AMERICA'S PHYSICIAN GROUPS

September 14, 2026

Mehmet Oz, MD, MBA
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Submitted via https://www.regulations.gov/docket/CMS-2026-2377

Re: 2027 Physician Fee Schedule and Medicare Shared Savings Program Proposed Rule [CMS-1848-P]

Dear Administrator Oz:

America's Physician Groups (APG) appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services' (CMS's) Calendar Year (CY) 2027 Proposed Rule for the Medicare Physician Fee Schedule and Medicare Shared Savings Program. We welcome the agency's openness to stakeholder input and its ongoing commitment to improving health care for all Americans.

Below, APG will first provide (I) a brief description of our organization, followed by (II) a summary of CMS's proposed rule, (III) a summary of APG's recommendations, and (IV) our fuller comments and recommendations. Together they reflect the voice of APG's membership and our commitment to working with the agency to ensure that all Americans have consistently accessible, high-quality, equitable, person-centered health care.

I. About America's Physician Groups

APG is a national association representing more than 300 physician groups that are committed to the transition to value, and that engage in the full spectrum of alternative payment models in original Medicare and in capitated and delegated relationships with health plans in Medicare Advantage (MA). APG members collectively employ or contract with approximately 260,000 physicians (as well as many nurse practitioners, physician assistants, and other clinicians), and care for approximately 90 million patients, including an estimated one in four Americans and one in three MA enrollees.

APG's motto, "Taking Responsibility for America's Health," underscores our physician groups' preference

for being in risk-based, accountable, and responsible relationships with all payers, including MA health plans, rather than being paid by plans on a fee-for-service basis. Delegation of risk from payers to providers creates the optimal incentives for our groups to provide integrated, coordinated care; make investments in innovations in care delivery; and manage our populations of patients in more constructive ways than if our members were merely compensated for the units of service that they provide.

II. CMS Proposed Rule

In the proposed rule, CMS proposes policy changes to the Physician Fee Schedule (PFS), the Medicare Shared Savings Program (MSSP), and the Quality Payment Program (QPP), together with updates to the Ambulatory Specialty Model (ASM), new reimbursement policies for skin substitutes reimbursed under Medicare Part B, and several Requests for Information (RFIs).

APG's top-line assessment is that this year's proposed rule includes both promising proposals and those that require modification. It includes a proposed cut to the physician fee schedule conversion factor and several other proposals that concern our members, alongside a number of constructive reforms to MSSP's financial methodology, meaningful new investment in ACO-affiliated primary care through a proposed split of HCPCS code G2211, and several changes APG has urged CMS to adopt in prior comment letters.

III. Summary of APG's Recommendations

Recommendations Related to the Physician Fee Schedule

- **APG urges Congress and CMS – using all administrative discretion the agency has – to reverse the proposed CY 2027 conversion factor reductions and to enact a durable, long-term fix to physician payment that keeps pace with the cost of providing care.**
- **APG recommends that CMS not finalize the proposed reduction in payment for E&M visits that overlap a global surgical period. At minimum, if CMS proceeds with this proposal, the agency should clearly state that the policy applies only to overlaps with 0-, 10-, and 90-day global procedure codes and does not affect annual wellness visits or other services without a global period.**
- **APG recommends that CMS not finalize the proposed requirement that RPM and RTM clinical staff be direct employees of the billing practitioner and instead strengthen enforcement of the existing incident-to requirement to address program-integrity concerns. If CMS proceeds with some version of this policy, APG recommends the following steps:**
    - **That the agency delay implementation and grandfather beneficiaries currently receiving RPM/RTM services to avoid a disruptive cliff for patients with chronic conditions.**
    - **That CMS consider the more targeted program-integrity safeguards described above, such as instituting physician ordering requirements, outcome reporting, EHR integration, and CMS vendor registration, as an alternative to a blanket employment mandate.**

- **That current RPM/RTM reimbursement rates be maintained at their existing levels, as reimbursement stability is necessary to the financial viability and clinical outcomes of these programs.**

- **APG supports finalizing the proposal to nationally price non-sheet form skin substitutes at parity with sheet-form products, along with the related technical clarification to the Part B rebatable drug exclusion.**

- **APG supports the proposed expansion of the Medicare Telehealth Services List and the additional teaching-physician and modifier flexibilities and urges CMS to continue working with Congress toward permanent telehealth authority.**

