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WHITE PAPER

The CY 2027 Medicare Physician Fee Schedule Could Reshape MSSP Economics

Who Benefits, Who Is At Risk, and Why It's More Than a 2027 Issue

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INTRODUCTION

On July 14, 2026, the Centers for Medicare & Medicaid Services (CMS) released the CY 2027 Medicare Physician Fee Schedule Proposed Rule, which includes one of the more consequential packages of Medicare Shared Savings Program (MSSP) financial changes in recent years.

Several headline proposals appear favorable for Accountable Care Organizations (ACOs). CMS would increase the BASIC Level E shared savings rate, give more credit for prior savings, risk adjust the cap on positive benchmark adjustments, and introduce an incentive for qualifying network growth.

The proposed rule will benefit only some ACOs. Regionally efficient ENHANCED ACOs that rebase or enter the program in 2027 may receive a smaller benchmark adjustment. Lower risk ACOs could have less room under the risk-adjusted benchmark cap. ACOs intending to take advantage of the incentive for network growth by adding providers may receive no growth adjustment if their assigned population remains stable with addition of new beneficiaries.

Some of the most impactful changes are not limited to 2027. The proposed Accountable Care Prospective Trend (ACPT) guardrail could affect payment year (PY) 2025 and PY 2026 shared savings for ACOs in agreement periods that began in 2024 through 2026. CMS also plans to delay PY 2025 financial reconciliation until November 2026 so the guardrail can be incorporated if finalized.

THREE TAKEAWAYS FROM OUR REVIEW

Following are three takeaways from our review. They are explored further in Table 1.

1. ACOs in current agreement periods may need to revise PY 2025 and PY 2026 forecasts before most of the 2027 provisions take effect.
2. CMS is changing the economics of the BASIC Level E versus ENHANCED decision for 2027+ start ACOs.
3. Several benchmark proposals interact, so modeling them individually can produce a misleading answer.

Important: All provisions discussed below remain proposed. The impact assessments are qualitative and should not replace ACO-specific modeling.

Table 1. Summary of MSSP Changes in the Proposed Rule

Proposed Change	Primary Timing	ACOs Most Affected	Directional Impact
Lower ACPT guardrail (can only be 1% below observed national trends)	PY2025 and later for 2024–2026 agreement starts	ACOs with ACPTs that materially under-project actual national growth	High positive if triggered; otherwise low or none
Two-sided ACPT guardrail and annual recalculation (can only be between 1% lower and 1.5% higher than observed national trends)	Agreement periods beginning in 2027 or later	All new and renewing ACOs entering a 2027+ agreement	Varies
BASIC Level E track sharing rate increases from 50% to 60%	Agreement periods beginning in 2027 or later	ACOs selecting or considering Level E	High positive
Maximum positive ENHANCED track regional weight falls from 50% to 35%	Agreement periods beginning in 2027 or later	Regionally efficient ENHANCED ACOs	High negative when the regional adjustment controls
Prior savings factor increases from 50% to 75%	Agreement periods beginning in 2027 or later	Renewing ACOs with material prior savings	High positive when the prior savings adjustment controls
The 5% benchmark cap becomes risk-adjusted	Agreement periods beginning in 2027 or later	ACOs with positive adjustments that reach the cap	Positive or negative, depending on risk
New benchmark growth adjustment	Agreement periods beginning in 2027 or later	ACOs with qualifying net growth through inexperienced providers and beneficiaries	Potentially high positive, but narrow eligibility

Proposed Change	Primary Timing	ACOs Most Affected	Directional Impact
Primary care code and assignment changes	PY 2027 and PY 2028	ACOs with affected billing patterns or clinicians billing through non-ACO taxpayer identification numbers (TINs)	Varies
New ACO-specific "MOD2" E/M FFS add-on modifier for visit complexity (32% add-on for ACO participants vs. 16% add-on for non-ACO participants)	CY 2027	ACO participants furnishing qualifying E/M services	Positive provider FFS revenue; ACO impact varies (potential offsetting shared savings impact)

START WITH THE QUESTION OF TIMING

The proposed rule has two distinct time horizons. ACOs in existing agreements should focus first on ACPT and reconciliation. ACOs entering or renewing an agreement in 2027 should then model a broader set of changes to sharing rates, regional adjustments, prior savings, benchmark caps, and growth incentives.

