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The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted via regulations.gov

Re: 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 Program (CMS-1848-P)

Dear Administrator Oz,

On behalf of Accountable for Health, we appreciate the opportunity to provide comments on the CY 2027 Medicare Physician Fee Schedule (PFS) proposed rule.

Accountable for Health (A4H) is a non-partisan, national advocacy and policy organization accelerating the adoption of effective accountable care. We aim to support policymakers to advance the movement in the health care system toward accountable care that achieves better outcomes, improved care experiences, increased access and lower costs.

This proposed rule reflects the Administration's continued commitment to accountable care and value-based payment. As outlined in more detail below, A4H supports the proposed G2211 changes, including extending MOD2 eligibility to Participant Providers in the Comprehensive Kidney Care Contracting Model, and supports maintaining the current payment rate for skin substitutes. On the Medicare Shared Savings Program, A4H supports the increased prior savings adjustment, the risk adjusted growth adjustment cap, and the ACPT guardrail reforms, while urging CMS to extend the prior savings adjustment to LEAD entities, raise the growth adjustment cap to 7 percent, reinstate the positive regional adjustment weight to 50 percent, and pair the ACPT reforms with a provisional settlement and true up process. A4H also recommends CMS build in off ramps for specialists who join ACOs under the Ambulatory Specialty Model (ASM). A4H supports the proposed increase to work RVUs for the Psychiatric Collaborative Care Model and calls for additional building blocks to further value behavioral health integration, and urges CMS to ensure AI and technology-enabled tools are deployed in true partnership with physician practices. However, A4H is disappointed in the proposed cut to the conversion factor and urges payment updates to be aligned with the current cost of care.

Our detailed recommendations are provided below.

Physician Payment Proposals

Conversion Factor

For CY 2027, CMS proposes a qualifying APM conversion factor of $33.17, a decrease of $0.40 (-1.19 percent) from the current conversion factor of $33.57, and a nonqualifying APM conversion factor of $32.84, a projected decrease of $0.56 (-1.68 percent). This reflects the expiration of the one-time 2.5 percent conversion factor increase that Congress provided for CY 2026 under the One Big Beautiful Bill Act, enacted in July 2025. A4H is disappointed that the 2.5 percent increase is expiring and supports legislation to address the resulting payment reduction. A4H urges Congress to act again to address the negative conversion factor and ensure that Medicare payment updates keep pace with the rising cost of delivering care.

A4H strongly believes that Medicare payment structures should incentivize participation in accountable care models while disincentivizing fee-for-service payment. For that reason, A4H supports the differential conversion factor as an incentive and benefit to QPs in Advanced APMs. However, A4H urges the Administration to work with Congress to ensure that there are strong incentives to move to accountable care. This is especially important given that the differential between QPs and non-QPs is relatively modest in 2026.

Evaluation and Management (E/M) Visit Complexity Add-On (HCPCS Code G2211)

For CY 2027, CMS proposes to convert HCPCS code G2211 from a flat add-on code to a percentage-based modifier ("MOD1"), valued at 16 percent of the base E/M code. CMS also proposes a separate, voluntary modifier (“MOD2”) for practitioners in Medicare Shared Savings Program (MSSP) or LEAD Model ACOs to recognize the additional resource costs of longitudinal, accountable care through a 32 percent increase to the associated E/M visit, with claims included in ACO beneficiary assignment and benchmark calculations.

A4H supports this proposal. A4H urges CMS to reflect the modifier in the fee for service trend and adjust historical benchmarks accordingly, and to extend the benefit to CAHs, RHCs, and FQHCs. CMS appropriately recognizes that clinicians participating in accountable care incur additional costs associated with providing longitudinal care, coordinating services, managing quality, and assuming accountability for the overall health and cost of care of their patients. G2211 can currently be reported with E/M office visit codes (99202 through 99205, 99211 through 99215) and home or residence E/M codes (99341, 99342, 99344, 99345, and 99347 through 99350). A4H urges CMS to also allow the new modifiers that will replace G2211 to be reported with Psychiatric CoCM codes (99492 and 99493), since G2211 reflects the time, intensity, and practice expense involved when a practitioner serves as the continuing focal point for a patient's health care needs, a construct that aligns well with Psychiatric CoCM, particularly when a physician is managing depression or anxiety alongside other preventive and chronic conditions or using Psychiatric CoCM to manage a single serious or complex condition such as bipolar disorder. In those instances, the physician should be able to report the modifier both for their E/M visits and for their monthly Psychiatric CoCM episode, since both activities provide holistic, longitudinal care to support the patient. CMS's new MOD2 framework is particularly well aligned with its stated goals, and additional payments for primary care teams delivering Psychiatric CoCM would provide the financial resources needed to build scalable, effective, and integrated care teams that improve beneficiary health and reduce Medicare spending. A4H also supports the recommendations

