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Re: CY 2026 Physician Fee Schedule and Medicare Shared Savings Program Requirements *(CMS-1832-P)*

The Health Care Transformation Task Force (HCTTF) appreciates the opportunity to share recommendations on the Calendar Year (CY) 2026 Physician Fee Schedule and Medicare Shared Savings Program (MSSP) Requirements (CMS-1832-P). HCTTF believes these recommendations will help the Centers for Medicare & Medicaid Services (CMS) achieve the goal of increasing access to high-quality value-based care (VBC) while eliminating waste, fraud, and abuse.

HCTTF is a non-profit collaborative that supports accelerating the pace of delivery system transformation to better pay for the value of care received. Representing a diverse set of organizations from various segments of the industry – including providers, payers, purchasers, and consumer/patient advocacy organizations – we share a common commitment to transform our respective businesses and clinical models to deliver better health through high-quality care at reduced costs. We strive to provide a critical mass of policy, operational, and technical support that, when combined with the work being done by CMS and other public and private stakeholders, can increase the momentum of delivery system transformation.

Our comments address (1) MSSP (sections I-X), (2) the Ambulatory Specialty Model (sections XI-XIII), (3) the Quality Payment Program (sections XIV-XVI), (4) chronic disease prevention and management (sections XVII-XIX), and (5) enhanced care delivery (sections XX-XXIII). Our recommendations are offered in the spirit of collaboration, with the goal of strengthening CMS' ability to deliver high-quality, accessible, affordable care to all Medicare beneficiaries.

MEDICARE SHARED SAVINGS PROGRAM

I. MSSP Risk Tracks

Starting in 2027, CMS proposes to limit MSSP participation options for one-sided risk arrangements. Accountable Care Organizations (ACOs) entering the BASIC risk track's glide path at Level A would only be eligible for one-sided risk for their first five-year performance period. CMS currently allows eligible ACOs to participate in one-sided models for up to seven

years. CMS recognizes that the one-sided risk option is particularly attractive to low-revenue ACOs; ACOs serving medically complex, high-cost populations; and small, rural, and safety-net providers. However, CMS believes that limiting participation in a one-sided model will encourage ACOs to transition to performance-based risk more quickly, which aligns with their strategic direction and allows for more meaningful changes to the health care delivery system.

In addition, CMS proposes to limit participation in Levels C and D of the BASIC track to an ACOs first agreement period in the glide path. Levels C and D currently have low and declining participation and limiting their use will support CMS' goal to transition ACOs to two-sided models with greater potential for risk and reward. For ACOs that complete a five-year agreement period in the BASIC track's glide path at Level A or B for former Track 1 ACOs, CMS proposes that these ACOs must enter their subsequent agreement period under Level E of the BASIC track or the ENHANCED track. Additionally, CMS proposes to limit the participation of ACOs with less than 5,000 assigned beneficiaries to the BASIC track at Levels A through E, prohibiting them from participating in the ENHANCED track, even if they are experienced with performance-based risk.

If these proposals are finalized, ACOs would be ineligible to enter a subsequent agreement period under the BASIC track's glide path starting in 2027. This would apply to ACOs currently participating in a first agreement in an upside only Level (A or B) in the BASIC tracks (with 2022-2026 start dates).

HCTTF is a strong proponent of two-sided risk arrangements to support care transformation. We agree with CMS' assessment that global risk is a key component that drives cost and quality outcomes within ACOs. Therefore, we are supportive of CMS' proposals to limit downside risk to the first five-year agreement period and accelerate the transition to higher levels of risk in subsequent agreements. However, we believe that the minimum performance years within a one-sided model should not be lowered any further than 5 years.

In addition, HCTTF urges CMS to provide additional flexibility for rural, safety net and small independent providers. These providers face unique challenges when participating in shared savings models. We recommend that CMS consider:

- Modifying existing APMs to better account for safety-net populations. For example, CMS should create a set of waivers specific to safety-net providers in APMs.
- Developing new ACO tracks/total cost of care models focused solely on rural and high-risk populations. Safety-net providers are often challenged by financial benchmarks because their populations have historically lacked access to care. These providers often also operate under a cost-based reimbursement system that reduces their ability to generate savings. An MSSP track exclusively for safety-net providers could help address these unique challenges and set these providers up for success.
- Developing global budgets, prospective population-based payments, or lower discounts or minimum savings rate for providers in risk-bearing models.

These flexibilities address the unique challenges of safety-net providers as they move from one-sided to two-sided risk arrangements.

II. ACO Eligibility Expansions

CMS has historically denied ACO applications with less than 5,000 beneficiaries in any historical benchmark year to avoid inaccurate assessment of an ACOs financial and quality performance. **Starting in January 2027, CMS proposes to change MSSP eligibility requirements to allow participation from ACOs with a minimum of 5,000 assigned beneficiaries in their third benchmark year (BY3), even if the ACO has fewer than 5,000 assigned beneficiaries in BY1 and/or BY2. CMS proposes to limit these ACOs to participation in the BASIC track.**

For ACOs with fewer than 5,000 assigned beneficiaries in BY1-2, CMS proposes an alternative method for calculating performance payments and losses. The alternate method would use the year with the lowest beneficiary count to calculate an alternative total benchmark expenditure, based on per capita costs and person-years. CMS would calculate the ACO's performance using both the standard and alternative methods and would apply the lower of the two amounts.

CMS also proposes to exclude ACOs with less than 5,000 beneficiaries from policies that provide certain low-revenue ACOs in the BASIC track with increased opportunities to share in savings. Currently, certain low-revenue ACOs participating in the BASIC track can share in savings even if the ACO does not meet the minimum savings rate (MSR). CMS is concerned that any shared savings payments made to an ACO with less than 5,000 beneficiaries may pay for normal or random expenditure fluctuations rather than reward true cost savings.

HCTTF supports CMS' proposals to address ACOs with fewer than 5,000 beneficiaries in the baseline. We agree that this adds flexibility for ACOs that will support continuity of care for the patients they serve, while excluding these ACOs from some low-revenue policies will protect against potential waste, fraud, and abuse.

III. Primary Care Services Definition

CMS proposes to revise the definition of primary care services used for beneficiary assignment to incorporate behavioral health services. Starting in January 2026, the attribution methodology would include the following HCPCS and CPT codes:

- **Enhanced Care Model Management Services:** Behavioral health integration (BHI) or Collaborative Care Model (CoCM) services that are furnished with alternative primary care management services.
- **HCPCS code GPCMI:** Initial psychiatric collaborative care management in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant and directed by the treating physician.
- **HCPCS code GPCM2:** Subsequent psychiatric collaborative care management, in a subsequent month of behavioral health care manager activities in consultation with a psychiatric consultant and directed by the treating physician.
- **HCPCS code GPCM3:** Care management services for behavioral health conditions, directed by a physician or other qualified health care professional, per calendar month.