Current Agreement Periods: ACPT Is the Immediate Driver of Change

For agreement periods beginning in 2024, 2025, or 2026, CMS proposes a lower ACPT guardrail beginning with PY 2025. Specifically, ACPT may be more than 1.0% below observed national expenditure growth.

For ACOs with these agreement periods, the proposal is generally favorable or neutral. The guardrail can increase the benchmark when the original ACPT materially under projects national growth, but it would not reduce the benchmark when ACPT exceeds actual growth. Given recent under projections of ACPT relative to actual national cost trends, the guardrail may increase benchmarks for many ACOs.
The likely impact depends on the size of the miss:

- High positive when the original ACPT is more than 1% below actual national growth.
- Low positive when the guardrail is triggered by only a small amount.
- No impact when ACPT is already within 1% of actual growth.

A Simple Way to Think About the Scale

If the prospective trend is 2% below observed national growth, the guardrail would reduce the gap to 1%. Because ACPT currently receives one-third of the weight in the three-way blended update factor, a 1% change in the ACPT component would translate to roughly 0.33% in the overall blend before compounding and other ACO-specific factors.

CMS also released ACPT Specifications Version 5. The update adds projected growth rates for ACOs with 2026 starts and revises certain aged/disabled projections for those with 2024 and 2025 starts to remove Medicare Advantage indirect medical education (IME) and graduate medical education (GME) expenditures included in the prior version. Those revisions should be reflected in current PY 2025 and PY 2026 forecasts.

CMS has also reopened PY 2024 shared savings settlements and issued revised benchmark reports to ACOs affected by the prior ACPT understatement associated with the IME and GME changes. Affected ACOs should review the revised settlement package and any downstream implications for partner distributions and financial reporting.

New Agreements: ACPT Becomes Two-Sided and Is Refreshed Annually

The approach would be different for agreement periods beginning in 2027 or later. CMS would apply a lower guardrail limiting ACPT to no more than 1% below national growth and an upper guardrail limiting ACPT to no more than 1.5% above national growth.

CMS would also calculate projected annualized growth rates separately for each performance year rather than fixing the growth pattern for the entire agreement period at the outset. The lower guardrail protects ACOs from material under projection. The upper guardrail can limit favorable benchmark results when projected growth substantially exceeds actual national spending growth.

Bottom Line on ACPT

The current agreement proposal is generally favorable or neutral. The 2027+ proposal can move in either direction. ACOs entering new agreements should model both sides of the guardrail rather than treating ACPT as an automatic benchmark increase.

THE LEVEL E TRACK VERSUS ENHANCED TRACK COMPARISON NEEDS REBUILDING

Three proposals work together to change the economics of downside risk: 1) a higher BASIC Level E sharing rate, 2) a lower maximum positive regional adjustment weight for ENHANCED, and 3) greater recognition of prior savings.

Level E Becomes More Competitive

CMS proposes increasing the maximum BASIC Level E shared savings rate to 60% from 50% for agreement periods beginning on or after January 1, 2027. The agreement period's start date matters. An ACO in an agreement period that began in 2024, 2025, or 2026 would remain subject to the 50% Level E sharing rate for the rest of that agreement period, even if it reaches Level E in a later performance year.

ENHANCED would continue to offer a 75% sharing rate, but the gap between Level E and ENHANCED would narrow from 25% to 15%. The decision would therefore depend less on the sharing rate alone and more on benchmark differences, loss exposure, capital requirements, and the ACO's confidence in producing savings.

The ENHANCED Benchmark May Be Less Favorable for Regionally Efficient ACOs

CMS proposes reducing the maximum weight used to calculate a positive regional adjustment for ENHANCED ACOs from 50% to 35%. The weights used for negative regional adjustments would not be reduced.

The effect could be material when the positive regional adjustment is the ACO's controlling benchmark adjustment. It may be modest when the regional adjustment is small, and there may be little or no impact when a prior savings or population adjustment is larger. An ACO with a negative regional adjustment would receive no direct benefit from this provision.

Hence, the Level E versus ENHANCED comparison should be modeled using more than sharing rates alone. A 15% advantage in the ENHANCED sharing rate may insufficiently offset a meaningful reduction in the benchmark.