submitted by a number of signatories on improvements to the underlying payment methodology for these codes, including establishing work RVUs for CPT codes 99492 through 99494 based on blends of Level 4 and Level 5 office visits, specifically 3.67 work RVUs for 99492, 2.99 work RVUs for 99493, and 1.50 work RVUs for 99494, as well as finalizing the proposal to increase the clinical labor value for the Behavioral Health Care Manager (L057B) from $0.57 to $0.70 per minute. Together, these payment refinements would help ensure that the MOD2 policy fully reflects the resources required to deliver integrated, longitudinal behavioral health care.

A4H also strongly supports this rationale and urges CMS to extend eligibility for MOD2 to Participant Providers in the Comprehensive Kidney Care Contracting (CKCC) Model and any successor accountable kidney care model. Nephrologists participating in CKCC have embraced the type of accountability MOD2 is designed to recognize, caring for complex beneficiaries while being held accountable for the quality and total cost of their care. A4H urges CMS to ensure that as it considers the future of accountable kidney care beyond CKCC, including a potential kidney-focused track within LEAD or a successor model, participating nephrologists continue to qualify for the enhanced modifier without interruption.

A4H also notes that because FQHC PPS and RHC AIR payment currently bundle G2211, these settings would likely not benefit from the proposed MOD1 and MOD2 modifiers as structured. A4H urges CMS to consider a claim-level modifier for institutional claims in FQHC and RHC settings so these providers can realize the benefit of this proposal.

Skin Substitute Payment

CMS proposes to nationally price the non-sheet form skin substitutes consistent with the payment rates associated with the sheet form skin substitutes. Accountable for Health applauds CMS for finalizing a single rational payment rate of $127 per square centimeter, which cut spending by 90 percent in the 2026 PFS, and urges CMS to keep that payment rate unchanged. For that reason, A4H supports continuing to pay for skin substitutes at the current rates set in the 2026 PFS. A4H thanks the Administration and CMS leadership for recognizing the problem and taking decisive steps to address it, since aligning payment and coverage rules to reflect clinical evidence and appropriate use will help protect beneficiaries and preserve resources for high-value care. A4H believes more must be done to ensure ACOs are not penalized for fraudulent and abusive behaviors outside their control. A4H urges CMS to adjust ACO benchmarks to reflect targeted cost spikes that national trends miss, create a rapid reporting pathway so ACOs can share fraud data in real time, protect ACOs from catastrophic costs for high-risk wound care patients through improved stop-loss policies, and allow reopening of ACO settlements when fraudulent claims are later proven.

Behavioral Health

CMS proposes increasing work RVUs and behavioral health care manager labor valuations for psychiatric Collaborative Care Model (CoCM) services to better reflect the work involved and comparable clinical labor rates. The proposed changes would result in increases of up to 46.3 percent for certain CoCM codes.

A4H supports CMS's proposed adjustments to the Collaborative Care Model codes, including increasing Collaborative Care payment, and calls for additional building blocks in the future. The core premise of Collaborative Care is activated, patient centered treatment that involves multiple treatment changes to optimize outcomes. Most patients engaged in Collaborative Care require a minimum of two to three treatment changes during a care episode. These treatment changes

involve registry review, monitoring, activation, discussion, psychiatric consultation, review of recommendations, and significant decision making by the primary care provider, psychiatric consultant, and behavioral health care manager. The foundation of Collaborative Care is a strong focus on measurement based care and quantifiable, treat to target outcomes. Collaborative Care is a powerful tool to help CMS focus on its stated intention to deliver preventive rather than reactive medicine, for health care rather than sick care. The Collaborative Care model has consistently demonstrated superior clinical outcomes and patient experiences, direct site of service savings compared with stand alone Behavioral Health services, and a consistent track record of lowering total cost of care. Further adoption of Collaborative Care is an important catalyst for the effort to Make America Healthy Again and for creating unprecedented access to evidence based behavioral health treatment in rural and underserved communities. We understand a number of signatories submitted a letter suggesting improvements to the payment methodology for CPT codes 99492 through 99494, including work RVUs based on blends of Level 4 and Level 5 office visits and an increase to the clinical labor value for the Behavioral Health Care Manager, and A4H supports those recommendations.