Including these new HCPCS and CPT codes in the definition of primary care services would improve accuracy by ensuring that all expenditures for BHI and CoCM are reflected in the assignment process.

Beginning in January 2026, CMS also proposes to remove HCPCS code G0136 for the administration of a social determinants of health risk assessment. CMS believes that the code is already accounted for in existing codes, including but not limited to evaluation and management visits.

HCTTF strongly supports CMS' proposal to include behavioral health services within the definition of primary care for ACO attribution. We applaud CMS for recognizing the critical role of behavioral health within both primary care and ACOs. We agree that behavioral health care is an essential form of care delivery, which also has the potential to prevent high-cost care delivery in the Emergency Department (ED) and inpatient settings. In addition, there is extensive research in support of the CoCM model and other behavioral health interventions delivered in conjunction with primary care.

HCTTF opposes the removal of code G0136 because it addresses upstream factors like nutrition, fitness, and transportation. We believe that CMS should continue to help clinicians identify and address non-medical factors that are relevant to patients' health, extending beyond the clinic to address lifestyle factors. The more clinicians understand about their patients' lives, the better they can provide holistic care to patients. **Instead of removing this code, HCTTF recommends that CMS rename G0136 as "Upstream Factors Assessment Services."**

IV. Quality Payment Program: Alternative Payment Model (APM) Performance Pathway

In the CY25 PFS final rule, CMS previously finalized the plan to incrementally add additional eCQM measures to the APM Performance Pathway (APP) Plus quality measure set. Two new eCQMs will take effect in the 2025 performance period:

- Quality measure #113: Colorectal Cancer Screening
- Quality measure #484: Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions

CMS proposes to revise previously finalized eCQM measures in future years to align with the Merit-Based Incentive Program System (MIPS) quality measure inventory. If finalized, this would remove the Screening for Social Drivers of Health measure, which was scheduled to take effect in 2028 or later.

HCTTF acknowledges CMS' efforts to reduce the burden for participants and align quality measure sets across programs. While we are supportive of both goals, we also believe that CMS should continue to help clinicians identify and address non-medical factors that are relevant to patients' health, extending beyond the clinic to address lifestyle factors. The more clinicians understand about their patients' lives, the better they can provide holistic care to patients. **CMS should explore opportunities to help clinicians identify and address non-medical drivers of health, such as nutrition, fitness, and transportation.**

V. Quality Payment Program: Advanced APM Proposals

In PY25, under statute, the Qualifying APM Participant (QP) thresholds increased from 50 to 75 percent of payments and from 35 to 50 percent of patients. Partial QP thresholds also increased from 40 to 50 percent of payments and from 25 to 35 percent of patients. To create more opportunities for providers to qualify, **CMS proposes to report on QP determinations at the individual level, as well as the APM Entity level. In addition, CMS proposes to use all Medicare covered professional services for attribution, rather than E/M codes alone**, as was proposed but not finalized in the CY25 PFS.

HCTTF appreciates CMS' interest in creating additional opportunities for clinicians to qualify as QPs, particularly as the thresholds increase under statute. We support CMS' proposal to allow clinicians to qualify either as individuals or as part of an AMP entity. However, we are concerned that using all covered professional services, rather than E/M codes alone, may make it harder for many clinicians to qualify for these thresholds. By adding all services in the denominator, this will make it more difficult for providers that deliver E/M services – particularly primary care – to qualify for QP thresholds. In addition, HCTTF continues to advocate for Congressional action to reduce the QP thresholds and extend the Advanced APM bonus.

VI. Beneficiary Eligible for Medicare CQM Definition

Reporting Medicare Clinical Quality Measures (CQMs) serves as a transition period for ACOs as they build the infrastructure, skills, knowledge, and expertise necessary to report all payer/all patient MIPS CQMs and electronic CQMs (eCQMs). However, the complexity of the current definition of a "beneficiary eligible for Medicare CQMs" has created confusion for some ACOs, given that the Medicare CQM beneficiary lists differ from assigned beneficiary files that ACOs receive from CMS. To better address ACO concerns, **CMS proposes to revise the definition of a "beneficiary eligible for Medicare CQMs" to require "at least one primary care service with a date of service during the applicable performance year from an ACO professional who is a primary care physician or who has one of the specialty designations included at** § 425.402(c)**, or who is a physician assistant, nurse practitioner, or clinical nurse specialist."** The current definition requires at least one claim with a date of service during the measurement period. Specifically, the revised definition uses the terms "primary care services" and "performance year" instead of "claims" and "measurement period." This change seeks to reduce ACO burden in patient matching.

CMS is proposing to update the breast cancer screening measure for the eCQM collection type by expanding the age range for the eCQM specification to women 40-74 years of age, which aligns with the MIPS CQM specification. CMS is also proposing to define the term "reviewed" as documented in the medical record that it was reviewed and discussed with the patient in the measure descriptions of the breast cancer screening and the colorectal cancer screening measures. This change would not be applied to eCQMs.

HCTTF supports CMS' proposal to clarify the definition of beneficiaries ACOs must report on for Medicare CQMs. We agree that the proposal will increase clarity for ACOs and align with the data ACOs using retrospective attribution receive, making it easier for these ACOs to report eCQMs. However, we remain concerned that ACOs with prospective alignment will not

have sufficient data to report accurately on eCQMs. Currently, ACOs using the preliminary prospective assignment must report on their "attributable" population. However, these prospective ACOs only receive data on the narrower attributed population. With the alignment of the Medicare CQM reporting population to the attributable definition, these ACOs may be required to report quality metrics for beneficiaries who are not aligned with their organization. For example, the reporting requirement could include beneficiaries who receive only primary care services from a Shared Care Provider (SCP) during the performance year. To close that gap, HCTTF recommends that CMS (1) expand the claims data they share with ACOs to include "attributable" beneficiaries, regardless of attribution methodology, and/or (2) require Medicare CQMs be reported for "attributed" beneficiaries only. These changes would ensure all ACOs are treated fairly from a quality reporting perspective, and that some ACOs don't have an undeserved advantage over others.

HCTTF supports the change to the age range for the breast cancer screening definition to align the eCQM and MIPS CQM definitions. This change will address the barriers ACOs are facing in PY 2025 data collection efforts due to the misalignment in age ranges for the eCQM and MIPS CQM/Medicare CQM collection type.