Prior Savings May Offset Part of the Change, But Only When That Adjustment Controls

CMS proposes increasing the prior savings adjustment factor from 50% to 75% for agreement periods beginning in 2027 or later. The increase could be highly favorable for renewing ACOs with material prior-period savings when the prior savings adjustment becomes the highest applicable benchmark adjustment.

The increase will not necessarily change the benchmark for every ACO with prior savings. CMS applies the highest applicable positive regional, prior savings, or population adjustment. These amounts are not added together. A larger prior savings adjustment may simply remain below the regional or population adjustment, producing no change in the final benchmark.

For some ENHANCED ACOs, the larger prior savings factor may partially offset the smaller positive regional adjustment. Whether it does so will depend on the ACO's savings history, population continuity, and the benchmark cap.

Table 2. Proposed Rule Changes by ACO Profile

ACO Profile	Likely Effect	Primary Modeling Question
One-sided ACO considering downside risk	Level E is more attractive, but the timing of entry and agreement start date remain important.	Compare expected upside, loss exposure, and the new Level economics.
Level E ACO in a pre-2027 agreement	No change in the 50% sharing rate during the current agreement.	Model the renewal decision separate from current performance.
ACO entering Level E in a 2027+ agreement	Potentially high positive impact from the 60% sharing rate.	Test whether the additional upside changes the preferred risk track.
Regionally efficient ENHANCED ACO	Potentially high negative impact if the regional adjustment controls.	Compare the benchmark reduction against ENHANCED's higher sharing rate.
ENHANCED ACO with robust prior savings	Impact varies. The larger prior savings adjustment may offset part of the regional change.	Determine which adjustment controls under each scenario.

CMS anticipates allowing January 1, 2027, applicants a limited opportunity to change their BASIC versus ENHANCED elections after the final rule is issued. ACOs should be prepared to revisit the decision quickly.

BENCHMARK MECHANICS ARE BECOMING MORE INDIVIDUALIZED

The risk-adjusted benchmark cap and the proposed growth adjustment are best considered together. The cap determines how much of the regional, prior savings, population, and growth value can ultimately reach the benchmark. The growth adjustment only matters when the ACO both qualifies and has room below that cap.

Risk Adjustment Can Increase or Decrease the Cap

CMS proposes risk adjusting the 5% cap on positive regional, prior savings, and population adjustments. The cap would be calculated separately for the end-stage renal disease (ESRD), disabled, aged/dual, and aged/non-dual enrollment populations.

For each population, CMS would broadly calculate the proposed cap formula as:

5% x national per capita FFS expenditures x the ACO's Base Year (BY) 3 risk score

In simple terms, a risk score of 1.10 produces an effective cap equal to 5.5% of the unadjusted national expenditure amount. A risk score of 0.90 produces an effective cap equal to 4.5%. A risk score of 1.00 leaves the cap unchanged.

The change is therefore not universally favorable. It is highly positive for cap-constrained ACOs with risk scores above 1.0 and potentially highly negative for a cap-constrained ACO with risk scores below 1.0. The impact is low or zero when the underlying benchmark adjustment is already below the cap.

An ACO should not assess this proposal using a single blended risk score. A higher ESRD or aged/dual risk score may increase the cap for those populations whereas a lower disabled or aged/non-dual score reduces it elsewhere.

CMS's simulation illustrates the mixed results. Among 228 ACOs in the analysis, approximately 49% had no benchmark change, 15% had an increase, and 36% had a decrease. The average increase among ACOs that benefited was larger than the average reduction among ACOs that lost benchmark value.

The first modeling question is not whether risk exceeds 1.0. The more important question is whether the ACO is likely to hit the benchmark adjustment cap in the first place. If the cap is nonbinding, the proposed risk adjustment may have no effect.

Growth Adjustment Is Narrower Than the Headline Suggests

CMS proposes a new benchmark adjustment for ACOs that recruit professionals with limited prior participation in specified Medicare accountable care arrangements and serve beneficiaries who are also new to those arrangements. The adjustment would be added to the highest applicable regional, prior savings, or population adjustment, but the total would remain subject to the risk-adjusted benchmark cap.

