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September 14, 2026

Submitted via regulations.gov

Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

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 the Complex Care Alliance ("CCA"), a collection of provider groups that participate in Medicare value-based models and serve Medicare beneficiaries with high health care needs, we appreciate the opportunity to provide comments on the CY 2027 Medicare Physician Fee Schedule (PFS) proposed rule.

The CCA represents provider groups and their affiliated accountable care organizations (ACOs) that deliver primary care services to Medicare beneficiaries with serious illness. Broadly speaking these beneficiaries typically have several chronic conditions, are often clinically homebound or home limited, and many permanently reside in communal living circumstances that range from assisted living to nursing facilities and memory care units. CCA members participate in traditional Medicare value-based models, as well as serve hundreds of thousands of Medicare Advantage patients. Certain members also sponsor their own Medicare Advantage special needs plans.

The CY 2027 proposed rule reflects meaningful progress toward strengthening Medicare's accountable care programs and the underlying fee-for-service structure that supports them. We support proposals to deepen participation in the Medicare Shared Savings Program (MSSP), including changes to the prior savings adjustment and regional efficiency adjustment for ACOs that are particularly impactful for organizations CCA represents.

We also welcome the Administration's continued attention to rightsizing traditional Medicare payments for care management and palliative care services for beneficiaries with serious illness. Specifically, we strongly support:

- The proposal to shift G2211 to one of two modifiers, and simultaneously update the payment rate for the base E&M when those modifiers are applied.

- The proposal to create new HCPCS codes for advanced care planning when furnished by clinical staff
- CMS' interest in a palliative care management bundle (as described in the RFI on this topic), and we encourage CMS to move forward with this concept, although we strongly recommend CMS to broaden the definition of "palliative" to include all beneficiaries with serious illness.
- CMS' proposals to maintain appropriate payment for skin substitutes and correct the indirect practice expense reduction for services furnished in place of service (POS) 31.

Our detailed recommendations are provided below.

Fee-For-Service Payment Proposals

Conversion Factor

Starting in CY 2026, there are two separate conversion factors, one for qualifying alternative payment model (APM) participants (QPs) and one for physicians and practitioners who are not QPs, with QPs receiving a 0.75% increase to the conversion factor and non-QPs receiving 0.25%. For CY 2027, CMS proposes a qualifying APM conversion factor of $33.17, a decrease of $0.40, or 1.19%, from the current conversion factor of $33.57, and a non-qualifying APM conversion factor of $32.84, a projected decrease of $0.56, or 1.68%. This reflects the expiration of the one-time 2.5% conversion factor increase Congress provided for CY 2026 under the One Big Beautiful Bill Act, passed in July 2025.

CCA is disappointed by this cut from the CY 2026 conversion factor. CCA continues to believe that Medicare payment structures should incentivize participation in accountable care models while disincentivizing fee-for-service payment and supporting the differential conversion factor as an incentive and benefit to QPs in Advanced APMs. Congress took important action last year to provide a one-time increase to the conversion factor, but its expiration now results in a net decrease for CY 2027, undermining the stability that organizations, particularly those serving complex and high-needs patients, need to sustain participation in these models. CCA urges Congress to act again to address this negative conversion factor and ensure that payment updates keep pace with the cost of delivering care.

Skin Substitutes

For CY 2027, CMS proposes to maintain the $127 per square centimeter payment rate for skin substitutes finalized last year. CCA fully supports maintaining this rate. This policy marked an important victory for patients, providers, and the integrity of the Medicare program, addressing spending that had grown from $250 million in 2019 to more than $10 billion in a single year, alongside significant patient harm tied to the prior reimbursement scheme. Since the rate was finalized, utilization has dropped without harm to quality, and the policy has reduced the number of predatory actors profiting from this category. ACOs were at the forefront of identifying these abuses, and their data and experience continue to demonstrate the value they bring as partners to CMS in rooting out fraudulent spending. ACOs have used model data to uncover waste and abuse related to skin substitute products that, according to a recent Department of Justice case, resulted in $900 million in unnecessary spending, a clear case study in how organizations can help protect

the Medicare trust fund when they have both the tools and accountability for total Medicare costs. CCA urges CMS to maintain the $127 rate in the final rule.

Technical Correction of Indirect Practice Expense Cut for Services Provided in POS 31

CMS proposes a multi-year change to the practice expense (PE) rate-setting methodology intended to reduce reliance on decades-old, specialty-specific practice-expense-per-hour survey data known as the Indirect Practice Cost Index (IPCI). CMS proposes to calculate indirect PE based on work relative value units (RVUs) and clinical labor RVUs for all services except 010- and 090-day global-period codes, phasing out the IPCI-based steps over a two-year transition period, and to add a PE stabilization factor capping year-over-year PE RVU swings at plus or minus 5 percent to reduce volatility during the transition.