However, HCTTF opposes adding "reviewed" in the colorectal and breast cancer screening measure definitions for the MIPS CQM and Medicare CQM collection types, to qualify as meeting the quality action. We believe that this change is an expansion beyond the original intent of the measure, which will increase documentation burden without any value added to the patient or provider. In addition, specifications across reporting options should remain aligned, and the eCQM specification does not currently include this requirement, nor would we support its addition to this specification in the future. ACOs often work with their participating practices to extract these data from EHRs even when reporting MIPS CQMs or Medicare CQMs and this change will make it even less feasible for them to minimize the data collection burden for practices if they cannot leverage data from the EHRs.

VII. Health Equity Adjustment Removal and Terminology

Beginning in performance year 2025 (PY25), CMS proposes to remove the health equity adjustment applied to an ACOs quality score. CMS believes that the application of the Complex Organization Adjustment and the extension of the eCQM/MIPS CQM reporting incentive have made it unnecessary to continue applying the health equity adjustment. **CMS considered but is not proposing to retain and rename the adjustment as the "Population and Income Adjustment and Bonus Points."**

The Complex Organization Adjustment increases an ACO's MIPS quality performance category score by up to 10% of the total measure achievement points in the quality performance category when the ACO reports eCQMs that all meet the case minimum and data completeness requirements. CMS believes that the Complex Organization Adjustment and the health equity adjustment are duplicative because they serve a similar function to upwardly adjust an ACO's quality score to increase an ACO's ability to meet the quality performance standard. The eCQM/MIPS CQM reporting incentive is available to all ACOs who report these measures and meet the criteria for the reporting incentive. CMS believes that these mechanisms are sufficient

in supporting ACOs that serve large proportions of dually eligible beneficiaries and those with low-income status.

Additionally, the four CY25 Medicare CQMs that are in the APP Plus quality measure will be scored using a flat benchmark. In cases where PY25 is the measure's first or second performance period in MIPS using the Medicare CQM collection type, ACOs with high scores would earn maximum or near maximum measure achievement points while rewarding improvement in subsequent years. Therefore, CMS believes that flat benchmarks also provide benefits that are duplicative of the health equity adjustment.

CMS proposes to change the terminology used to describe the health equity adjustment due to confusion around the terms "quality score" and "quality performance score." CMS proposes to define the term "quality score" as an ACO-level quality score. CMS also proposes to define the term "quality performance score" as a measure-level score. CMS proposes additional changes to replace the phrase "health equity adjusted quality performance score" with "quality score," and "health equity adjustment bonus points" with "population and income adjustment bonus points," or "bonus points." Similarly, CMS proposes to revise MSSP regulations that include references to the "health equity benchmark adjustment" to "population adjustment" and "HEBA scaler" to "scaler." CMS believes that these updates more accurately reflect the populations served by the ACOs receiving the adjustment.

HCTTF recommends that CMS retain and rename the adjustment as the "Population and Income Adjustment and Bonus Points," as CMS considered but did not propose. We agree with CMS that population adjustment is a more accurate description. In addition, the population adjustment is a critical tool for a small number of ACOs serving primarily dual eligible populations, such as patients living in nursing homes. While this adjustment will impact only a small number of ACOs – only 33 in total, of which 13 are new – for ACOs that primarily provide care to high-risk, dual eligible patients, the adjustment provides key support and does not duplicate the complex organization adjustment. The population adjustment aligns with CMS' aims of advancing prevention, wellness, and chronic disease management, since these ACOs are more likely to be treating patients with numerous chronic conditions and managing them appropriately.

More broadly, HCTTF acknowledges CMS' efforts to streamline the financial methodology applied to ACOs and to clarify the terminology used to describe the adjustments. While we understand these goals, we also believe that CMS should continue to help clinicians identify and address non-medical factors that are relevant to patients' health, extending beyond the clinic to address lifestyle factors. The more clinicians understand about their patients' lives, the better they can provide holistic care to patients. **CMS should explore opportunities to create incentives to identify and address non-medical drivers of health, such as nutrition, fitness, and transportation.**

VIII. CAHPS Survey Administration Expansion

CMS proposes that starting in 2027, CMS-approved survey vendors will have to administer the CAHPS for MIPS survey via a web-mail-phone protocol. ACOs are required to administer CAHPS to meet the quality reporting requirement under MSSP. Currently, data are

collected using a mail-phone survey administration protocol. CMS believes that the web-based survey protocol could help increase response rates. **Additionally, beginning in PY26, CMS proposes that CMS-approved survey vendors must submit the range of costs for their services, including the cost of adding the web survey mode as part of the overall cost of CAPHS.**

HCTTF strongly supports CMS' proposal to create a web-mail-phone protocol for CAHPS. This will help modernize the survey and increase the response rate, creating a more accurate estimate of quality performance.

IX. ACO Participant Change of Ownership

To be eligible to participate in MSSP, ACOs must submit to CMS an accurate and complete ACO participant list and report any changes. However, requiring ACOs to wait until the upcoming change request cycle to update their certified ACO participant list can create operational difficulties that interfere with an ACOs ability to provide coordinated care. Without the ability to report a change of ownership (CHOW), an ACO may be unable to provide coordinated care to an ACO participant's patient population, which may cause the ACO's beneficiary count to fall below 5,000. **Effective January 1, 2026, CMS proposes to require ACOs to update their certified ACO participant list to reflect participant CHOWs outside of the change request cycle, whereby the surviving Medicare-enrolled TIN has no Medicare billing claims history.** CMS would require this change to be made no later than 30 days after the CHOW occurs.

CMS also proposes to allow ACO participants that undergo a CHOW and receive a new Medicare-enrolled TIN with no prior billing history to remain part of the ACO. CMS proposes to include the new TINs in beneficiary assignment, financial benchmarking, performance year calculations, and quality reporting requirements. This change would prevent disruptions in ACO participation and patient attribution due to administrative changes, supporting the delivery of high-quality care.

MSSP currently doesn't allow ACOs to add a new TIN to its Skilled Nursing Facility (SNF) affiliate list outside of the annual change request cycle, including instances where a SNF affiliate experiences a CHOW resulting in a change to the Medicare-enrolled TIN. If a SNF affiliate experiences a CHOW resulting in a change to the Medicare-enrolled TIN, it can no longer admit eligible beneficiaries without a prior 3-day inpatient hospitalization due to the change in Medicare enrollment. **CMS proposes to require ACOs to notify CMS no later than 30 days after a CHOW of a SNF affiliate that has resulted in a change to the Medicare-enrolled TIN of the SNF affiliate and to submit supporting documentation confirming reassignment to the new TIN.** This would allow the SNF affiliate to continue participating in the ACO under the SNF 3-day rule waiver during the performance year without having to wait until the next change request cycle to notify CMS.

