September 10, 2026

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Re: CY 2027 Physician Fee Schedule and the Medicare Shared Savings Program (CMS–1848–P)

The Health Care Transformation Task Force (HCTTF) appreciates the opportunity to share recommendations on the Calendar Year (CY) Physician Fee Schedule (PFS) and Medicare Shared Savings Program (MSSP) Requirements (CMS–1848–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 dedicated to driving outcomes, access, and affordability through accountable care. We represent a diverse set of organizations from across the industry – including providers, payers, purchasers, and consumer/patient advocacy organizations – that share a common commitment to deliver better health through high-quality care at reduced costs.

Our comments address (1) Primary Care Investments (section II-III of the proposed rule), (2) Proposals to the Medicare Shared Savings Program (MSSP) (section III of the proposed rule), (3) Updates to the Ambulatory Specialty Model (ASM) (section III of the proposed rule), and (4) Proposals to the Medicare Quality Payment Program (QPP) (section IV of the proposed rule).

Primary Care Investments

I. Primary Care Payment and Service Updates

Background & Proposal

CMS proposes several policies intended to strengthen primary care payment and expand access to primary care and related services. These include:

- Maintaining the higher PFS conversion factor for clinicians participating in Advanced Alternative Payment Models (APMs), as required by statute.
- Converting the G2211 visit complexity add-on from a separate flat-rate payment to a percentage-based modifier on evaluation and management (E/M) services, with a higher adjustment for clinicians participating in eligible Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs)
- Establishing new codes for advance care planning (ACP) services furnished under physician supervision.

- Establishing payment for diabetes self-management training and medical nutrition therapy in Rural Health Clinics (RHCs)
- Extending telehealth flexibilities for RHCs and Federally Qualified Health Centers (FQHCs).
- Establish separate coding and payment for shared medical appointments, as well as completing the behavioral health code valuation transition by incorporating tobacco cessation and Screening, Brief Intervention, and Referral to Treatment (SBIRT) services.

Collectively, CMS intends for these proposals to expand and standardize access to comprehensive primary care.

HCTTF Recommendations

HCTTF is strongly supportive of CMS's continued investment in primary care and appreciates the agency's efforts to better recognize the resources required to provide longitudinal, coordinated, and comprehensive care. HCTTF supports maintaining the higher payment rate for clinicians participating in Advanced APMs, as well as CMS's proposals related to ACP, shared medical appointments, and behavioral health services. We strongly support the additional payments and telehealth flexibilities for RHCs and FQHCs. These policies can help strengthen the primary care infrastructure necessary to support continued movement toward accountable, value-based care.

HCTTF supports the goal of appropriately recognizing the complexity of longitudinal primary care through G2211, including CMS's effort to strengthen incentives for clinicians participating in ACOs. However, we encourage CMS to carefully consider the implications of converting G2211 from a flat-rate add-on payment to a percentage-based modifier. This change may have unintended consequences for employed physicians whose compensation arrangements are tied to relative value units (RVUs) and coding. CMS should assess whether the proposed methodology appropriately recognizes the work associated with these services without inadvertently disrupting physician compensation arrangements.

II. Request for Information (RFI) on Redesigning Primary Care

Background and Proposal

CMS seeks stakeholder input on novel approaches to redesign primary care payment. Questions focus on provider and ACO readiness, payment design and operations, global primary care payments, clinical outcomes and accountability.

HCTTF Recommendations

HCTTF applauds CMS's continued efforts to reform and improve primary care payment, including added investment in primary care through PFS. We urge CMS to continue its efforts to correct for the longstanding underpayment of primary care, as well as the focus on alternative payment methodologies as the core reimbursement for primary care through Medicare. To this effort, the Task Force offers input related to two areas of high-impact within the RFI:

1. Prospective Primary Care Payment in MSSP
2. Primary Care "Global Period" Payment outside MSSP.

We thank CMS for the opportunity to offer meaningful policy solutions to invest in comprehensive primary care, supported by APMs.