Medicare Shared Savings Program (MSSP)

Proposal to Increase the Prior Savings Adjustment by Increasing the Scaling Factor

CMS proposes to increase the prior savings adjustment scaling factor, program wide, from 50 percent to 75 percent, beginning with agreement periods starting January 1, 2027, and subsequent agreement periods. A4H supports this proposal but believes CMS could go farther. The ratchet effect is reduced rather than removed. The CMS proposal takes a step to further combat the ratchet effect from rebasing, allowing successful ACOs to keep more of their historical earnings in their new benchmark. This increase could be highly favorable for renewing ACOs. A4H asks CMS to set the scaling factor at 95 percent rather than 75 percent. A 75 percent factor still claws back a quarter of the savings an ACO earned in its prior agreement period, so the ratchet is reduced rather than removed. A 95 percent factor carries nearly all prior savings into the rebased benchmark, eliminating most of the penalty for early success while leaving CMS a margin against overstatement, and ACOs will invest in the first agreement period when they can keep the benchmark credit for what those investments produce.

Regardless of where CMS sets the scaling factor, that increase needs to reach every ACO that has earned it. A4H applauds CMS's intention to reward high performing ACOs through this proposal. However, entities that participated in ACO REACH in 2024 and 2025 and are entering LEAD or MSSP for 2027 would receive zero credit for achieving savings in those years under this proposal, even though they earned very high savings, leaving them disappointed to find themselves inadvertently penalized for a program change. Recognizing the ability to generate prior savings is a net positive for ACOs generally, as CMS would take the average savings generated across 2024 through 2026 and apply 75 percent of that back to the benchmark, which makes the gap for affected entities more pronounced rather than less. A4H strongly advocates that all dual-sided risk ACOs be treated the same, and that the prior savings adjustment be applied consistently regardless of an ACO's prior participation. What should matter is that the ACO generated significant savings, and the benchmarking adjustment should recognize that. A4H estimates that this treatment is even more punitive to affected entities than the proposed change to the regional adjustment. A4H urges CMS to apply this same prior savings adjustment to entities transitioning from ACO REACH into LEAD or MSSP and to extend the adjustment to ACO REACH and any future ACO models.

Proposal to Reduce the Maximum Weight on the Regional Adjustment for ACOs under the ENHANCED Track

CMS proposes reducing the maximum weight for the positive regional adjustment for lower-spending ACOs in the ENHANCED track from 50 percent to 35 percent for agreement periods beginning January 1, 2027, while maintaining the current weight for higher-spending ACOs and clarifying the existing methodology for determining an ACO's spending relative to its regional average.

A4H urges CMS to reinstate the positive regional adjustment weight to 50 percent. For ACOs in the ENHANCED track, CMS currently applies a 50 percent positive regional adjustment weight to help mitigate rebasing, and the proposed rule would reduce this maximum weight to 35 percent. This proposal appears to rest on the premise that ACOs can "passively earn shared savings…by solely relying on baseline efficiency." There is nothing passive about the hard work ACOs must do to keep costs below regional averages while improving the quality of care, and rebasing policy should recognize that effort. This proposal is inconsistent with the goals CMS has established for the MSSP program, since it risks weakening an already limited incentive for ACOs to generate cost savings and could dampen MSSP participation.

A4H encourages CMS to focus on proposals that properly incentivize ACOs to generate more cost savings, rather than finalizing this proposal to reallocate existing savings. If CMS proceeds with the 35 percent weight, A4H believes CMS should defer the change to the 2028 agreement period, since CMS issued this proposed change very late, after many ACOs had already made their 2027 program participation decisions.