HCTTF strongly supports CMS' proposal related to CHOWs, because it would prevent disruptions in access and care delivery for patients. These proposals reduce administrative delays that may adversely impact ACOs and the patients they serve.

X. Revision to the Extreme and Uncontrollable Circumstances (EUC) Policies

Starting in performance year 2025, CMS proposes 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 by the Quality Payment Program (QPP). If an ACO is impacted by a cyberattack and wants relief from MSSP quality reporting requirements, the ACO must submit a MIPS EUC Exception application. This policy would apply to ACOs impacted by a cyberattack that reports the APP Plus quality measure set, meets the data completeness requirement, and receives a MIPS quality performance category score. For these ACOs, CMS would use the higher of the ACO's quality score or the equivalent of the 40th percentile MIPS quality performance category score across all category scores for the relevant performance year. This proposal allows ACOs impacted by a cyberattack to meet the MSSP quality performance standard for sharing in savings at the maximum rate and to have any shared losses pro-rated based on the duration of the cyberattack. CMS is also seeking comments on additional scenarios the agency should consider recognizing under EUC politics.

CMS also proposes to apply MSSP finance EUC policies to 100% of the ACO's assigned beneficiaries. CMS proposes that if an ACO does not provide an end date in the ACO's MIPS EUC Exception application prior to the end date of the application submission period, then CMS would apply a 90-day default duration for purposes of mitigating shared losses. This is consistent with the timeframe used for determining a public health emergency.

HCTTF strongly supports CMS' proposals to expand EUC policies to include cyberattacks and apply to all assigned beneficiaries. This policy modernizes the EUC policy and recognizes real threats that many ACOs experience.

AMBULATORY SPECIALTY MODEL

XI. Mandatory ASM Participation

CMS is proposing the Ambulatory Specialty Model (ASM), a mandatory APM for individual clinicians who treat heart failure and low back pain. If approved, the model will run for 5 years from January 1, 2027 to December 31, 2031. The model aims to enhance quality of care and reduce low-value care by improving chronic condition management and coordination between primary care providers and specialists. **ASM would be a two-sided risk model that aligns with MIPS, with a maximum adjustment that would start at +/-9% in 2027 and rise incrementally to +/-12% by 2031.** Participants would receive these adjustments on future Medicare Part B payments for covered professional services, with a two-year lag time after the ASM participation year. **Specialists' performance scores would be based on comparisons to other ASM physicians during the performance year, rather than all physicians who report on these measures.**

HCTTF strongly agrees that specialist integration in VBC is critical to the goal of improving access to high-quality care. We believe mandatory models can serve an important role in driving model participation. Therefore, we have a longstanding policy to assess our

support for mandatory models on a case-by-case basis considering their design and impact. **We support CMS' goals in the design of ASM, and we believe this model may be positive step in advancing specialist integration in VBC. However, we have several key recommendations to refine the design of ASM to better meet the goals of increasing access to high-value specialty care, including:**

1. **Create incentives for Advanced APM Participation by excluding specialists participating in these models:** HCTTF believes it is essential to retain non-financial incentives for Advanced APM participation, particularly the exemption from traditional MIPS reporting – which includes MVP reporting. **Therefore, since CMS is proposing ASM through the MVP framework, ASM should exempt Advanced APM participants. This exemption would create incentives for specialists to join Advanced APMs – thus encouraging participation in global risk models, which is a key goal under the new CMS strategy.** In addition, the exemption would reduce administrative complexity for ACOs that include specialists, allowing the ACO the flexibility to establish incentive structures and gainsharing arrangements with their participating specialists without having to account for model overlap with ASM.

2. **Ensure that specialist performance is accurately measured by accounting for statistical variation driven by small numbers**: Because ASM proposes to assess individual specialists' performance within a single calendar year, many clinicians will see a very small number of patients that trigger an episode. This creates significant statistical variation, where specialists may appear to have excellent or terrible performance based solely on statistical chance, rather than actual performance. The primary options to address this variation are to (1) increase the low volume threshold (currently proposed at 20 episodes), (2) aggregate performance across multiple years or multiple people (e.g., by allowing clinicians in a practice to pool their results), and (3) risk adjust the quality measures based on patients' clinical complexity. **HCTTF recommends that CMS raise the low volume threshold to a minimum of 30 episodes, allow specialists the opportunity to pool with others in their practice, and risk adjust the quality measures.**

3. **Strengthen specialist incentives by reducing lag time in payments:** HCTTF believes that CMS can strengthen the ASM incentive structure by making the performance incentives more urgent for specialists. Reducing the lag time between the performance year and the payment year will increase the relevance to specialists and create a more effective incentive structure. HCTTF recommends that CMS apply the payment adjustment in the year after the performance period, rather than the two-year lag time that CMS proposed.

4. **Drive specialist performance setting thresholds in advance**: HCTTF believes that CMS will drive specialist engagement and performance under ASM by setting the performance incentive in advance. This change would allow specialists to know what number they're trying to hit during the performance year. If CMS bases financial adjustments on the median in the current performance year (as proposed), specialists will have no way to know whether they are performing well or poorly during the current year, which will reduce their incentive to improve performance. Instead,

HCTTF recommends that CMS set the threshold based on the median performance in the previous performance year, allowing specialists to know how they are doing by tracking their own data.

5. **Provide specialists with data to understand their performance**: HCTTF recommends that CMS provide specialists with both aggregated and claims-level data to understand their own performance, which will help specialists improve. At minimum, CMS should provide quarterly claims-level data feeds and aggregated reports to specialists on the patients that triggered episodes, including performance on the relevant ASM quality measures. Ideally, CMS would provide monthly claim-level data feeds and aggregated reports to ensure the data is as real-time as possible. In addition, CMS should consider providing aggregated benchmark data on other ASM specialists' performance, which would increase competition among specialists.

HCTTF congratulates CMS on exploring new opportunities to engage specialists in VBC. In addition, we encourage CMS to think more broadly about population-based models with global risk. **For example, HCTTF recommends that CMS develop a voluntary longitudinal total cost of care model for patients with Congestive Heart Failure, potentially expanding to other major cardiovascular conditions.** This would supplement ASM by increasing specialist engagement in global risk.

XII. ASM Participant Identification

CMS proposes mandatory ASM participation for individual clinicians in select geographic areas. CMS believes that required participation in ASM will eliminate selection bias, yield generalizable results, and ensure an evaluable comparison group. Mandatory geographic areas are defined as core-based statistical areas (CBSAs) or metropolitan divisions defined by the Office of Management and Budget. CMS proposes to assign each clinician to a single CBSA or metropolitan division based on the ZIP code of their service locations. **CMS proposes to randomly select approximately 25% of CBSAs and metropolitan divisions to participate in ASM using a stratified sampling method.** These areas will be grouped into six distinct categories based on three factors: (1) average total Parts A and B episode spending (using 2024 data), (2) volume of eligible episodes, and (3) metropolitan division status.