Prospective Primary Care Payment *in MSSP*

HCTTF supports CMS's exploration of prospective primary care payment (PPCP) within MSSP as a means of increasing investment in primary care and supporting more comprehensive, longitudinal care. The PPCP should:

- Provide predictable, prospective payments that are meaningfully higher than FFS
- Reduce reliance on visit- or productivity-based payment
- Allow primary care practices in ACOs to receive payments directly at the practice level

HCTTF also encourages CMS to make PPCP broadly available to all MSSP ACOs, because comprehensive primary care is foundational to accountable care regardless of risk level. In addition, CMS should ensure appropriate financial protections for participating ACOs, such as benchmark adjustment to account for any increased investment in primary care.

HCTTF encourages CMS to design PPCP in a manner that provides clear, predictable cash flow by avoiding retrospective payments to reconciliation or claw backs. Historically, most CMS and CMMI models with prospective payments have involved retrospective reconciliation. As a result, many participants were concerned the prospective payments may be clawed back. Therefore, these participants did not use the funding for up-front investments in care delivery, because they otherwise would not have the cash reserves available to pay any losses. Instead, **HCTTF recommends that CMS pursue prospective payments that function like true capitation, by paying predictable amounts up front without retrospective reconciliation, similar to the Primary Care Flex Model within MSSP.**

HCTTF also encourages CMS to provide flexibility in the services and levels of primary care supported through PPCP. A base payment could support core primary care functions, including E/M services, care management, and screening and referral for behavioral health and non-medical drivers of health. Higher payment tiers could support more comprehensive integration of behavioral health, health promotion, and social care. CMS should also establish appropriate payment guardrails to facilitate participation by FQHCs and RHCs, without disrupting existing PPS and AIR payment levels.

Finally, CMS should prioritize payment predictability and appropriate accountability in designing PPCP. Prospective attribution may provide greater certainty than retrospective attribution, while policies like the voluntary alignment option in ACO REACH would allow practices to account for new patients throughout the year. Payment arrangements should include clear outcome measures without creating unnecessary reporting burden.

Primary Care "Global Period" Payment across FFS

HCTTF supports CMS's consideration of prospective, population-based payment for primary care in Original Medicare. Traditional FFS payment does not adequately capture the full scope of comprehensive, longitudinal primary care, including care coordination, patient communication, and other services provided outside of discrete visits. **While improvements to PFS valuation remains important, CMS should use this opportunity to begin transitioning primary care payment away from FFS and toward more flexible, predictable population-based payments.**

HCTTF encourages CMS to consider a hybrid prospective payment as a practical pathway toward this transition. Such a model could provide a prospective payment for a defined set of

core primary care services while retaining FFS payment for services outside the bundle, giving practices greater flexibility and predictable resources while allowing CMS to build toward more comprehensive population-based payment over time.

HCTTF also encourages CMS to make any prospective primary care payment broadly available to primary care providers in Original Medicare rather than limiting participation to providers participating in ACOs or other accountable care. Broader availability would allow practices to gain experience with prospective payment and create a pathway for more providers to eventually participate in advanced APMs. CMS should also ensure that the payment supports a sufficiently broad range of primary care services—including care management, E/M services, communication, preventive care, and behavioral health and social needs integration—rather than simply repackaging existing care management payments. We also caution CMS that practices outside of ACOs may require additional technical assistance than those in ACOs, who would benefit from the ACO infrastructure and experience with risk.

Medicare Shared Savings Program (MSSP) Proposals

III. Financial Methodology and Benchmarking

Background & Proposal

CMS proposes several changes to MSSP financial methodology intended to refine ACO benchmarks and shared savings calculations. Specifically, CMS proposes to:

- For ENHANCED ACOs, increase the weight of the prior savings adjustment from 50 percent to 75 percent, while reducing the maximum weight of the regional adjustment from 50 percent to 35 percent.
- Increase the Level E sharing rate from 50 percent to 60 percent.
- Risk adjust the 5% cap on upward adjustment to the historical benchmarks to account for an ACO's case mix.
- Establish a growth adjustment to the historical benchmarks for ACOs that add inexperienced value-based care providers who serve beneficiaries new to accountable care. This would be added to existing benchmark adjustments, not to exceed the 5% cap.
- Introduce guardrails for the Accountable Care Prospective Trend (ACPT) at no more than 1 percentage point below and no more than 1.5 points above observed national spending growth, to limit projection errors. This would be applied retroactively.