Proposal to Risk Adjust the 5 percent Cap on Upward Adjustments to the Historical Benchmark

CMS proposes to risk adjust the 5 percent cap on each of the upward adjustments to the historical benchmark: the positive regional adjustment, the prior savings adjustment, and the population adjustment. A4H supports risk adjusting the cap and asks CMS to raise the ceiling to 7 percent in the same step. Risk adjustment corrects who the cap binds against, it does not change how tightly it binds.

High-savings ACOs routinely see the upward benchmark adjustments collide with the 5 percent ceiling, which mutes the incentives each adjustment was built to create. The proposed growth adjustment makes the case sharper. An ACO built on providers new to value-based care can stack the growth adjustment on top of its highest existing adjustment and reach the capped maximum immediately, the same ceiling a high-savings ACO earns only through years of demonstrated performance under the prior savings adjustment. ACOs that have delivered savings for years should be rewarded above entrants who have not yet participated, and a cap set at 7 percent of risk-adjusted national per capita FFS expenditures creates the headroom for that distinction while preserving a real guardrail against overstatement.

Proposal To Incentivize New Participation Through a Growth Adjustment to the Historical Benchmark

CMS proposes to risk adjust the 5 percent cap on positive adjustments and prior savings adjustment to the national per capita dollar amount for each Medicare enrollment type (ESRD, Disabled, Aged/Dual, and Aged/non-dual). A4H supports this proposal.

A4H understands that CMS seeks to avoid overly rewarding new entrants, but the caps may inadvertently penalize long-standing participants. A4H wants to reward growth and recommends raising the risk-adjusted cap to 7 percent. A4H urges CMS to preserve the distinction between rewarding entry and rewarding performance. As proposed, the growth adjustment stacks on top of an ACO's highest existing benchmark adjustment up to the cap, so an ACO recruiting providers and beneficiaries new to value-based care can reach the capped maximum in its first agreement period. That is the same ceiling a high-savings ACO reaches only through years of demonstrated performance via the prior savings adjustment. ACOs that have generated savings for years should be rewarded above ACOs that have not yet participated. Raising the risk-adjusted cap to 7 percent, as recommended above, restores that headroom growth gets rewarded within the current bounds while demonstrated savings earn more.

Proposal To Reform the Accountable Care Prospective Trend (ACPT) Component of the Benchmark Update Factor

CMS proposes reforming the ACPT benchmark update methodology by calculating performance-year-specific modified USPCC growth rates rather than setting a fixed five-year schedule, with new guardrails limiting how much these rates can deviate from actual national expenditure growth. For existing ACOs, CMS proposes applying a lower-bound guardrail retroactively beginning with PY 2025, which would delay PY 2025 financial reconciliation and shared savings payments pending the CY 2027 PFS final rule. CMS plans to issue PY 2025 financial results in November 2026 and distribute shared savings payments in December 2026, if the proposal is finalized. A4H strongly supports the ACPT proposals, but asks for a provisional settlement followed by a true up in December.

The ACPT has been a source of significant anxiety for ACOs. CMS is now proposing a standardized, prospectively available rate similar to the stability found in Medicare Advantage, including a retroactive downside guardrail of 1.0 percent for ACOs within agreement periods with 2024, 2025, and 2026 start dates, applying to PY 2025 and beyond. Ensuring that the administrative trend cannot fall more than 1 percentage point below observed national growth is a significant, stabilizing move.

However, A4H asks CMS for a provisional settlement followed by a true up in December, because a two-month payment delay, given the complexity already faced in ACPT and cash flow dynamics, would be challenging. A4H asks CMS to preserve the original PY 2025 settlement timing rather than delay all payment to December 2026. CMS should issue a provisional settlement payable in September 2026 on the pre-existing schedule, withholding a percentage sized to cover the range of outcomes from the proposed retroactive ACPT guardrail, with the withheld amount paid at final settlement in December 2026. ACOs and their physician partners have built 2026 distribution and reinvestment plans around the September date, and a blanket delay pushes savings earned in performance year 2025 more than 22 months past the start of that performance year. A provisional-plus-withhold structure gives CMS full protection against overpayment while keeping cash flowing to the practices that earned it. CMS should also publish final settlement reports on the typical reporting timeline even where payment moves later, so ACOs can validate performance at the ACO level and set accurate expectations with their providers. Ideally CMS would publish two versions, with and without the proposed ACPT changes, giving ACOs the answer under both scenarios. Either version alone would still let ACOs validate performance and provide timely updates to their networks.