CMS proposes to exclude Rural Health Clinics and Federally Qualified Health Centers, as well as any CBSAs or metropolitan divisions with no eligible clinicians between January 1, 2024 and December 31, 2024. **However, clinicians who provide services at Critical Access Hospitals that are paid under Method I would be required to participate given that these services are paid under the Medicare PFS.** CMS considered excluding AHEAD geographies from ASM's mandatory CBSA or metropolitan divisions but determined that ASM would not interact with the payment methodology in AHEAD and may help align clinicians toward the goals of AHEAD.

CMS proposes to identify individual clinicians to participate in ASM using TIN/NPI, which is the method used by QPP. This method will allow CMS to create a direct comparison of specialist performance with more granular performance data allowing for more meaningful assessment among peers. CMS also plans to use TIN/NPI to determine whether clinicians meet the APM participant eligibility criteria. Finally, identifying ASM participants at the TIN/NPI level

will allow CMS to identify claims for a single provider who bills under multiple TINs. This is the same method used by QPP. CMS proposes that clinicians who meet the ASM participant eligibility criteria would be exempt from MIPS reporting for any ASM Performance year that they meet ASM eligibility. Any ASM participant who notifies CMS of a change in TIN during an ASM performance year would no longer be required to meet ASM requirements and would instead be subject to MIPS reporting obligations.

For the heart failure cohort, CMS proposes to only include clinicians with a cardiology specialty code because they are well positioned to improve outcomes by addressing the root cause of illness. CMS considered including clinicians in other cardiac specialties such as cardiac surgery and interventional cardiology, however, these specialists don't commonly participate in managing patient care longitudinally. CMS proposes to identify specialty type based on the specialty code indicated on the plurality of a clinician's Medicare Part B claims. CMS is seeking comment on whether to use the Provider Enrollment, Chain, and Ownership System (PECOS) codes and/or the Health Care Provider Taxonomy Codes to identify specialists for ASM.

For the low back pain cohort, CMS proposes to include several surgical and nonsurgical specialties that commonly manage long-term relationships with patients with low back pain, including: anesthesiology, interventional pain management, neurosurgery, orthopedic surgery, pain management, and physical medicine and rehabilitation. As with the heart failure cohort, CMS proposes to identify specialty type based on the specialty code indicated on the plurality of a clinician's Medicare Part B claims.

If approved, only clinicians who furnish 20 or more attributed low back pain or heart failure services would be identified as ASM participants. CMS proposes to identify heart failure and low back pain participants using the volume of episodes attributed to a TIN/NPI in accordance with MIPS episode-based cost measures (EBCMs). **An episode is initiated when a clinician submits a professional claim for at least two separate services, provided to a single beneficiary, that are clinically related to the chronic condition being assessed.** For the heart failure EBCM, CMS will also check that the clinician prescribed at least two condition-related prescriptions on two different days to two different patients within a calendar year to ensure attributed clinicians are involved in providing ongoing chronic care management. CMS believes that this threshold is appropriate for identifying ASM participants that can be held accountable for quality and cost related to ASM targeted chronic conditions.

CMS proposes to identify preliminarily eligible ASM participants using the ASM participant eligibility criteria and applicable data from CY 2024 for PY 2027. CMS expects to release this information by the end of CY 2025. To finalize participants for performance year 2027, CMS proposes to confirm that the preliminarily eligible ASM participants continue to meet the ASM eligibility criteria using data from CY 2025. Selected participants for PY 2027 will be released by the end of July 2026. Beginning with PY 2028, CMS proposes to identify ASM participants by using applicable data from the calendar year 2 years prior. CMS proposes to identify ASM participants on an annual basis and intends to make this information public by the end of July in the year preceding the start of the applicable ASM performance year.

HCTTF is generally supportive of CMS' proposals related to specialist identification for ASM participation. In particular, we support the approach to use specialists' geography with a

stratified sampling methodology to identify mandatory participants. We also support the identification of the specialties identified for both cardiology and low back pain episodes, including the use of claims to both identify clinicians and create episodes. In addition, we support the exclusion of RHCs and FQHCs from ASM. **However, HCTTF recommends the low volume threshold be raised to 30 episodes and allow specialists to pool with others in their practice to help address small volume variation, as noted above.** CMS should also provide technical assistance to small and independent practices to help them prepare for the model.

XIII. ASM Scoring

CMS proposes to evaluate participants' performance through a combination of weighted cost and quality metrics, adjustments for improvement activities and promoting interoperability, and bonuses for complex patients and small practice adjustments. Overall, this formula contains the same scoring factors as MIPS, with some differences in application.

Unlike traditional MIPS, ASM requires clinicians to select quality measures from a specific set designed to be relevant to their specialty type and to the chronic condition (Figure). Clinicians will only be evaluated against other clinicians who treat the same condition (heart failure or low back pain). Quality and cost metrics are not adjusted for risk factors impacting patient populations. Like MIPS, a complex patient adjustment is added separately, determined by the Hierarchical Condition Category (HCC) risk score and the proportion of dual-eligible enrollees. ASM also includes a small practice bonus that is larger than in MIPS, as well as an additional bonus for solo practitioners.

Under MIPS, all providers are evaluated against a static target score announced in advance. **For ASM, CMS will not create a static target but will instead calculate a median score based on the final score of all providers in each cohort (heart failure and low back pain).** Providers who score above the median will receive positive payment adjustments, while providers who score below the median will be subject to negative payment adjustments.

Figure: Proposed ASM Quality Measures

	Proposed Measures	Other measures under consideration
Heart Failure	• Risk-standardized acute unplanned cardiovascular-related admission rates for patients with heart failure • Heart failure: beta-blocker therapy for left ventricular systolic dysfunction • Heart failure: angiotensin-converting enzyme inhibitor or angiotensin receptor blocker or angiotensin receptor-neprilysin inhibitor therapy for left ventricular systolic dysfunction • Controlling high blood pressure	• Patient activation measure • Advance care plan • Clinician and clinician group risk-standardized hospital admission rates for patients with multiple chronic conditions • Cardiac rehabilitation patient referral from an outpatient setting

	• Functional status assessments for heart failure	
Low Back Pain	• Magnetic resonance imaging (MRI) lumbar spine for low back pain, respecified to be relevant to ASM participants treating low back pain • Use of high-risk medications in older adults • Preventive care and screening: screening for depression and follow-up plan • Preventive care and screening: body mass index screening and follow-up plan • Functional status change for patients with low back impairments	• Patient activation measure • Falls: plan of care