Several conditions limit the potential value:

- The beneficiary and the beneficiary's principal ACO professional must both meet the applicable inexperience tests.
- Qualifying growth cannot exceed the ACO's overall net growth in assigned beneficiary person-years.
- CMS subtracts a minimum-growth threshold before calculating the adjustment.
- The ACO must still have room under the risk-adjusted benchmark cap.

CMS would calculate the incentive factor as 5% of the ACO's historical benchmark before the regional, prior savings, or population adjustment. The growth adjustment equals that incentive factor multiplied by the ACO's qualifying new-growth share.

Illustrative Example

If qualifying growth after the threshold represents 10% of the ACO's current assigned population, the growth adjustment would equal approximately 0.5% of the unadjusted historical benchmark before application of the overall cap. The calculation is 10% x 5% = 0.5%.

The distinction between growth and replacement is paramount. Moving beneficiaries from experienced clinicians to newly recruited clinicians without increasing total assignment would not generate an additional growth adjustment.

Growth Scenario	Likely Impact
Qualifying inexperienced providers, net assignment growth, and cap headroom.	**High positive**
Qualifying growth, but a small growth share or limited cap headroom.	**Medium positive**
Most recruited providers already have Medicare accountable care experience.	**Low or no impact**
Provider additions replace existing population rather than increasing it.	**No impact**
Existing benchmark adjustment already reaches the cap.	**No incremental impact**

PROVIDER REVENUE AND ACO ECONOMICS MAY MOVE IN DIFFERENT DIRECTIONS

The assignment and evaluation and management (E/M) proposals are less likely to drive the risk track decision, but they could still change both provider incentives and ACO financial results.

CMS proposes adding primary care service codes used for assignment beginning in PY 2027. The additions include services related to screening and intervention, vaccine adverse-effects management, and advance care planning. The impact will depend on where those services are furnished and billed within each ACO's market.

Beginning in PY 2028, CMS proposes excluding certain primary care allowed charges billed through a non-ACO TIN when the furnishing clinician is an ACO participating provider. Those charges would be excluded from the plurality determination used for assignment.

The change could help preserve alignment when an ACO professional treats the same beneficiary both inside and outside the ACO's participant TIN structure. This would happen in a situation where the beneficiary was previously not being attributed to an ACO, but would now be attributed under the new exclusion rules. While this could drive additional attribution, the additional beneficiaries also increase the risk for the ACO, as each beneficiary is associated with their corresponding performance year expenditures and risk scores. The result is therefore ACO-specific. It may be positive when the ACO currently loses beneficiaries because participating clinicians bill some primary care services through outside TINs. It may be negative when additional assignment brings higher-cost beneficiaries without a corresponding benchmark or care-management advantage. The impact should be low when ACO professionals already bill assignment-eligible services only through participant TINs.

The Proposed ACO-Specific E/M Modifier Is Not Pure Upside

CMS also proposes replacing CPT code G2211, an E/M visit complexity add-on code, with percentage-based modifiers. MOD1 would be billed by healthcare professionals who do not participate in an ACO and would add 16% to the FFS payment rate of the base E/M code. MOD2, available to ACO providers, would increase payment for a qualifying associated E/M service by 32%.

MOD2 would be voluntary for eligible MSSP and LEAD practitioners and could be billed for patients beyond the ACO's assigned population. MOD2 claims would be included in MSSP assignment, historical benchmark expenditures, and performance year expenditures.

- Provider perspective: Additional FFS revenue and a stronger economic incentive to participate in an ACO.
- ACO perspective: Higher claims may affect assignment and increase measured expenditures.
- Modeling implication: Provider revenue, benchmark effects, performance year spending, and assignment should be evaluated together.

ALSO ON OUR RADAR

Several additional proposals may not drive the track decision, but they could be relevant to specific ACOs:

- Continued availability of MIPS CQMs and the related reporting incentive for PY 2027 and later.
- A new Medicare eCQM reporting option based on assigned Medicare beneficiaries.
- Limited TIN exclusions from quality reporting beginning in PY 2026, provided the remaining TINs represent at least 95% of assigned beneficiaries.
- Three alternative CEHRT compliance pathways beginning in PY 2027.
- Optional Part B cost sharing support arrangements beginning April 1, 2027, subject to CMS approval.
- No new prepaid shared savings cohorts after the January 1, 2027, application cycle.
- Revised advance investment payments beginning in PY 2028.
- A narrower definition of risk experience for certain legacy TINs that had no written agreement to participate in a prior risk arrangement.