- **APG strongly supports finalizing the proposal to replace HCPCS code G2211 with the two-tiered MOD1/MOD2 structure, including the enhanced payment for ACO-affiliated and LEAD Model physicians, and recommends CMS evaluate the cumulative effect of this and other CY 2027 proposals on continuity of care.**

- **APG recommends CMS address three implementation issues with the MOD1/MOD2 proposal: creating a claim-level modifier or ACO-specific additional payment for FQHCs and RHCs, whose bundled payment systems would not otherwise reflect the new modifiers; undertaking steps — through guidance or automatic claims processing — to increase MOD2 utilization among eligible ACO-affiliated practices; and consideration of a two-G-code alternative to a modifier-based structure to preserve compatibility with existing physician compensation systems.**

- **APG supports finalizing the proposed work RVU revaluation for CPT code 99492 and the conforming changes to G2214, G0568, and G0569.**

Recommendations Related to the Medicare Shared Savings Program (MSSP)

- **APG supports raising the BASIC track Level E sharing rate from 50 percent to 60 percent and increasing the prior savings adjustment scaling factor from 50 percent to 75 percent and recommends that CMS explore applying the improved scaling factor before an ACO's next agreement period begins.**

- **APG recommends that CMS not finalize the proposed reduction in the ENHANCED track regional adjustment weight from 50 percent to 35 percent for lower-spending ACOs, which risks penalizing ACOs for genuine market efficiency rather than addressing the concern CMS has identified.**

- **APG supports risk-adjusting the five (5) percent cap on the regional, prior savings, and population adjustment, but recommends CMS separately raise the cap itself — APG members have suggested six (6)to seven (7) percent — so that risk adjustment and the proposed new growth adjustment can provide meaningful benefit to ACOs that would otherwise remain at the ceiling.**

- **APG recommends that CMS address the MSSP "ratchet effect" directly by raising or eliminating the five (5) percent cap on the regional, prior savings, and population adjustment, and by**

allowing ACOs to apply the prior savings adjustment and the regional efficiency adjustment together rather than limiting relief to whichever adjustment is highest, so that ACOs generating the greatest long-term savings are not penalized the most by benchmark rebasing.

- **APG strongly supports finalizing the proposed ACPT reforms, including annual (rather than fixed five-year) growth-rate calculation, the new guardrails bounding ACPT to within one point below and 1.5 points above actual national growth, and the retroactive reopening of the 2024 and 2025 benchmark reconciliations. APG recommends CMS continue to monitor the guardrails' performance and adjust them if warranted in future rulemaking.**

- **APG supports the proposed changes to beneficiary assignment, including excluding out-of-ACO primary care charges from non-ACO TINs and expanding the assignable-beneficiary definition to those with at least one month of Part A/B enrollment, and recommends CMS publish additional data on the expected size and characteristics of the newly assignable beneficiary population. On the proposed new GACP1/GACP2 advance care planning codes specifically, APG has no comments on the codes themselves but recommends CMS first expand their availability under Original Medicare generally and delay their inclusion in the primary-care-services definition used for assignment by one year, to allow ACOs to better understand how the codes are used and how they would affect assigned populations.**

- **APG supports finalizing the proposed Part B cost-sharing waiver expansion and the simplified beneficiary notification requirements.**

- **APG supports finalizing the proposed two-year phased transition to FHIR-based digital quality measurement beginning in the 2028 performance period, the extension of MIPS CQM and Medicare CQM reporting, the expansion of flat benchmarking to all five applicable measures, the new Medicare eCQM collection type limited to assigned beneficiaries, the ability to exclude specialty-use TINs that lack EHR support for a measure, and the elimination of Quality 305 and Quality 493 from the APP Plus measure set.**

- **APG recommends CMS continue to calibrate performance thresholds to account for the demonstrated accuracy differences between chart-validated and electronic-only quality reporting as it develops FHIR-based digital quality measurement, allow ACOs to receive and aggregate QRDA Category III reports from participants, and expand the proposed "other circumstances CMS determines" exclusion criterion to include the ability to adjust the 95 percent assigned-beneficiary reporting threshold on a case-by-case basis.**

- **APG supports eliminating the Promoting Interoperability measure category for ACOs, and recommends CMS clarify in the final rule that the three proposed compliance options are offered in the alternative, preserving ACOs' existing ability to document certified EHR use through the Certified Health IT Product List.**