HCTTF Recommendations

HCTTF is pleased to see that CMS is seeking to grow participation in MSSP while promoting sustainability for long-term participants in the program. **ACOs that have participated in MSSP over many years face substantial challenges to remaining in the program, due to the ratchet effect that penalizes ACOs for previously obtaining savings.** While we understand that CMS is seeking to mitigate the impact of the ratchet effect, we believe that these proposals will not effectively address this problem.

CMS should develop benchmark methodologies that provide successful ACOs with a sustainable opportunity to continue generating savings and invest in innovation over multiple agreement periods. CMS should also ensure that the MSSP benchmarking policies remain consistent with its broader movement toward regional benchmarking in other accountable care models. For example, the LEAD Model eliminates periodic rebasing during its 10-year performance period, recognizing the importance of providing ACOs with a predictable opportunity to sustain savings and investment over time. Weakening the regional efficiency adjustment in MSSP would move in the opposite direction and could undermine the longer-term transition toward regional, sustainable benchmarking. **HCTTF recommends allowing ACOs to benefit from both the prior savings and regional efficiency adjustments, rather than requiring ACOs to rely on only one of these mechanisms. This approach would provide greater protection against the effects of rebasing and better preserve incentives for high-performing ACOs to sustain investments in care transformation over multiple agreement periods.**

In addition, the 5% cap on upward benchmark adjustments prevents many ACOs from realizing the full value of the savings they have generated. ACOs make substantial investments in person-centered care – including care coordination, population health initiatives, health information technology, and beneficiary education – which represent non-billable care. As a result, the gap between the benchmark and the resources required to deliver high-quality outcomes become more disconnected over time, particularly as ACOs enter their third or more contract period. **Therefore, while HCTTF supports CMS's proposal to risk adjust the cap to account for the ACOs case mix, we believe this change alone does not address the underlying challenges that the 5% cap creates**. **HCTTF recommends raising to cap to at least 7%, potentially by offering a tiered cap based on the ACO's length of participation.**

Similarly, while we appreciate CMS increasing the weight on the prior savings adjustment, this change also does not adequately address the ratchet effect. **In combination with the proposed reductions to the regional efficiency adjustment, the net effect for many long-term participants will be limited or even negative.** This change will disproportionately affect ACOs that achieved regional efficiency early in their participation. These ACOs may have fewer opportunities to generate additional savings, particularly because the prior-savings component considers only the final three years of an agreement period rather than an ACO's complete savings history. Importantly, regional efficiency should not be treated as self-sustaining. ACOs must make ongoing investment in care transformation to keep regional spending levels low. The challenge is compounded by the fact that ACOs manage a continually changing patient population, meaning savings achieved for beneficiaries early in an agreement period must be replicated as beneficiaries enter and leave the ACO. Regional efficiency therefore reflects sustained care transformation rather than passive maintenance. Thus, CMS's proposals may have the unintended consequence of further reducing incentives for long-term ACOs to maintain investments in care transformation.

HCTTF recognizes that the ACPT is another component of the methodology intended to address the ratchet effect, and we applaud CMS's efforts to make the ACPT methodology fair and accurate. **We strongly support the proposed ACPT guardrails and appreciate CMS's decision to apply these guardrails retroactively. We thank CMS for their attention to stakeholder feedback on this important issue.**

We also support CMS's goal to increase participation in ACOs and give organizations time to build capacity for risk. HCTTF supports the proposal to increase the Track E shared savings rate, which will give ACOs more incentive to remain in this track longer as they build capacity for full risk. We also support the growth incentive, but although we believe that few ACOs will benefit from it unless CMS also raises the 5% cap.