The legacy TIN proposal may be especially relevant for ACOs that have yet to take downside risk. Depending on participant history, the change could affect whether CMS views the ACO as experienced with performance-based risk and therefore which participation options are available.

QUESTIONS EVERY ACO SHOULD CONSIDER BEFORE THE FINAL RULE IS RELEASED

1. **How does this change our current forecast?**
   ACOs with 2024 to 2026 agreement starts should first quantify the proposed ACPT guardrail's effect on PY 2025 and PY 2026. ACOs with retroactive PY 2024 settlement changes should also review the updated reconciliation package and any downstream impact on partner distributions, cash flow, and financial reporting.
2. **Would we make the same 2027 participation decision today?**
   The BASIC Level E versus ENHANCED analysis should include the 60% Level E sharing rate, the 75% ENHANCED sharing rate, the lower positive regional weight under ENHANCED, the larger prior savings adjustment, the risk-adjusted cap, and expected shared losses and capital requirements. Looking only at the sharing rate change will miss much of the economic difference.
3. **Which benchmark adjustment actually controls?**
   For each scenario, calculate the positive regional, prior savings, and population adjustments before and after the proposal. Then determine which adjustment is highest, whether the ACO reaches the cap, and how much cap headroom remains for the growth adjustment. An increase in a non-controlling adjustment may have no effect on the final benchmark.
4. **Does our growth strategy create qualifying assignment growth?**
   ACOs considering network expansion should distinguish between providers who meet CMS's proposed inexperience criteria, providers with prior Medicare accountable care experience, beneficiaries likely to qualify as new to accountable care, growth that increases total assignment, and provider additions that primarily replace existing assignment. The last two categories may look similar in a provider roster but have very different benchmark implications.
5. **Are provider incentives aligned with ACO economics?**
   Provider finance teams may focus on the additional MOD2 E/M revenue. ACO finance teams will also need to estimate changes in assignment, benchmark expenditures, performance year spending, and provider incentives. The answer may differ by provider specialty, billing TIN, and beneficiary population.

FINAL THOUGHTS

The proposed rule does not simply make MSSP more or less attractive; it shifts value between different ACO profiles.

BASIC Level E ACOs entering new agreements would receive more upside. ACOs with strong prior savings could receive more benchmark credit. Higher-risk, cap-constrained ACOs may benefit from room on their benchmark caps. ACOs with qualifying network growth may receive a new incentive.

At the same time, regionally efficient ENHANCED ACOs may lose benchmark value, lower risk ACOs may face smaller caps, and provider growth strategies that do not produce net assignment growth may receive little or no benefit.

For most ACOs, the most useful question is not whether the proposed rule is favorable overall, but what currently drives their benchmark and how that result changes when the proposals are modeled together.

Wakely's Value-Based Payment team is working with ACOs to quantify these provisions and evaluate the implications for current performance and 2027 participation strategy. Contact us to discuss what the proposed changes may mean for your organization.

SOURCE MATERIALS

1. Centers for Medicare & Medicaid Services. Calendar Year (CY) 2027 Medicare Physician Fee Schedule Proposed Rule (CMS-1848-P) — Medicare Shared Savings Program Proposals. Fact Sheet. July 14, 2026. Available at: https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2027-medicare-physician-fee-schedule-proposed-rule-cms-1848-p-medicare-shared.
2. Centers for Medicare & Medicaid Services. Medicare and Medicaid Programs; CY 2027 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**.** *Federal Register*. July 16, 2027. Available at**:** https://public-inspection.federalregister.gov/2026-14327.pdf.
3. Centers for Medicare & Medicaid Services. Shared Savings and Losses, Assignment and Quality Performance Standard Methodology: Specifications of the Accountable Care Prospective Trend (ACPT) and Three-Way Blended Benchmark Update Factor Medicare Shared Savings Program ACPT Specifications. Version 5. July 2026. Available at: https://www.cms.gov/files/document/medicare-ssp-acpt-specifications.pdf.

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