Recommendations Related to the Ambulatory Specialty Model (ASM)

- **APG recommends that CMS exempt clinicians who participate in an Advanced Alternative Payment Model, including MSSP ACOs and the LEAD Model, from mandatory participation in the Ambulatory Specialty Model.**

- **APG supports the proposed rural scoring adjustment, the flexibility to submit Improvement Activities data at the individual or group level, and the new low back pain imaging and functional-status measures, and recommends CMS use its authority to advance greater EHR standardization across vendors to reduce the reporting burden ASM and other value-based models place on practices.**

Recommendations Related to the Quality Payment Program (QPP)

- **APG appreciates Congress's extension of the QP payment and patient-count thresholds (50 percent/35 percent) and the 3.1 percent Advanced APM incentive payment for performance year 2026 and urges Congress to act again to prevent these provisions from reverting to less favorable terms.**
- **While APG appreciates CMS's goal of addressing potential gaming through TIN separation, APG recommends CMS consider narrower alternatives — such as more targeted safeguards against TIN separation, potentially paired with a return to a 50 percent/35 percent QP threshold test — that address CMS's program-integrity concern without risking unintended reductions in Advanced APM participation and incentive payments.**

Recommendations Related to Requests for Information (RFIs)

- **APG recommends that CMS's approach to FHIR-based digital quality measurement explicitly accommodate the reality that clinical data is stored in many different systems and formats, use precise and consistent terminology, and recognize that the eCQM standard itself has never required CEHRT-only data — that limitation has been a CMS policy choice, not a feature of the standard.**
- **APG recommends that CMS anchor the FHIR transition timeline to CMS's own demonstrated capability to receive and process FHIR-based submissions rather than to a fixed calendar date, build a defined post-go-live correction period into the transition given the operational adoption lag CMS experienced with QRDA Category I reporting, and avoid measure-specification and payment-policy mismatches such as the depression-screening frequency example discussed above.**
- **APG recommends that any new prospective or hybrid primary care payment model in MSSP remain strictly voluntary and tightly anchored within an ACO or total-cost-of-care framework, that CMS offer ACOs a choice among a full-capitation option, a hybrid FFS-plus-enhanced-payment option, and the choice to remain in the existing model, and that CMS build on the proposed MOD1/MOD2 modifier framework — rather than a new family of G-codes — for any future longitudinal-versus-acute E&M categorization.**
- **APG recommends that CMS (1) address the financial obstacles to specialty care integration in MSSP by fixing the rebasing problems discussed elsewhere in this letter, and separately (2)**

reduce administrative friction to specialist collaboration by continuing to expand data-sharing infrastructure such as CEHRT Direct and TEFCA, calibrating quality measurement scope to a specialist's actual role in an ACO, reserving an enhanced payment for ACO-participant practices providing transitional care management, and expanding the data available through the 835/837 eligibility system.

- **APG welcomes CMS's RFI on disease treatment and encourages the agency to continue engaging stakeholders as it develops specific proposals to support chronic disease prevention and incorporate well-being measures into QPP in future years.**
- **APG has no strong position on the Query of PDMP RFI but cautions CMS against converting the measure from attestation-based to performance-based without a clear evidentiary basis and careful attention to added reporting burden.**
- **APG urges CMS to account for real-world variation in EHR capability and adoption as it develops new performance-based measures and data-quality scoring changes, and to continue encouraging greater standardization among EHR vendors.**
- **APG welcomes the opportunity to provide more detailed input on the MIPS-to-MVP transition as this RFI develops into specific rulemaking proposals.**
- **APG recommends that CMS clarify how any MVP scoring normalization would interact with ACO-level APP Plus scoring, publish MVP benchmarks and normalization methodology before each performance period begins, test new scoring methodology through a pilot before full implementation, pair any within-MVP normalization with continued investment in specialty and subspecialty MVP development, and account for data-accuracy and patient-panel-size differences when weighting performance.**

IV. APG's Detailed Comments and Recommendations

Physician Fee Schedule

Physician Fee Schedule Payment Update

For CY 2027, CMS proposes two separate conversion factor updates depending on Qualifying APM Participant (QP) status. The conversion factor used to calculate PFS payments for QPs would decrease by 1.19 percent from CY 2026, to $33.17. The conversion factor for MIPS-eligible and other non-QP clinicians would decrease by 1.68 percent, to $32.84.