Proposal To Simplify Shared Savings Program CEHRT Use Requirements

CMS proposes to sunset, beginning with PY 2027, the requirement for Shared Savings Program ACOs and their eligible clinicians to report MIPS Promoting Interoperability measures and earn a corresponding performance category score. CMS also proposes to recognize ACO reporting of eCQMs as sufficient to satisfy the Shared Savings Program's CEHRT use requirements, without requiring additional reporting.

A4H agrees that sunsetting the interoperability requirements currently in place is good. However, A4H has some concerns about the replacement requirement set to take effect for 2027. CMS is proposing to sunset the current requirement that ACOs report all MIPS Promoting Interoperability measures and activities and replace it with a requirement that ACOs complete one of three new activities starting PY 2027. These are completing reporting of at least one of the five ACO reported measures in the APP Plus quality measure set through the eCQMs or Medicare eCQMs collection type, using CEHRT to support complete reporting of at least one measure and attesting to FHIR based API use through a certified Health IT Module, or attesting to one of three ACO level CEHRT use metrics covering e-prescribing, health information exchange, or patient electronic access, each requiring at least one provider in every participating TIN. Each pathway carries its own completeness or attestation standard, a substantively different bar than the current reporting requirement. A4H's position is that ACOs need additional time before this requirement takes effect. A4H is pushing for another year of enforcement discretion and asks CMS to recognize the complexity of a late change, since the requirement is not yet finalized and cannot be built into the contracting that is happening now.

Proposal to Allow ACOs To Reduce or Eliminate Part B Cost Sharing

CMS proposes that eligible ACOs may, subject to certain conditions and safeguards, enter into Part B cost sharing support agreements with ACO participants, under which ACO participants reduce or eliminate cost sharing for those categories of eligible Part B items and services and eligible beneficiaries identified by the ACO.

A4H strongly supports CMS's proposal to expand the Part B cost sharing waiver to eligible MSSP ACOs. Elimination of the 20% Medicare Part B coinsurance for eligible services provides a tangible benefit to beneficiaries aligned to the program and gives this value-based program a competitive advantage benefiting the consumer that otherwise would not exist within fee-for-service Medicare. A4H has observed a positive reaction and experience among beneficiaries in REACH ACOs that offer the cost sharing waiver, and providers are equally supportive of the measure, since it helps ensure beneficiaries are encouraged to receive care from providers aligned with the goals and objectives of the program.

<u>Merit-based Incentive Payment System (MIPS)/Quality Payment Program (QPP)</u>

CMS proposes policies supporting MVP only reporting for MIPS. Specifically, beginning in the CY 2029 performance period and 2031 MIPS payment year, eligible clinicians participating in MIPS and not reporting the APM Performance Pathway would be required to report the measures and activities in a selected MVP. CMS also proposes to apply Qualifying APM Participant designations at the TIN/NPI level rather than the NPI level, so a clinician would be exempt from MIPS and receive the QP conversion factor only at the TIN(s) through which they achieved QP status.

A4H does not believe the MVP strategy proposed by CMS will achieve the goal of deepening specialists' engagement in and connectivity with accountable care. Specialists are already

participating in accountable care entities and models today, and A4H's primary concern is that linking payment adjustments for specialists to the MIPS MVP framework will create further fragmentation and competing incentives for specialists, pulling them away from the goals of total cost of care models and participation in accountable care. A4H urges CMS to decouple MSSP quality reporting from MIPS reporting and to revise the quality measure set for MSSP to be streamlined, reducing burden for ACOs and creating more meaningful information for doctors and their patients.

