assesses the performance of ACOs, their ACO participants, and ACO providers/suppliers to ensure ACOs satisfy their MSSP requirements. Monitoring policies regarding compliance with quality performance standards are specified at §425.316(c). Under those policies, CMS reviews an ACO's submission of quality measure data to identify those that are not meeting quality performance standards. The agency may take pre-termination actions against an ACO found in non-compliance with the quality performance standard or, depending on the nature and severity of non-compliance, may immediately terminate the ACO's participation agreement. CMS observes, though, that this monitoring and enforcement authority is specific to the quality performance standard and does not acknowledge the alternative performance standard. The agency explains that it inadvertently had not proposed to modify the monitoring policies when it proposed and finalized the alternative standard.

Therefore, CMS is finalizing, for performance years beginning on or after January 1, 2026, to incorporate the alternative quality performance standard into its monitoring policies at §425.316(c). Specifically, if an ACO fails to meet *both* the quality performance standard and the alternative quality performance standard, the agency will be authorized to take one or more of the pre-termination actions specified before termination of the ACO's participation agreement. Similarly, the ACO participation termination provisions at §425.316(c)(2)(ii) will be modified to make each specified term of noncompliance relative to failing to meet both the quality performance standard and alternative quality performance standard (rather than only the quality performance standard, as the regulations currently specify).

[23] 87 FR 70234; §425.512(a)(4)(ii) and (a)(5)(ii).