Unlike last year's proposed rule, which included a statutorily required increase to the conversion factor, CMS's CY 2027 proposal constitutes a cut to physician payment for both QP and non-QP clinicians. APG members are deeply concerned that these reductions come after years of insufficient increases relative to the growth in practice costs, and that a further cut threatens the viability of physician practices as well as the continued access to care for patients, particularly in the case of practices already operating on thin financial margins. During APG's member input session on August 27, 2026, members emphasized that fixing the conversion factor ultimately requires congressional action, since CMS's discretion in this area is limited by statute. APG intends to continue pressing Congress — including through APG's October 2026 congressional fly-in

— for a durable physician payment fix for 2027 and separately urges CMS to use whatever administrative discretion it has to mitigate the impact of these reductions.

- **APG urges Congress and CMS – using all administrative discretion the agency has – to reverse the proposed CY 2027 conversion factor reductions and to enact a durable, long-term fix to physician payment that keeps pace with the cost of providing care.**

Overlap of Global Periods and Evaluation & Management Visits

CMS proposes to reduce payment when a physician furnishes an evaluation and management (E&M) visit on the same day as a 0-, 10-, or 90-day global surgical procedure. Under the proposal, the more expensive of the overlapping services would be paid at 100 percent of the fee schedule rate, and the other service(s) would be paid at 50 percent.

APG members raised substantial concerns with this proposal. Several members noted that reducing payment for combined E&M and procedural visits will discourage practices from delivering both services during a single visit, requiring patients to return for a second appointment. Members warned that many patients will not follow through on a second visit, undermining both access and quality of care, and that the policy could accelerate physician employment by hospitals and health systems seeking to offset the reduced payment. Broad-scope primary care practices, which routinely bill for a wider range of same-day services than narrower specialties, are likely to be disproportionately affected.

Members also identified a significant source of confusion: Because the policy is limited to overlaps with 0-, 10-, and 90-day global procedure codes, it should not apply to annual wellness visits (AWVs) or other preventive medicine services, which do not carry a global period. However, members reported that this distinction is not well understood among practicing physicians, and APG believes CMS should make this scope explicit in the final rule and in accompanying guidance.

- **APG recommends that CMS not finalize the proposed reduction in payment for E&M visits that overlap a global surgical period. At minimum, if CMS proceeds with this proposal, the agency should clearly state that the policy applies only to overlaps with 0-, 10-, and 90-day global procedure codes and does not affect annual wellness visits or other services without a global period.**

Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM)

CMS proposes to require that remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM) clinical staff be direct employees of the billing practitioner, eliminating the use of third-party monitoring vendors. RTM would also newly require a prior patient relationship, matching the existing RPM rule; a separately billable visit would be required to specifically discuss monitoring and obtain consent before services begin; setup and education codes would be re-crosswalked to lower-value codes; and treatment management codes would lose practice expense inputs entirely. CMS also seeks comment on consolidating the 17 existing RPM/RTM codes into four G-codes.

CMS states that this proposal is intended to address fraud, waste, and abuse risk associated with physician groups contracting with third-party monitoring vendors. APG members strongly disagree with CMS's proposed remedy. Several members noted that they had already submitted separate comments to CMS raising this concern, and that the agency's approach addresses a program-integrity problem with a structural mandate rather than more targeted enforcement of existing rules. Members emphasized that requiring direct

employment of RPM/RTM staff on the proposed timeline — effective January 1, 2027 — would be highly disruptive. Many patients currently benefiting from RPM would simply lose access to the service, with one member reporting that its organization has documented condition-control improvements of 60 to 80 percent within a three-month period among patients using RPM. Members urged CMS, at minimum, to delay the effective date and to grandfather beneficiaries already receiving RPM/RTM services under existing vendor arrangements.

Other members raised a more targeted legal concern. As drafted, the proposal appears to disqualify RPM/RTM billing even when and where an arrangement satisfies Medicare's existing "incident-to" requirements — for example, where a medical group contracts with employees of another entity within the same health system and relies on incident-to rules to bill for their services. APG believes that CMS should instead strengthen and enforce the incident-to requirement itself, rather than layering a direct-employment mandate on top of it.