HCTTF is generally supportive of CMS' proposals related to quality measures and performance. In particular, we applaud CMS for selecting clinically relevant quality measures and comparing ASM specialists against others participating in the model. **However, as noted above, HCTTF recommends that CMS enhance the incentives for specialist performance by: (1) reducing the lag time between performance and payment, (2) setting the threshold in advance using the cohort median from a previous year, and (3) providing specialists with data on their performance. In addition, HCTTF recommends that CMS remove any quality measures that have been topped out.**

HCTTF also recommends that CMS address small volume variation by risk adjusting the quality measures, in addition to raising the low volume threshold and allowing specialists to pool with others in their practice. Without risk adjustment in the cost or quality metrics, physicians treating higher-risk populations will face more difficulty in consistently achieving high scores on cost and quality, which constitute a majority of the formula to determine payment adjustment. While HCTTF acknowledges that CMS seeks to address this through bonuses to clinicians treating high-risk patients, as well as solo practitioners, we believe these policies do not adequately address statistical variation within a mandatory model. **Ultimately, improving the accuracy of quality scores – through risk adjustment, pooling, and higher minimum volumes – will increase the effectiveness of ASM at driving specialist performance and rewarding high-quality care.**

HCTTF supports the inclusion of clinical outcomes and patient-reported outcomes in the proposed ASM quality measures. For example, HCTTF supports the adoption of the functional status assessment for heart failure, although we also recommend that CMS monitor to ensure that data collection is feasible and does not add extreme burdens for patients or providers. In addition, HCTTF recommends that CMS establish a process to add or remove quality measures to adjust for advances in evidence over the course of ASM. For example, the American Heart Association anticipates that, starting in 2027, they may not support the measure related to beta-blocker therapy for heart failure because it will be topped out. In addition, measures may change due to new clinical evidence, which would complicate longitudinal measure tracking.

XIV. MIPS Value Pathways (MVPs)

CMS proposes to freeze the performance threshold at 75 points for the next three years. This would apply from the CY2026 performance period/2028 MIPS payment year until the CY2028 performance period/230 payment year.

CMS proposes to add six new MVPs for reporting starting in the CY2026 performance period:

- Diagnostic Radiology
- Interventional Radiology
- Neuropsychology
- Pathology
- Podiatry
- Vascular Surgery

CMS also proposes to modify all existing MVPs to align with updates to the quality measure and improvement activities inventory. CMS proposes that Qualified Clinical Data Registries would have one year to fully support a new MVP after it is finalized.

Starting in the 2026 performance period, CMS is proposing that multispecialty groups will no longer be able to report MVPs as a single group. Provider groups would attest to their specialty and report as subgroups or individuals. CMS proposes exceptions for small practices to allow them to continue reporting as a single group, in acknowledgement of small groups' resource constraints and low volume, which would add to statistical unreliability.

HCTTF continues to support the underlying concept behind the MVPs, and we see the value in a mechanism that has the potential to create a streamlined glidepath for providers to participate in Advanced APMs. **In particular, HCTTF has long advocated for CMS to encourage sub-group reporting and supports CMS' decision to require this for multi-specialty practices, with appropriate exemptions for small practices.** In addition, we believe the following recommendations would strengthen the MVP program:

- Encourage additional sub-group reporting and the integration of specialty care measures into the MVP and other value-based programs. In particular, HCTTF urges CMS not to restrict sub-group participation population to specialty providers. Primary care practices may have different specialties that report to the MVP. Therefore, restricting sub-group participation conflicts with the goal of aligning primary care practices with Advanced APMs.
- MVPs occur within a fee-for-service (FFS) system that does not provide the stability and flexibility offered by prospective payments. The use of Total Per Capita Cost (TPCC) and similar measures in MVPs will serve as a deterrent to participation in MVPs and in APMs in the future.

Collectively, these changes support providers as they operationalize MVPs.

XV. APP Plus and QP Thresholds

CMS proposed policies related to the APP Plus measure set and QP thresholds that impact ACOs and other Advanced APM Model Participants. HCTTF summarized these provisions and provided our feedback in the MSSP section above.

XVI. Request for Information (RFI): Transition to Digital Quality Measurement

CMS is seeking information on the transition toward digital quality measurement and the HL7 FHIR standard. In particular, CMS is seeking ACO experience with the transition to FHIR-based eCQM reporting.

HCTTF has repeatedly expressed the concern that the move to eCQM adoption is weakening incentives to participate in MSSP. The large financial outlay and operational complexity of implementing these measures is already impacting ACO network participation decisions. As many ACOs have shared with CMS, the eCQM requirements are extremely expensive and major electronic health record (EHR) vendors do not yet have standard processes to support their implementation. HCTTF appreciates CMS releasing this RFI to learn more about the challenges that organizations are facing related to eCQM adoption.

Additionally, HCTTF strongly supports the acceleration of Bulk FHIR and Electronic Health Information (EHI) Export requirements. Timely and efficient access to large datasets is fundamental for analytics, population health management, and supporting value-based care models. To ensure meaningful implementation, we urge CMS to establish clear performance standards for these requirements, including metrics for data completeness, accuracy, and timeliness. This will help prevent delays and ensure that health care organizations can effectively leverage these capabilities to improve patient care and operational efficiency.

To fully realize the potential of FHIR for comprehensive data exchange and interoperability, HCTTF urges CMS to advocate for and support the enhancement of FHIR standards to include robust write capabilities. This is critical for enabling bidirectional data flow, which is essential for effective care management, population health initiatives, and clinical research. Furthermore, FHIR standards are not enough: organizations need strong governance frameworks, clear data provenance, and comprehensive audit trail capabilities to ensure data integrity, security, and trustworthiness, particularly as data exchange becomes more widespread and complex.

CHRONIC DISEASE PREVENTION & MANAGEMENT

XVII. Skin Substitutes

CMS is proposing to address waste, fraud, and abuse by changing payment mechanisms for skin substitutes. This builds on previous CMS actions to address the potentially fraudulent billing that ACOs identified and flagged for CMS review. CMS proposes to systemically change the payment structure for skin substitutes effective January 1, 2026. As proposed, skin

substitutes would be paid as incident-to supplies and grouped into three payment categories based on their FDA regulatory pathway. In 2026, CMS would calculate a single payment rate across all three categories based on hospital outpatient utilization patterns. In 2027, CMS would use the volume-weighted Average Sales Price for each category, with payment rates updated through rulemaking.