A4H also urges CMS to add additional security protections to Authorized Officials of the Quality Payment Program (QPP) accounts to ensure only Authorized Officials can submit a quality submission on an ACO's behalf. We also urge CMS to create notifications that are sent to all QPP Authorized Officials when a quality submission is submitted on behalf of an ACO. Because ACOs are sending CMS an aggregate submission that includes multiple practices' data, there is the possibility for confusion among ACO participant TINs as well as vendors they use regarding how submissions are completed. This confusion can occur despite ongoing communications from the ACO about the process. When a misunderstanding like this occurs, there is currently no communication to the ACO and over-riding the submission can be a difficult process, particularly if a practice leader or vendor may be out of the office and unable to help rectify an error. We believe the ACO should retain the sole right to submit data and should at a minimum receive a communication when a submission has been reported on the ACO's behalf to alert leadership if there has been an error and to give sufficient time to resolve the issue.

A4H also opposes the proposal to apply QP designations at the TIN/NPI level and asks CMS to retain NPI-level QP determinations. Physicians routinely bill under more than one TIN. A primary care physician in an ACO participant practice may also take hospital calls, staff a rural clinic, or see patients under a separate group TIN. Under the proposal, the physician keeps the QP conversion factor and MIPS exemption only at the ACO TIN and absorbs a payment cut plus new MIPS reporting obligations everywhere else, for the same clinician delivering the same care. The QP incentive is the strongest individual level reason for a physician to join an Advanced APM and splitting it by TIN weakens it precisely for the multi-site physicians accountable care organizations most need to recruit, working against the growth in Advanced APM participation this rule is otherwise designed to produce.

Relatedly, A4H continues to work with Congress to reinstate and extend the APM bonus. The original 5 percent incentive payment fell to 3.5 percent and then to 1.88 percent before being replaced entirely by a differential conversion factor beginning with the 2024 performance year and 2026 payment year. That differential remains modest, with the proposed CY 2027 qualifying and non-qualifying conversion factors set at $33.17 and $32.84, a gap of roughly 1 percent, continuing the cliff that detracts from the movement to accountable care. A4H urges CMS to examine whether there are additional steps it can take administratively to smooth this cliff for Advanced APM participants.

RFI: Fast Healthcare Interoperability Resources (FHIR)-Based Quality Measurement in the Shared Savings Program

CMS is advancing quality measurement by transitioning existing quality measures and reporting processes to Fast Healthcare Interoperability Resources (FHIR) based digital reporting options. In this proposed rule, CMS seeks input on the anticipated transition timeline, key milestones, and implementation considerations for FHIR-based quality reporting in the Quality Payment Program and other CMS quality reporting programs.

Accountable care entities are generally comprised of many participant providers, each of whom has one or more electronic medical records and numerous other digital tools that collect and store information on a patient's health and health care. To report eCQMs, quality information must be extracted, standardized, and aggregated across participants by the accountable care entity, and accurate quality reporting, both of eCQMs now and digital quality measures in the future, relies on EMRs functioning as expected. A4H urges CMS to preserve real-world testing requirements to ensure EMRs function as expected in native technology environments, and to preserve and expand new technologies such as Bulk FHIR and API infrastructure to enable reporting on larger populations such as those aligned to accountable care entities.

On the FHIR conversion timeline, A4H notes that twenty-four months does not offer enough time for implementation of FHIR-based eCQM reporting. One member recently implemented FHIR-based eCQM reporting over a five-year period and reports that vendors are likely to need a three-year, or 36-month, timeline with additional guidance and experience, and smaller, independent providers often lack the resources to do this on their own or to hire a vendor. A4H recommends CMS adopt an implementation timeline and policies flexible enough to accommodate a range of provider types at different resource levels, including an option for manual reporting and manual aggregation of provider-level data.

Ambulatory Specialty Model

CMS proposes clarifying ASM participation and eligibility requirements, including the definition of the dual-eligible proportion, mandatory participation duration, and exceptions for certain heart failure participants whose specialty type is redesignated. CMS also proposes updates to the ASM quality measure set and reporting requirements, as well as changes to Collaborative Care Arrangements to improve implementation and alignment with existing standards.

A4H supports the goals of the ASM model as a mechanism for enabling specialists to get on a glidepath to accountable care. In terms of overlap with Advanced APMs and ACOs, A4H recommends that CMS build in off ramps for specialists who join ACOs. ACO participation and Advanced APM QP status should exempt a specialist from mandatory participation in ASM, since participants in ACOs and other Advanced APMs are already clinically and financially accountable for their patient population, making it unnecessarily punitive and administratively burdensome to hold them accountable for additional metrics and benchmarks.