Mount Sinai Health System, an APG member, submitted additional data illustrating the operational and financial implications of the proposed employment mandate. Mount Sinai described operating RPM under both a fully employed clinical staffing model and a vendor-integrated model — using contracted clinical and operational support furnished under Mount Sinai's own governance and clinical protocols — providing what amounts to a natural experiment in the likely effects of CMS's proposal. Under the employed-staff model, 16 employed full-time-equivalent staff supported 751 patients and produced a net loss of approximately $2.3 million, leading Mount Sinai's finance department to pause the program. Under the vendor-integrated model — in which contracted personnel operate pursuant to a master services agreement and defined scope-of-authority provisions, with Mount Sinai retaining accountability for all patient care decisions — three employed FTEs supported roughly 2,000 patients, and the program was approved for continued growth.

Clinical outcomes were maintained across both models, according to Mount Sinai. Among more than 1,300 actively monitored patients with hypertension, obstetric hypertension, diabetes, and heart failure, Mount Sinai reported an average reduction of 19 mmHg systolic and 12 mmHg diastolic blood pressure among previously uncontrolled hypertension patients; a 31.2 mmHg systolic reduction among the highest-risk patients (74 percent of whom achieved blood pressure control); and 9.5-out-of-10 average patient satisfaction. Other APG member organizations reported comparable efficiency gains, with one estimating that a vendor-integrated staffing model reduces program expenses by at least $1 million relative to a fully employed model at similar patient volumes, moving programs from significant losses toward break-even sustainability. APG members further cautioned that eliminating vendor-supported staffing models would not simply shift costs to employed staff but would render many RPM programs financially unsustainable, forcing providers to scale back or discontinue services, with particular impact on the substantial share of monitored patients attributed to risk-based, value-based care arrangements.

In place of a direct-employment mandate, members proposed more targeted safeguards to address CMS's program-integrity concerns while preserving clinically integrated vendor arrangements. Such alternative approaches could be (1) requiring a documented physician or qualified clinician order from the billing provider entity to initiate RPM/RTM services for a given patient; (2) requiring periodic outcome reporting and potentially transitioning a portion of payment to an outcomes-aligned methodology, similar to the ACCESS (Advancing Chronic Care with Effective, Scalable Solutions) Model, after an initial pay-for-reporting period; (3) requiring integration of RPM data and associated clinical documentation into the billing provider's electronic health record (E HR), a process that members noted could be implemented through an annual provider attestation; and/or (4) requiring that RPM vendors themselves register with and be approved by CMS, similar to the ACCESS Model's vendor registration requirement. Members believe these measures would meaningfully improve transparency and oversight of RPM/RTM billing without disrupting clinically integrated care models that are producing measurable patient outcomes.

- **APG recommends that CMS not finalize the proposed requirement that RPM and RTM clinical staff be direct employees of the billing practitioner and instead strengthen enforcement of the existing incident-to requirement to address program-integrity concerns. If CMS proceeds with some version of this policy, APG recommends the following steps:**
    - **That the agency delay implementation and grandfather beneficiaries currently receiving RPM/RTM services to avoid a disruptive cliff for patients with chronic conditions.**
    - **That CMS consider the more targeted program-integrity safeguards described above, such as instituting physician ordering requirements, outcome reporting, EHR integration, and CMS vendor registration, as an alternative to a blanket employment mandate.**
    - **That current RPM/RTM reimbursement rates be maintained at their existing levels, as reimbursement stability is necessary to the financial viability and clinical outcomes of these programs.**

Payment for Skin Substitutes

Building on last year's reclassification of skin substitutes as incident-to supplies, CMS proposes to nationally price non-sheet form skin substitutes at the same payment rates already established for sheet-form products, replacing current Medicare Administrative Contractor (MAC)-based pricing for non-sheet form products with a single national rate. CMS separately proposes a technical clarification to the Part B rebatable drug exclusion for skin substitutes tied to inflation-rebate (CPI-U) calculations.

APG supports these proposals as sensible, incremental refinements that build on the significant reforms to skin substitute payment that APG advocated for and CMS finalized last year. Standardizing payment across product forms will further reduce opportunities for the kind of pricing arbitrage that drove unsustainable growth in skin substitute spending.