IV. Beneficiary Alignment and Engagement

Background & Proposal

CMS proposes several changes to beneficiary alignment within MSSP, including:

- Excluding primary care services billed through non-ACO TINs when assigning beneficiaries to an ACO, beginning in 2028.
- Standardizing prospective assignment eligibility so that beneficiaries need only one month during the 12-month assignment window in which they are enrolled in both Medicare Parts A and B without other Medicare coverage (effective in 2028).
- Updating the definition of primary care services used for assignment to align with other PFS changes in 2027, to include SBIRT, ACP & Vaccine Adverse Effects Management.

CMS further proposes allowing approved ACOs to reduce or eliminate Part B cost sharing for certain services, which would replace the current prepaid shared savings option. In addition, CMS proposes to substantially simplifying beneficiary notification requirements by requiring notification only once per agreement period and eliminating required follow-up communications.

HCTTF Recommendations

HCTTF is broadly supportive of CMS's proposed beneficiary alignment and engagement policies. **In particular, we strongly support proposals to provide beneficiary cost sharing waivers and streamline beneficiary notification requirements.** These changes reflect longstanding stakeholder concerns and can reduce unnecessary administrative burden, while providing ACOs with additional tools to engage beneficiaries in accountable care.

HCTTF also supports CMS's efforts to standardize beneficiary eligibility but encourages the agency to carefully evaluate potential unintended consequences associated with beneficiaries transitioning from Medicare Advantage (MA) to fee-for-service Medicare. **We encourage CMS to fairly assess how risk scores are carried forward for these beneficiaries, to ensure that incomplete information does not artificially disadvantage ACOs in subsequent benchmark calculations.**

Furthermore, we also request that CMS clarify whether the proposed streamlined beneficiary notification requirements apply to retrospective ACOs. While the proposed language refers to "all ACOs," explicit clarification would provide certainty to organizations and eliminate unnecessary implementation questions.

V. MSSP Quality Reporting

Background & Proposal

CMS proposes several changes to MSSP quality reporting and benchmarking, including:

- Modifying quality reporting rules to allow ACOs to exclude certain participant TINs from data submission, while maintaining the 75% data completeness threshold and the 95% beneficiary representation standards.
- Continuing the MIPS CQM reporting option and associated incentive beyond 2026.
- Maintaining flat benchmarks for Medicare CQMs and expanding that approach to additional measures (diabetes & high blood pressure)
- Aligning the population used for Medicare CQM reporting with an ACO's assigned beneficiary population
- Establishing a Medicare eCQM reporting option that requires data for only Medicare beneficiaries, rather than all payers.

CMS also proposes revisions to the APP Plus measure set, resulting in an eight-measure set for 2027 (Figure), representing the removal two measures: adult immunization and the substance use disorder initiation and engagement measures.

Lastly, CMS proposes to replace the existing requirement to report all Promoting Interoperability measures across the ACO with more flexible approaches for demonstrating use of certified electronic health record technology, including through digital quality reporting or attestation. CMS also proposes allowing qualifying ACOs to use certain TIN-level exclusions without prior CMS approval, accompanied by new public reporting requirements.

Figure: Proposed APP Plus Measures

	APP Plus Measures	Collection	First Year
321	Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS	CAHPS for MIPS Survey	2025
479	Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups	Claims	2025
484	Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	Claims	2026
001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control	eCQM, Medicare eCQM, Medicare CQM	2025
134	Preventive Care and Screening: Screening for Depression and Follow-up Plan	eCQM, Medicare eCQM, Medicare CQM	2025
236	Controlling High Blood Pressure	eCQM, Medicare eCQM, Medicare CQM	2025
112	Breast Cancer Screening*	eCQM, Medicare eCQM, Medicare CQM	2025
113	Colorectal Cancer Screening*	eCQM, Medicare eCQM, Medicare CQM	2026

HCTTF Recommendations

HCTTF is broadly supportive of CMS's proposed MSSP quality reporting changes. We also support the updated APP Plus measure set, which represents a judicious and appropriate list of

quality measures. **HCTTF also encourages CMS to reconsider the proposed denominator exclusion for the Depression Screening and Follow-Up Plan measure to ensure that the change reduces, rather than adds to, reporting complexity.**