RFI: Integrating Specialists into Accountable Care

CMS is seeking feedback on policy changes and resources that could improve clinical outcomes and reduce inappropriate Medicare spending through accountable care programs and models. Specifically, CMS requests input on meaningful engagement, CMS-delivered tools and support, attribution and assignment modifications, benchmarking, specialist performance measurement, waiver flexibilities, and reducing administrative burden for ACOs and providers.

A4H recommends CMS mandate more frequent NPPES attestation, biannually for physicians and annually for APRNs, and add greater specialty-level nuance to improve attribution. A4H urges CMS to create standardized, condition- and procedure-specific performance profiles and to support FHIR-based quality reporting for high-value specialties, since much of specialty quality data lives in the EMR rather than in claims, and if EMR vendors do not support this, ACOs and specialists will not be able to provide adequate quality and outcomes data. This data should roll up into longitudinal, public-facing specialist performance profiles covering risk-adjusted quality, outcomes,

complications, utilization, patient experience, and cost. A4H notes that organizations with employed specialists generally have stronger internal cost and quality data available to them, since claims and EMR data can be paired with episodic bundled data to evaluate specialist performance, including for outside referrals, while organizations without employment relationships with specialists have far less direct insight. CMS-delivered tools would be most valuable in closing this gap for non-employed specialist arrangements, where CMS fee-for-service claims and clinical data obtained from other payers, such as encounter data, could help. A4H also urges CMS to ensure that specialist benchmarking accounts for risk-adjusted utilization, cost, and quality by region, with unique risk adjustment by episodic or chronic episode, and to vary CMS-delivered tools and data by ACO size, since episode and bundle data should reflect different benchmarks and inclusion criteria for low revenue versus high revenue ACOs.

RFI: Redesigning Primary Care To Make America Healthy Again

Establishing Prospective Primary Care Payment in MSSP

CMS is seeking comments on redesigning Medicare primary care payment, including whether payment should evolve toward prospective or capitated primary care models within the Shared Savings Program, in better recognition of longitudinal relationship-based care, and simplification of care management services.

A4H supports bringing LEAD-like primary care capitation, set at 7 percent of benchmark, into the Shared Savings Program, with two design requirements. First, the mechanism should allow hybrid fee-for-service and capitation arrangements, including an option that leaves fee-for-service claims payment untouched and delivers the incremental roughly 4 percent of benchmark to the ACO as capitation. Second, the incremental capitation should be repayable over the life of the agreement period rather than at each annual settlement. When capitation is owed back at settlement every year, ACOs can only justify investments with sub one-year paybacks, and the longitudinal care investments CMS is trying to encourage take several years to pay back. Repayment across the agreement period matches the financing to the payback horizon of the investments CMS wants ACOs to make.

CMS is also seeking input on whether Shared Savings Program ACOs have access to sufficient data, including shadow bundles, claims data, public use files, and data from arrangements with other payers, to support the development and ongoing administration of an Advanced Payment Option similar to what is available today through ACO REACH and PC Flex, and what additional data would be necessary if not.

A4H does not believe ACOs currently have sufficient data to support the development and administration of an Advanced Payment Option. Timely public use files with key regional and national benchmark data, including admissions per 1,000, readmissions, ER visits, and medical cost PMPM, would be valuable to help ACOs monitor trends and identify improvement opportunities in near real time. Data is foundational to success in accountable care arrangements, and few data sources are more important than timely access to admission, discharge, and transfer notifications, since accountable care providers cannot effectively manage quality and total cost of care if they do not know when an aligned beneficiary has been hospitalized, discharged, or treated in the emergency department. Members currently receive ADT notifications for only approximately 60 to 80 percent of their attributed patient populations, with wide variance by market, ranging from close to 90 percent coverage where a mature state HIE or dominant aggregator has achieved broad participation to as low as 30 to 40 percent where a large health system has not connected or state HIE infrastructure is underfunded or technically dated. A4H recommends CMS require hospitals to

provide timely and complete ADT feeds for attributed ACO beneficiaries via health information exchanges, and prioritize policies that strengthen HIE infrastructure by making HIEs more open, stable, and capable, alongside requirements for hospital participation in HIEs and national aggregator networks.