As part of this effort, CMS also proposes a technical correction for CY 2027 to equalize the facility and non-facility practice expense RVUs for nursing facility evaluation and management codes, addressing an unintended site of service differential that resulted from the CY 2026 final rule. That policy shifted indirect PE from the facility to the non-facility setting based on a beneficiary's Part A versus Part B status rather than the actual setting of care, resulting in lower payment for services furnished in POS 31 even though the resource costs of furnishing the service do not differ based on a patient's payment status.

CCA fully supports this technical correction. As CMS itself has recognized, a class of providers, including home-based primary care clinicians, palliative care and hospice clinicians, skilled nursing facility clinicians, and long-term care facility clinicians, specialize in caring for patients with complex illness and have developed models of care built around interdisciplinary care teams, the ability to deliver care in the home and virtually, advance care planning, care management and coordination, greater patient and family engagement, assessment and support for social needs, and 24/7 access. These providers deliver this care despite a payment system that was not designed with their patients or care models in mind, and an uncorrected site of service differential tied to Part A status rather than actual setting of care would have further disadvantaged them. CCA urges CMS to finalize this correction.

Medicare Shared Savings Proposals

Risk Adjusting 5% Cap on Prior Savings and Regional Efficiency Adjustment

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.

We strongly support CMS's proposal to risk adjust the 5% cap on the prior savings adjustment and the regional efficiency adjustment to the historical benchmark for ACOs in the Medicare Shared Savings Program (MSSP). This proposal is ***foundational*** for MSSP to enable long-term participation from ACOs and providers that focus on beneficiaries with high-needs and high benchmarks.

MSSP benchmarks incorporate an ACO's own historical performance at the start of each agreement period, and for ACOs serving complex and high-needs patients, this reliance on historical performance can be particularly problematic. Given the smaller patient panel sizes,

higher mortality and turnover rates, and the concentration of expenditures across a relatively small number of beneficiaries that characterize high-needs populations, historical expenditures can quickly become unrepresentative of an ACO's future patient population. Patients with complex illness often decompensate rapidly. CMS has appropriately recognized that high need beneficiaries have more highly variable cost and utilization, and risk adjusting the cap on these upward adjustments is a meaningful step toward ensuring that MSSP benchmarks reflect the actual risk profile of the patients an ACO serves, rather than penalizing organizations whose patient mix changes as they expand into new geographies or take on more complex patients.

The current unadjusted cap has a disproportionate effect on ACOs serving high-needs patients, since it applies equally to the prior savings adjustment and the regional efficiency adjustment. CCA members serving high-needs populations have been able to carry over only approximately 10 percent of their prior savings under the current cap, while standard ACOs serving healthier patients are able to carry over much closer to the full 50 percent, simply because their benchmarks are lower to begin with. Risk adjusting the cap would correct this disparity and better align the benefit of the prior savings adjustment with the actual savings ACOs generate. CCA urges CMS to finalize this proposal.

Prior Savings Adjustment - Increasing Prior Savings to 75% From 50%

CMS proposes to increase the prior savings adjustment scaling factor, program wide, from 50 percent to 75%, beginning with agreement periods starting January 1, 2027, and subsequent agreement periods. CMS explains that the current methodology may not provide sufficiently strong or consistent incentives for ACOs to generate and sustain savings and may not sufficiently incentivize ACOs to continue participation in future agreement periods when compared against benchmarks that include their own previous success in reducing expenditures. CMS believes a scaling factor of 75% strikes the appropriate balance between encouraging long-term participation and continued savings, while also supporting savings to the Trust Funds.

We support this proposal. High-needs care is significantly more resource intensive in the short term, but it pays for itself over the long run through better outcomes and avoided utilization. CCA agrees with CMS that a stronger prior savings adjustment is warranted. A higher scaling factor better rewards ACOs for the savings they generate, which strengthens the incentive to continue participation into future agreement periods. This is especially important for organizations serving high-needs patients, who require more resource-intensive interventions to achieve savings and stand to benefit most from an adjustment that more fully credits that work.