HCTTF appreciates the agency's efforts to provide ACOs with greater flexibility while continuing the transition toward digital quality measurement (dQM) through Fast Interoperability Healthcare Resources (FIHR). As CMS pursues this transition, HCTTF emphasizes that modernization must involve more than replacing one technical reporting format with another. For example, the CMS policy to require eCQM reporting to be drawn from a single electronic health record (EHR) is out of date. Instead, ACO should be able to use all available data to report the most accurate quality measurements of their patients. EHRs are increasingly dependent on one another for completeness, with the growing use of TEFCA and CMS's Health Technology Ecosystem, as well as with Application Programming Interface (APIs) and other means of data exchange. CMS recognizes this interconnectedness in other policies, such as the HEDIS Electronic Clinical Data Systems (ECDS) Reporting requirements that include four data types. **FHIR-based reporting should enable ACOs to use all available and reliable data to develop the most complete picture of patient quality, including information obtained through direct laboratory feeds, claims, EHRs, and other appropriate sources. CMS should avoid recreating the existing siloed reporting environment through a new technical standard.**

HCTTF strongly supports the proposal to allow qualifying ACOs to exclude certain participant TINs from quality reporting requirements. This will increase the opportunity for small and rural practices to join and remain in ACOs, which current reporting requirements discourage. To maximize the inclusion of these providers, CMS should provide a specific list of the types of TINs that qualify for these exclusions. Greater specificity will allow ACOs to determine eligibility prospectively and reduce uncertainty and administrative burden during implementation. Greater specificity will allow ACOs to determine eligibility prospectively and reduce uncertainty and administrative burden during implementation. **HCTTF also supports applying these changes retroactively to PY 2026, which would reduce burden and uncertainty for ACOs during the upcoming quality reporting period. CMS should also ensure that this exclusion applies when a CEHRT product does not support the applicable APP Plus measures, regardless of whether the product is specifically designed for specialty use.**

HCTTF also encourages CMS to use an ACO's final assigned beneficiary population as the starting population for calculating the proposed 95% data completeness threshold. This approach would more appropriately account for differences between prospective assignment and the performance year and ensure that the calculation reflects the beneficiaries for whom ACOs remain accountable.

HCTTF also supports continuing the MIPS CQM reporting option and associated incentive beyond 2026, as well as the continued use of flat CQM benchmarks. These approaches provide important flexibility to ACOs and address challenges that can arise when benchmark distributions produce counterintuitive results. **Most importantly, reporting policies should allow ACOs to use the full range of reliable clinical information available to them to accurately measure the quality of care delivered to patients.**

HCTTF strongly supports aligning the population used for Medicare CQM reporting with an ACO's assigned beneficiary population, and urges CMS to implement this change beginning in 2026 rather than waiting until 2027. This alignment more appropriately reflects the Medicare beneficiaries for whom an ACO is accountable and addresses an issue that HCTTF has previously raised with CMS.

HCTTF also supports providing ACOs with multiple options for demonstrating CEHRT use. We appreciate CMS's work to minimizes unnecessary administrative burden, by providing flexibly through multiple compliance pathways. We encourage CMS to provide additional operational detail regarding how each option would be satisfied before implementation, so ACOs have sufficient clarity to assess which pathway is most appropriate for their participating practices and to prepare for compliance.

HCTTF is particularly concerned about replacing the existing small-practice exemption with exemptions based on rural or Health Professional Shortage Area status under one of the proposed pathways. Members indicated that a substantial share of participating TINs currently rely on the small-practice exemption from Promoting Interoperability reporting. Removing that exemption could therefore have significant consequences for ACOs with large numbers of small practices**.** Retaining the small-practice exclusion would also preserve alignment with the MIPS Promoting Interoperability framework and avoid creating a new CEHRT reporting requirement for practices that are currently eligible for this flexibility. **HCTTF urges CMS to assess the impact of this change and preserve appropriate flexibility for small practices so that CEHRT reporting requirements do not become a barrier to their continued participation in accountable care.**

VI. Request for Information on Expanding Specialty Care in the Shared Savings Program

Background & Proposal

CMS seeks stakeholder input on opportunities to better incorporate specialty care into MSSP and strengthen incentives for specialists to participate in accountable care. CMS seeks novel approaches to increase specialty care participation in ACOs, related to (1) meaningful engagement of specialists, (2) CMS-delivered tools and supports, (3) attribution or assignment modifications, (4) benchmarking, (5) specialist performance measurement, and (6) waiver flexibilities.