Technology Enablement of Primary Care

CMS is seeking information on the current and emerging role of AI in primary care, including which use cases are most common, how clinical AI is affecting practice, resource costs, quality and downstream cost outcomes, clinician productivity, patient data protection, and gaps in the current coding and payment system for AI-enabled care.

Clinical decision support and clinical documentation are the predominant areas of AI usage in primary care, though the pace of adoption for other use cases has accelerated significantly over the past six to eight months. Reported use cases include custom LLM chatbots supporting nurse care management and navigator teams working with high-risk patients, active pilots of agentic AI for ED and discharge follow-up, LLM-driven tools for weekly inpatient admissions trend detection, and ambient listening technology used during office visits and telephonic outreach to support documentation, post discharge assessments, and medication reconciliation.

Some members reported piloting ambient listening with residents starting in residency and maintaining an internal AI ethics team to oversee appropriate use across the organization, not limited to primary care, while others described a clinical insights engine still being stood up to draw on sources such as discharge summaries to support clinical decision making. A4H members are actively seeking to integrate AI-driven solutions into clinical workflows in a way that does not introduce new friction, such as separate portals, separate log-ons, or competing metric definitions, and are taking a workflow-driven approach to avoid wasted time and effort amid the current volume of tools and vendors in the market.

Members have achieved meaningful reductions in total medical cost for patients identified through AI-driven risk models, including reduced admissions per 1,000, readmissions, and ER visits through resulting care management, though these tools have primarily helped identify the right patients for the right engagement rather than eliminating clinician work outright. On investment criteria, provider efficiency, patient benefit, workflow speed, and downstream impact on outcomes such as readmission rates and ED visits were cited as key factors for evaluating AI tools. Members also described developing organizational AI policy in partnership with Compliance, Legal, physicians, IT, and purchasing, requiring standard MSA and BSA agreements for vendor partners, with some maintaining in-house AI development capability to reduce dependence on vendor solutions.

Given CMS's valid concerns regarding program integrity, including fraud, waste, and abuse within care management code families, A4H believes it is imperative to establish stringent standards that define a "good" AI platform, with reimbursement strictly tied to transparency and interoperability. A4H strongly advocates that any AI tool qualifying for reimbursement must be fully transparent, functioning as a "glass-box," so that physicians can clearly see why the AI is making a specific recommendation and trace the exact data sources used to formulate that insight. This level of explainability ensures clinical autonomy, mitigates liability, and builds the trust necessary for widespread adoption.

Technology and AI-Augmentation via Medicare AWV

A4H members reported that the primary barriers to AI-enabled Annual Wellness Visit delivery stem from a lack of data sharing and interoperability standards rather than regulatory or statutory rules, since payers, CMS, vendors, and provider practices currently operate with different file formats, data requirements, and levels of technology capability. Without strong alignment with a provider group or PCP, A4H is concerned that tech-enabled AWVs will become a lowest common denominator risk adjustment recapture process rather than genuinely supporting patient wellbeing. CMS should permit tech-enabled AWV models only when paired with a strong partnership with physician practices and PCPs that ensures action and follow-through on identified findings. Without a strong handoff to care delivery, tech-enabled AWV models risk creating additional points of fragmentation and lost follow-up, worsening rather than improving the current delivery system challenges. One reported use case involves AI supporting risk stratification ahead of a visit, such as flagging a patient's history of anxiety to prompt a behavioral health questionnaire, though AI is currently used primarily for post visit follow-up, such as determining next steps or referrals based on assessment results, rather than for scheduling or structuring the visit itself, and current use for this purpose remains uncertain in some cases. CMS should hold technology companies accountable for long-term outcome measures such as admissions per 1,000, progression in severity of chronic conditions, readmission rates, and overall medical cost PMPM, rather than short-term volume, documentation completeness, or coding intensity metrics. CMS should also require standardized data specifications and interoperability via common protocols such as SFTP, FHIR, and API to ensure consistent, timely information flow across payers, providers, and AWV vendors.

Conclusion

Accountable for Health appreciates the opportunity to provide feedback on this proposed rule. Please do not hesitate to contact us if we can be a resource.

Sincerely,

Mara McDermott

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Accountable for Health