While the High-needs ACO Model operated under ACO REACH rather than MSSP and the two models are not directly comparable, the High-needs track's results are instructive on this point. Financial results from 2023 showed High-needs ACOs generating $143 million in gross savings and a 13.3% net savings rate[1], and the third evaluation report found statistically significant reductions in total gross spending for High-needs ACOs relative to the comparison groups, at $903 per

[1] ACO REACH Model: Performance Year 2023 Financial and Quality Performance Results' Highlights. https://www.cms.gov/priorities/innovation/aco-reach-py2023-financial-and-quality-performanceresults-fact-sheet

beneficiary per year, 2.3%, and $19.6 million in the aggregate[2]. At the same time, the model reached some of the most underserved, high need patients in the Medicare population. The average aligned beneficiary had 12 chronic conditions, and over two thirds of those aligned were dually eligible for Medicare and Medicaid. Organizations serving these patients typically incur higher costs upfront to build the care management infrastructure needed to achieve savings, and a stronger prior savings adjustment helps ensure that investment is reflected in future benchmarks

Accountable Care Prospective Trend (ACPT)

CMS proposes updates to the historical benchmark using a three-way blend of national and regional growth rates as well as the ACPT, a variant of the modified United States Per Capita Cost (USPCC) set prospectively at the start of an agreement period, and proposes calculating the ACPT on a performance year basis rather than an agreement period basis to improve consistency, along with prospective guardrails beginning in 2027 and retroactive guardrails for 2024 through 2026 limiting how far predicted growth can deviate from actual growth.

CCA supports this proposal. ACOs, and particularly those caring for high-needs populations, need more stable and accurate benchmarks. As CCA has previously raised with CMS, historical expenditure-based benchmarks are a poor fit for high-needs ACOs because of the inherent instability in the high-needs population, where historical expenditures can quickly become unrepresentative of current experience due to small changes in population driven by relatively smaller panel sizes, concentration of costs, and high patient turnover tied to mortality. Greater accuracy and stability associated with regional benchmarks would enable the sustained participation of high performers that reduce costs and improve quality and satisfaction, which in turn would provide a dynamic, model-initiated pathway for successful organizations to scale and increase beneficiary access to the care they provide. Moving the ACPT calculation to a performance year basis and adding growth guardrails should help ensure MSSP benchmarks better reflect current cost trends rather than becoming outdated over the course of an agreement period. CCA urges CMS to finalize this proposal.

Quality Metrics

CCA supports CMS's proposed changes to the quality performance category, including CMS's focus on chronic and complex illness through the expansion of the MVP portfolio to include Diabetic Disease and Hypertension MVPs. CCA also supports CMS's proposal to sunset traditional MIPS reporting beginning with the CY 2029 performance period/2031 MIPS payment year for MIPS eligible clinicians not participating in the APM Performance Pathway (APP), in favor of MVP-only reporting. MVPs align measures and activities across the quality, cost, improvement activities, and Promoting Interoperability performance categories around specific specialties, conditions, or patient populations, which makes reporting more meaningful and can generate comparative performance data that is valuable to patients and caregivers in evaluating clinicians and making care decisions.

[2] Evaluation of the ACO REACH Model: Third Evaluation Report
https://www.cms.gov/priorities/innovation/data-and-reports/2026/aco-reach-3rd-eval-report

CCA supports this approach but urges CMS to go further to ensure MSSP quality metrics are not punitive to high-risk ACOs, including through more predictive risk adjustment of admission and readmission outcomes measures. CCA would welcome a set of MSSP quality measures purpose-built for organizations treating patients with complex illness and high-needs, in the same way MVPs are tailored to specific specialties, conditions, and patient populations. To the extent CMS continues to apply measures designed for a broader population, such as risk-standardized all-cause readmissions, CCA encourages CMS to calibrate the risk-adjustment methodology specifically for high-risk populations, since these measures typically rely on risk-adjustment calculations calibrated on the general Medicare population and may inadvertently penalize organizations serving patients who are homebound, home-limited, or seriously ill.

Care Management Proposals

G2211 Code Modifier

CMS proposes to convert HCPCS code G2211, which recognizes the visit complexity inherent to longitudinal E/M care, from a flat add-on code to a percentage-based modifier for CY 2027. Alongside this change, CMS proposes a second, separate modifier, MOD2, to recognize the added resource costs of longitudinal, accountable care, available only to practitioners in an MSSP ACO or a LEAD Model ACO. MOD2 is voluntary and valued at a 32 percent increase to the associated E/M visit, and claims billed with MOD2 would be included in ACO beneficiary assignment and benchmark calculations.

CCA supports this proposal. G2211 is designed to recognize the inherent complexity and additional resources associated with longitudinal, continuous care, and high-needs care requires exactly this kind of specialized expertise and model of care. While providers that care for average risk populations could develop high-needs expertise for the small subset of high-needs patients in their panel, they rarely have enough such patients to justify significant investment or to keep a dedicated high-needs resource busy. Instead, high-needs providers typically function as specialty providers that receive high-needs patients from across a region and remain smaller because the population they focus on is small and has intensive needs. Because of inadequate fee for service reimbursement, many rely on charitable donations or are operated at a loss by larger institutions that view them as a community service, which limits the number of patients they can accept. High quality, longitudinal care for high-needs patients cannot be sustained without value-based reimbursement models, and existing fee-for-service payment systems inadequately account for the care these patients need. CCA supports MOD2 as a step toward addressing this gap but urges CMS to require Medicare Advantage plans to conform to the modifier structure, so that providers delivering this same longitudinal, high-needs care are appropriately recognized regardless of a beneficiary's coverage type.