HCTTF Recommendations

Meaningful Engagement of Specialists

HCTTF strongly supports specialty engagement in VBC. With specialty care representing an estimated 70% of outpatient visits, effective accountable care models require specialists who practice high-value care. We recommend that CMS consider several key opportunities related to effective specialty engagement in accountable care:

1. **CMS should prioritize testing novel approaches to specialty engagement through the Long-term Enhanced ACO Design (LEAD) Model.** These include CMS-administered risk arrangements to test nested bundles for select specialties, as well as the option for non-primary care capitation. These novel arrangements allow ACOs to test a variety of specialty engagement strategies, with varying degrees of financial risk aligned to the

clinical needs of each specialty's patient population. allow ACOs to test approaches that are more comparable to those in use among MA plans, creating more parity and alignment across the services available to all Medicare beneficiaries. CMS should carefully evaluate LEAD's impact on patient outcomes and the total cost of care, with the intention of carrying over effective strategies into MSSP.

2. **Within MSSP, CMS should build on both financial and non-financial incentives to drive specialty participation.** While many specialists are motivated by financial incentives related to ACO participation – including shared savings and the Advanced APM bonus – the non-financial incentives are also critical. The most important non-financial incentive is the exemption to MIPS reporting. CMS should maintain and increase this non-financial incentive for specialty participation, but avoiding QPP policies that require specialists and other clinicians to report MIPS despite being in an ACO. As discussed elsewhere in this letter, CMS has two opportunities to address this in the current proposed rule, by (1) exempting specialists in an ACO from the Ambulatory Specialty Model and (2) by maintaining the current policy of determining Qualified APM Provider (QP) status at the TIN level, rather than the proposed TIN/NPI level.

3. **CMS should support greater integration between primary and specialty care, through mechanisms that encourage beneficiaries receiving specialty care to maintain alignment with a primary care provider within the ACO.** ACOs have found value in protocols that establish when patients should be managed by primary care versus a specialist and when patients should transition back to primary care. CMS should also consider supporting evidence-based approaches endorsed by professional societies, which may facilitate greater specialist adoption while preserving clinical autonomy.

4. **CMS should recognize that operational barriers—not simply financial incentives—can limit specialist participation.** Specialty electronic health records (EHRs) often lack interoperability capabilities, which limits their ability to meet QPP reporting requirements. Thus, ACOs may be disincentivized to include specialists due to inflexible QPP requirements because it would jeopardize the entire ACO's ability to be in compliance, similar to the barriers facing small and rural practices. CMS should consider these barriers when designing participation requirements, to avoid imposing high administrative burdens or excessive costs on practices and ACOs.

HCTTF strongly supports CMS efforts to better engage specialists, as we believe this is critical to the long-term success of accountable care.

CMS-Delivered Tools and Support

HCTTF encourages CMS to provide ACOs and specialists with more actionable data to support specialty care integration and referral management. Experience with episode-based models suggests that timely access to claims and attribution files can help specialists identify patients who would benefit from primary care follow-up. In addition, CMS should also explore ways to provide ACOs with more granular information on total cost of care attributable to individual specialists and specialty populations, to support care coordination and reduce duplication.

HCTTF encourages CMS to improve the usefulness of specialty care data by addressing limitations in sample size, attribution, and time horizons. In many cases, ACO-level procedure volumes are too small to support meaningful analysis and identify high-value specialists. CMS should explore opportunities to overcome these challenges, for example incorporating broader data from beneficiaries with Original Medicare and/or MA, including additional years of data, and by reporting costs by diagnosis rather than procedure. CMS should also ensure that specialist quality information is available to primary care clinicians who play a central role in coordinating referrals.