HCTTF strongly supports CMS' efforts to eliminate waste, fraud, and abuse related to skin substitutes. We applaud CMS for this proposal to change the reimbursement structure for skin substitutes, which will reduce wasteful spending. We believe this will help address ongoing concerns related to suspicious billing activity for these services, which were originally flagged to CMS by ACOs. This illustrates the essential role of ACOs in identifying and eliminating fraud, waste and abuse. ACOs have direct incentives and the technical capability to comb through CMS data to identify and root out fraud. Therefore, **ACOs present a key partner for CMS in identifying and eliminating waste, fraud, and abuse.**

CMS should continue to support ACOs to protect taxpayer dollars and ensure that Americans are getting appropriate care. We remain concerned about broader significant, anomalous, and highly suspect (SAHS) billing practices that can distort ACO performance metrics. Such billing can unfairly penalize high-performing ACOs and undermine the integrity of value-based payment models. High-value ACOs are penalized when fraudulent billing is included as part of national and regional benchmarking calculations. We encourage CMS to implement robust data analytics and oversight mechanisms to identify and mitigate these distortions, ensuring that ACO performance is accurately measured and appropriately rewarded based on true value delivery. **In addition, CMS should remove skin substitute and other fraudulent payments from benchmark and performance year financial calculations for performance years 2025 and prior.**

XVIII. Medicare Diabetes Prevention Program

CMS proposes updates to the Medicare Diabetes Prevention Program (MDPP) to increase access to this program through telehealth through 2029. Specifically, CMS proposes that MDPP clinicians would be allowed to deliver services asynchronously online, allowing the live coaching to occur via email or text messages. CMS also proposes a new G-code and payment for online sessions, which will allow the agency to monitor and evaluate this change. To account for these new delivery options, CMS proposes additional flexibilities to allow the beneficiary to self-report their weight and have it documented in their medical record within two days of the MDP session, rather than the same day.

HCTTF strongly supports the proposed changes to MDPP, which will increase access to this evidence-based program to prevent and treat diabetes. We believe CMS is making important investments to modernize and expand the use of this critical program. To overcome the limited availability of MDPP, CMS should also set a clear goal of transitioning the model into a permanently covered Medicare benefit, which could entice more clinicians to join.

XIX. RFI: Prevention & Management of Chronic Disease

CMS included an RFI on how to better support chronic disease prevention and management. In particular, the agency is seeking feedback on whether to create separate coding and payment for services related to social isolation and loneliness, intensive lifestyle interventions, medically tailored meals, digital therapeutics, and motivational interviewing. CMS is also looking for ideas to increase uptake of annual wellness visits (AWVs).

HCTTF believes that successful behavior change is fundamental to better health outcomes for those living with or at risk of chronic physical and/or behavioral health conditions. Clinicians can support behavior change through a trusted partnership with patients and caregivers. However, the predominant FFS reimbursement system does not support robust, team-based care to deliver holistic preventive care and chronic disease management. In contrast, **ACOs and other value-based models support more integrated, prevention-oriented care that includes BHI, nutrition and exercise advice, and other services to help patients achieve their health and wellness goals.**

There is strong evidence supporting a range of interventions to support behavior change, including coaching, motivational interviewing, intensive lifestyle interventions, and shared appointments. Similarly, the evidence shows that these services can be delivered in a variety of locations (outpatient primary care practices, community settings, and telemedicine) and team structures. **CMS should strengthen investments in ACOs and other value-based models to give providers incentives and flexibility to deliver this holistic care. In particular, CMS should:**

1. **Increase opportunities for ACOs to invest in capitation, which allow ACOs to create real-time incentives for clinicians to engage in preventive care (rather than waiting for over two years for potential shared savings). CMS should explore opportunities to incorporate capitation options into future total cost of care models, as well as opening the ACO Primary Care Flex Model to ACOs of all sizes and structures. Capitation options also help to better engage specialists.**
2. **Define the long-term proposition for providers to participate in total cost of care models by ensuring that providers are not penalized for their prior success in the models and establishing benchmark practices that promote fairness, accuracy, and predictability.**
3. **Unleash innovation in the models by reducing the burden of waivers and giving ACOs more flexibility by developing customized waivers.**

These changes will help to sustain ACOs and other ACOs while boosting competition through innovative pathways to further increase savings.

HCTTF is strongly supportive of CMS efforts to increase access to services that address non-medical drivers of health, including lifestyle interventions, medically tailored meals, loneliness, and digital therapeutics. We believe CMS should help clinicians identify and address these non-medical factors, which are highly relevant to patients' health and clinical outcomes. The more clinicians understand about their patients' lives, the better they can provide holistic care to patients. **CMS should explore opportunities to create incentives related to non-medical drivers of health, such as nutrition, fitness, and transportation. These incentives could be in the**

form of separate coding and payment, but could also be incorporated as wrap-around payments within ACOs and other Advanced Alternative Payment Models.

In addition, HCTTF recommends that CMS waive the statutory restrictions on scheduling annual wellness visits (AWVs), to allow AWVs to be scheduled and provided once a year at any time during that calendar year. The 12-month timeline results in arbitrary barriers to care and is also implemented differently in different regions at the discretion of the MACs. This has caused confusion, scheduling challenges, and uncompensated care.

ENHANCED CARE DELIVERY

xx. Advanced Primary Care Management & Behavioral Health

CMS proposes to create optional add-on codes for Advanced Primary Care Management (APCM) services to facilitate BHI. CMS would propose three new codes (G0556, G0557, G0558) to eliminate the time-based requirements for existing BHI and CoCM codes. These codes would supplement the existing APCM services, as established in the CY25 PFS final rule, which bundled together a set of care management and technology-based communication services. CMS believes the addition of these behavioral health codes will reduce the administrative burden for delivering BHI services, resulting in increased uptake.

HCTTF strongly supports the adoption of three new add-on codes related to behavioral health integration and psychiatric CoCM services for Advanced Primary Care Management (APCM) service codes. The development of APCM codes was designed to alleviate billing restrictions, such as time-based billing requirements and patient eligibility determinations, to grant primary care providers more flexibility to deliver advanced, team-based primary care services. Expanding APCM bundled payments through new behavioral integration add-on codes builds upon the benefits of the original APCM codes that grant primary care providers and auxiliary personnel the opportunity to be better compensated for their role in delivering collaborative and integrated psychiatric care.

Adoption of payment codes for APCM services continues to be a crucial step in moving away from FFS economics for primary care delivery and toward hybrid or population-based payments that provide more sustainable payment for primary care providers and ultimately drive higher value health care. By reducing the administrative burden of billing for individual care management services for behavioral health, providers will have more time to spend with patients rather than navigating complex billing codes. In addition, patients — who want better access to their doctors, improved communication between providers, and more personalized care — continue to benefit from APCM services, including 24/7 access to the care team, continuity of care, and comprehensive care management. The inclusion of behavioral health services as add-on codes affords providers additional flexibility to deliver services that best meet patients' needs while ensuring that primary care providers and auxiliary personnel are adequately compensated for all the work they do to meet patients' physical and behavioral health needs.