Community-Based Palliative Care RFI

CCA appreciates CMS's request for information on community-based palliative care and care management for beneficiaries with serious illness. CCA supports the creation of a care management bundle for beneficiaries with serious illness.

CCA urges CMS to frame this work around beneficiaries with serious illness rather than palliative care specifically, and to define eligibility broadly rather than tying it to an assessment of life expectancy. Restricting eligibility to a terminal prognosis would exclude many beneficiaries with serious illness who could benefit from more intensive care management well before end of life. CMS already has several definitions it could draw on for this purpose, including the CMS Innovation Center's high-needs criteria used in ACO REACH[3] and the LEAD Model[4], as well as the criteria used to qualify beneficiaries for the Independence at Home statutory model[5], which was a precursor to REACH.

There are clear and significant differences between the general Medicare population and beneficiaries with complex illness and high-needs, and it is critical for CMS to treat them differently in eligibility criteria and payment policy. While there is debate about what qualifies someone as high-needs, the population generally includes patients with severe and debilitating illness, physical, cognitive, or mental disabilities, and overall declining health status. These beneficiaries typically have a health status substantially different from the general Medicare population, requiring a level of clinical and care management that goes well beyond that of a typical beneficiary. They also tend to rapidly decompensate in ways not fully accounted for in traditional prospective risk adjustment models, and are often homebound, home-limited, or otherwise need care brought to them. Current care management payments are designed for healthier beneficiaries and the practice expense associated with care management efforts for a Medicare beneficiary who is homebound and have eight chronic conditions and five hospitalizations in the last year is significantly different (significantly higher) than the costs associated with delivering the same services to a beneficiary with two chronic conditions. While the high-needs population is definitionally smaller than the broader Medicare population, it has an outsized impact on total fee-for-service spending. Recent estimates indicate that high-needs patients represent 10 percent of the traditional Medicare population but account for 44 percent of all traditional Medicare spending.

Advance Care Planning G Codes

CMS proposes to create additional codes in the annual wellness visit family that more explicitly describe and value the contributions of clinical staff in the provision of advance care planning (ACP) services. CMS proposes two new HCPCS codes, GACP1 and GACP2, to describe ACP services furnished by clinical staff under the direct supervision of the billing physician or other practitioner and incidental to their professional services and proposes that existing CPT codes 99497 and 99498 be used only to report time personally spent by the billing practitioner.

CCA supports this proposal. Separating time spent by clinical staff from time spent by the treating practitioner more accurately reflects how ACP conversations are often delivered in practice, particularly for organizations serving complex and high-needs patients, where clinical staff play a substantial role in preparing patients and caregivers for these conversations and following up on care preferences over time. Distinct coding for this work should improve the accuracy of billing and

[3] https://www.cms.gov/priorities/innovation/data-and-reports/2026/aco-reach-3rd-eval-report
[4] https://www.cms.gov/priorities/innovation/files/lead-rfa.pdf
[5] https://www.cms.gov/priorities/innovation/media/document/iah-rev-act-meth-specs

help ensure that the full range of resources involved in delivering meaningful ACP services is appropriately recognized. CCA urges CMS to finalize this proposal.

RPM Changes

For CY 2027, CMS proposes several changes to Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM), prompted by two OIG reports flagging billing abuses. CMS proposes that RTM, like RPM, be furnished only to established patients, and that practitioners furnish a separately reportable initiating visit, conducted face-to-face by the billing practitioner, in association with the onset of RPM or RTM services. CMS also proposes to allow payment for RPM or RTM only when furnished by clinical staff who are direct employees of the billing practitioner or practice, which would not permit contracting out to third-party RPM/RTM companies, and is soliciting comment on how often third-party billing currently occurs and how this policy could affect access to remote monitoring services.

CCA is in favor of RTM/RPM requirements for a more robust initiating visit and for limiting eligible time to in-house clinical staff. There are a lot of loose players in this space. They prey on our patients and, while not nearly as bad as what CCA has seen with skin substitutes, this dynamic still fragments care, and it needs to be cleaned up. CCA is supportive of these proposals but recognizes that the industry may need more time to adjust, particularly practices that currently rely on third-party arrangements and would need to bring staff in-house or restructure supervision to comply. CCA recommends that CMS delay implementation of these requirements until it has crafted stronger, more balanced guardrails, informed by the comments CMS receives. CCA urges CMS to use this comment period to develop a final approach that addresses bad actors without unnecessarily disrupting legitimate arrangements that support patient care.

Conclusion

CCA 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

Mara McDermott
CEO
Accountable for Health