Attribution or Assignment Modifications

HCTTF encourages CMS to refine attribution methodologies to ensure that beneficiaries receiving care from Advanced Practice Providers (APPs) functioning in specialty roles are not inadvertently attributed to an ACO through a specialty encounter. Research shows that a meaningful share of beneficiaries attributed through NPP services were linked to NPPs functioning in specialty roles, suggesting that attribution methodologies that do not distinguish specialty from primary care practice settings may overstate ACO responsibility for those beneficiaries**.** CMS should consider an approach similar to the methodology used in LEAD that allows APPs identified as practicing in specialty settings to be excluded from primary care attribution. Such changes could improve the accuracy of attribution while better reflecting the role of specialists within ACOs.

Benchmarking

HCTTF encourages CMS to develop more granular and clinically appropriate benchmarks for specialty populations. For example, the concurrent benchmarking being tested in LEAD for specialty subpopulations could better account for differences in patient complexity. This would provide a more meaningful assessment of specialist performance.

CMS should also consider additional adjustments to account for factors outside an ACO's control that may affect specialty spending. This includes non-medical drivers of health, as well as rapidly increasing costs for Part B drugs – especially for oncology – which may warrant consideration in future risk adjustment and benchmarking methodologies.

Specialist Performance Measurement

HCTTF encourages CMS to recognize that specialist performance measurement presents distinct clinical, cultural, and operational challenges. Specialists generally should not be expected to assume responsibility for population health measures or care gaps that are primarily managed by primary care. Instead, CMS should focus specialty performance measurement on measures that are clinically relevant to the specialist's role. We recognize that this is a challenge for some specialties, which may not have numerous specialty-specific measures or may rely on measures that are not claims-based. In these cases, CMS should prioritize new measure development and/or seek access to broader data sources to ensure that specialty measurement is as clinically targeted as possible to a given specialty.

Data access and interoperability remain significant barriers to specialist participation. Specialty EHRs are often not interoperable with ACO and primary care systems, while the cost and complexity of extracting quality data can be prohibitive. **HCTTF encourages CMS to work with**

EHR vendors to reduce these barriers and ensure that providers are not held accountable for reporting requirements without reasonable access to the underlying data.

Waiver Flexibilities

CMS should consider appropriate Anti-Kickback Statute and Stark Law protections that would allow ACOs to more effectively support specialist participation and coordinated referral patterns. Safe harbors could enable ACOs to provide technology, infrastructure, and other forms of support to independent specialists without creating unnecessary legal barriers to the integration of specialty care within accountable care arrangements. If CMS believes that the existing safe harbors provide sufficient protections, additional guidance for ACOs and specialists would help ensure the appropriate use of these protections.

Updates to the Ambulatory Specialty Model

VII. Ambulatory Specialty Model Proposals

Background & Proposal

CMS proposes several updates to the Ambulatory Specialty Model related to participant identification, quality measurement, and scoring. CMS proposes changes to account for specialists who change TINs before or during a performance year, as well as certain exceptions for heart failure specialists whose Medicare specialty designation changes.

For quality measurement, CMS proposes adding a claims-based measure of MRI use for low back pain and replacing MIPS Quality Measure 220 with a Functional Outcome Assessment measure. CMS also proposes a potential five-point rural adjustment and five bonus points for voluntarily submitting patient-reported outcome data. Small practices would be permitted to report ASM quality data at either the individual clinician or group level.

HCTTF Recommendations

HCTTF appreciates CMS's continued efforts to refine ASM as the agency prepares for implementation. We support the agency's goal of creating specialty-focused payment models that improve quality, strengthen accountability, and advance the transition toward value-based care. We encourage CMS to consider additional methodological refinements, 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 – which represents a substantial administrative burden. **HCTTF recommends that 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 CMS strategy.**
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. This is particularly important for small and rural practices.**

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 creating opportunities to engage specialists in VBC. We support the proposed policies and encourage additional refinements to meaningfully reward specialists for high-quality outcomes.

VIII. MIPS Value Pathways

Background & Proposal

CMS is proposing to sunset traditional Merit-based Incentive Program (MIPS) after the CY28 performance period/2030 MIPS payment year. Beginning in CY29, MIPS Value Pathways (MVPs) would be the only reporting option for clinicians not in a MIPS APM. Clinicians in a MIPS APM would continue to report via the APM performance pathway (APP).