HCTTF believes that the future of primary care payments should not rely solely on code-based reimbursement. We see the addition and improvement of payment codes for APCM services as both an important achievement and a stepping stone to transition away from traditional FFS economics toward a payment system built on capitated, population-based payments that ensures providers have sustainable, predictable payments to run their businesses and meet the health needs of the patients they serve. As a result, we recommend that **CMS continue efforts to invest in primary care, streamline billing processes, and move away from the inefficiencies of traditional FFS through the advancement of more hybrid and population-based payment models that occur in conjunction with accountable care arrangements.**

In particular, the Task Force believes the APCM proposals should be refined to increase their adoption:

1. The APCM codes trigger cost-sharing for patients, which, for many patients, is a significant barrier to care – particularly since the APCM includes preventive services. Patient advocates and health care providers have long raised concerns about affordability, with specific concerns about care management and other services that trigger patient cost-sharing outside of a normal PCP visit, taking patients by surprise. This limits providers' ability to use the codes which harms patient access to care. **HCTTF believes that CMS should establish waivers for patient cost sharing for the new APCM codes, which include preventive services. Allowing providers to waive patient cost sharing for these services would mitigate access barriers and increase PCPs' adoption of these codes.**

2. This proposal is designed to be cost-neutral relative to the current care management codes. **While the APCM does not provide more funding, it does require more extensive operational requirements for PCPs.** The reporting requirements in the CY25 PFS final rule were roughly equivalent to those required in CPC Plus track 2 and are more extensive than any previously imposed through rulemaking. For example, the final rule required additional reporting through the Value in Primary Care MVP and the implementation of population health management tools. This requirement is duplicative with other QPP requirements and breaks with precedent by tying the use of individual primary care codes to quality reporting requirements. **To support the adoption of APCM codes, CMS should eliminate the reporting requirements for the use of these codes.**

With these refinements, the Task Force believes that CMS will better support the adoption of ACPM, to promote patient access to high-quality care.

Lastly, CMS is clarifying that both marriage and family therapists and mental health counselors, in addition to clinical social workers, can bill Medicare directly for community health integration (CHI) and principal illness navigation services they perform for the diagnosis or treatment of mental illness. The Task Force supports this proposal, which will expand access to care.

XXI. RFI: Advanced Primary Care Management & Preventive Services

CMS issued an RFI on the inclusion of preventive care within the APCM bundle. CMS believes that some of the current services included in the APCM may be considered preventive care and is seeking feedback on whether to include additional preventive services within the bundle. In particular, CMS is seeking feedback on how CMS should apply cost-sharing to APCM services.

HCTTF strongly agrees with CMS that the APCM includes preventive care services. Clinically, the blending of prevention and treatment is inseparable in a primary care setting, because primary care teams must often balance prevention and treatment in the life of the individual patient. Currently, the APCM codes trigger cost-sharing for patients, which is a significant barrier to care for many patients. Patient advocates and health care providers have long raised concerns about affordability, with specific concerns about care management and other services that trigger patient cost-sharing outside of a normal PCP visit, taking patients by surprise. This limits providers' ability to use the codes and therefore harms patient access to care. **HCTTF believes that CMS should establish waivers for patient cost sharing for the APCM codes starting in 2026, in recognition of the fact that the APCM includes preventive services.** HCTTF does not recommend that CMS apply a partial co-pay reduction, as this would be burdensome for CMS, providers, and patients. **CMS should allow providers to fully waive patient cost sharing for these services to mitigate access barriers and increase PCPs' adoption of these codes, thus increasing CMS' investment in preventive care and chronic condition management.**

More broadly, HCTTF believes that APCM should align with MSSP and other accountable care arrangements, to achieve the broader goal of improving patient outcomes while reducing costs. Prospective payment of APCM and the proposed BHI add-on codes is a constructive step that could help MSSP ACOs develop operational pathways for receiving prospective payment and distribute them to participating practices. However, this policy alone is not sufficient. CMS should accelerate primary care participation in value-based care by:

- Removing spending on APCM services and BHI add-on services from the expenditures compared against spending benchmarks in MSSP.
- Offering all MSSP ACOs a primary care capitation option.
- Reopening the ACO Primary Care Flex Model to a new cohort of applicants in 2026 for a January 1, 2027 start.

These policies would accelerate the transition to global risk, with a strong focus on prevention, in alignment with the new CMS strategy.

XXII. Telehealth

CMS proposes to increase access to telehealth services by granting providers additional flexibilities and streamlining administrative processes. In particular, CMS proposes to:

- Permanently lift the frequency limits on subsequent inpatient, nursing facility, and critical care consultations.
- Permanently allow virtual direct supervision.

- Add five services to the 2026 Medicare Telehealth List using the appropriate audio-only or audio-video modifier on the E/M code.
- Simplify the process for adding services to the Medicare Telehealth List by streamlining the current five-step process to a three-step process.

However, CMS proposes to limit virtual teaching physician billing for services involving supervision of residents to non-metropolitan areas.

HCTTF is broadly supportive of CMS' proposals to streamline and increase access to telehealth services. We believe these changes will increase patients' access to high-quality care while reducing administrative burden for providers. In particular, we strongly support CMS' proposal to simplify the review process for adding services to the Medicare Telehealth Services List and eliminate the "provisional" status for telehealth services. We also support CMS' proposal to permanently remove frequency limitations on Medicare telehealth services for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations. However, we have concerns about CMS's proposal to limit virtual teaching options outside of rural areas, as we believe this may exacerbate challenges related to workforce training. **HCTTF has long supported expanded access and reimbursement for telehealth services through PFS. Granting all services permanent status on the Medicare Telehealth Services List is particularly important because it provides stability, ensuring that providers investing in telehealth technology will be able to continue billing those codes in future years.**

XXIII. Home-Based Care

CMS proposes to expand billing for G2211 add-on codes to include home and residence visits. As discussed above, this code is an add-on payment for complex payments that can be combined with other preventive care services.

HCTTF strongly supports this proposal to empower primary and preventive care, particularly for complex patients who are living in nursing homes and other residential settings. Essential medical care is delivered across a wide variety of settings, including patients' homes and nursing facilities. Adoption of this proposal would grant primary care physicians additional payment flexibilities, allowing them to provide coordinated, longitudinal care to more patients nationwide.

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The Task Force appreciates the opportunity to provide feedback on the CY2026 PFS Proposed Rule. Please contact Theresa Dreyer, the CEO of HCTTF (theresa.dreyer@hcttf.org), with questions related to these comments.

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