CMS is proposing to add three new MVPs starting in CY27: diabetic disease, hypertension, and hospitalist. CMS would also modify all 27 existing MVPs to add more measures relevant to a given specialty, keep all measures up to date, and to include MIPS core measure selections. CMS proposes to allow virtual groups to report MVPs starting in CY29.

Lastly, CMS proposes to update the extreme and uncontrollable circumstances (EUC) policy to allow more flexibility to use the most up to date and accurate data source to determine eligibility, rather than exclusively pulling from the Provider Enrollment, Chain, and Ownership System (PECOS).

HCTTF Recommendations

HCTTF supports the sunsetting of traditional MIPS, but we have concerns about the structure of MVPs. We urge CMS to use its existing authority to reform MIPS so that the program functions as a meaningful pathway toward Advanced APM participation, by aligning MIPS and MVP measures with Advanced APM requirements. Under both MIPS and MVPs, clinicians receive a positive, negative, or neutral payment adjustment to their fee-for-service payment based on their performance on certain measures. Findings show that these pay-for-performance incentives do little to shift away from fee-for-service and produce mixed results on improving care quality or affordability.[1] While MIPS was intended to serve as a glidepath toward provider participation in Advanced APMs, research shows that the program is not preparing providers to take on full accountability for the care they deliver and their patients' health outcomes.[2] **We urge CMS to develop fundamental reforms to MIPS that transform the program into one that adequately prepares and transitions providers into Advanced APMs.**

While HCTTF believes that MVPs do not adequately prepare clinicians for Advanced APMs, we appreciate CMS's efforts to refine the program. For example, HCTTF appreciates the proposals to three new MVPs, which offer more options for providers to report specific and relevant quality measures. HCTTF also supports expanding MVP reporting to virtual groups. In addition, we support the use of additional data sources outside of PECOS to determine eligibility for the EUC policy.

[1] https://www.ovid.com/journals/aime/abstract/00000605-201703070-00006~the-effects-of-pay-for-performance-programs-on-health-health?redirectionsource=fulltextview
[2] https://accountableforhealth.org/a4h-recommends-macra-reforms-to-accelerate-the-transformation-to-accountable-care/

Additionally, HCTTF encourages CMS to allow additional sub-group reporting in 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 AAPMs.

IX. Advanced APMs

Background & Proposal

CMS is proposing to apply QP and partial QP determinations at the TIN/NPI level, rather than just at the NPI level. As a result, financial incentives will only be directed to TINs actively participating in Advanced APMs, meaning that clinicians would only be exempt from MIPS at the TIN that achieved QP status, rather than exempt from MIPS at every TIN they bill under.

CMS proposes to reduce the QP thresholds in Performance Year (PY) 2026, as required by the Consolidated Appropriations Act, 2026. The QP threshold will revert to 50% of Part B payments of 35% of Medicare beneficiaries for PY26, but will increase to 75% of payments and 50% of Medicare beneficiaries starting in PY27 and beyond. The Consolidated Appropriations Act also establishes an APM incentive payment of 3.1% in CY26.

HCTTF Recommendations

HCTTF opposes the proposal to apply QP and partial QP determinations at the TIN/NPI level. This would increase reporting burden for clinicians who currently qualify at the NPI level, but who are employed at a TIN that does not qualify – which would further erode a key non-financial incentive for specialists and other clinicians to participate in accountable care. Additionally, this proposal would create job lock for providers who must remain employed at a TIN to receive their Advanced APM incentive payment. Given the payment lag, providers must remain employed at a TIN for two years after the performance year to receive their incentive payment. These concerns create disincentives for providers to participate in Advanced APMs, which runs counter to the CMS strategy.

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HCTTF appreciates the opportunity to provide feedback on the CY 2027 PFS Proposed Rule. Please contact Theresa Dreyer, CEO (theresa.dreyer@hcttf.org) and David Goldstein, Director of Policy and Strategic Initiatives (david.goldstein@hcttf.org), with questions related to these comments.

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