- **APG supports finalizing the proposal to nationally price non-sheet form skin substitutes at parity with sheet-form products, along with the related technical clarification to the Part B rebatable drug exclusion.**

Payment for Telehealth Services

CMS proposes to add five new codes to the Medicare Telehealth Services List: two advance care planning codes (GACP1, GACP2), a group medical visit code (GSMAS), a pediatric speech-language code (GSLPP), and a vaccine adverse-effects E&M code (GADV1). CMS also proposes additional flexibility for teaching physicians, permitting resident-furnished telehealth services to be billed when either the teaching physician or the resident (rather than requiring both, plus the beneficiary, in three separate locations) is in the same room as the beneficiary. New modifiers BB and BC would become mandatory January 1, 2027, to indicate telehealth furnished via a contracted virtual platform or billed incident-to — a statutory, compliance-only requirement. Telehealth flexibilities extended under the CAA of 2026 continue through December 31, 2027 (general flexibilities) and January 1, 2028 (audio-only and the mental health in-person exception).

APG supports these proposals, which would continue CMS's practice of incrementally expanding the

permanent telehealth services list and reducing administrative friction for teaching settings. As APG has noted in prior comment letters, most of the authority needed to make telehealth flexibilities durable and permanent lies with Congress rather than CMS, and APG will continue to advocate for congressional action extending these flexibilities beyond their current expiration dates.

- **APG supports the proposed expansion of the Medicare Telehealth Services List and the additional teaching-physician and modifier flexibilities and urges CMS to continue working with Congress toward permanent telehealth authority.**

Evaluation and Management Visits — Splitting HCPCS Code G2211

CMS proposes to eliminate add-on code G2211 and replace it with two new modifiers reflecting the complexity of longitudinal care. MOD1 would be valued at 16 percent of the base E&M code and would be available to all eligible clinicians; MOD2 would be valued at 32 percent of the base E&M code — double MOD1 — and would be available only to MSSP ACO participants, ACO professionals and providers/suppliers, and LEAD Model participant providers. This is the first PFS coding mechanism that pays more for the identical E&M visit specifically because the treating clinician is affiliated with a Medicare ACO; qualification is determined at the physician level and, once established, applies to all of that physician's patients regardless of whether a given patient is currently ACO-assigned.

APG strongly supports this proposal as a meaningful and overdue recognition of the value that ACO-affiliated physicians provide through longitudinal, coordinated care. Members noted that the increase is likely to be implemented in a budget-neutral manner within existing G2211 utilization, shifting value toward ACO-affiliated physicians rather than adding new program spending. Several specialists commented that the enhanced rate, while welcome, does not fully offset the financial effect of separate proposals — such as the same-day E&M/global-period reduction discussed above — that can interrupt continuity of care. APG encourages CMS to consider the cumulative, sometimes offsetting effects of these proposals as it finalizes the rule, so that policies affecting continuity of care are applied consistently.

One APG member's claims analysis illustrates the scale of this shift. Analyzing more than 16.5 million professional claims paid by traditional Medicare in 2025 across more than 3,600 partner practices, the member found that its practices earned a combined $18.5 million from billing G2211 under current policy. Under the proposed structure, those same claims would have generated $21.7 million using MOD1 alone, and more than $43.4 million had MOD2 applied wherever eligible. The result would have been a 1.80 percent increase in total fee-for-service revenue for traditional Medicare beneficiaries under MOD2, compared with a more modest 0.22 percent increase under MOD1 alone. At the claim level, the same analysis found that MOD1 increased total payment on eligible claims by 10.5 to 12.8 percent relative to the original claim amount (after backing out G2211's own contribution), while MOD2 increased total payment on those claims by 21.5 to 25.6 percent. APG views MOD1 as roughly payment-neutral relative to current G2211 utilization, with MOD2 providing the meaningful new incentive for ACO participation that CMS intends.

APG recommends that CMS address three implementation issues as it finalizes this proposal.

First, because the Federally Qualified Health Center Prospective Payment System and the Rural Health Clinic All-Inclusive Rate bundle payment for G2211 into a single all-inclusive rate, FQHCs and RHCs would not benefit from the new MOD1/MOD2 structure absent a fix; APG recommends CMS consider a claim-level modifier for institutional claims in these settings, or an additional payment specifically for FQHCs and RHCs participating in ACOs, so that the incremental value of ACO participation is not built into a bundled rate that does not vary with it.

Second, APG members report that G2211 utilization has been well below where CMS likely intended: of practices billing an eligible E&M code in 2025, only about half billed G2211 at all, and those that did applied it to roughly a third of eligible claims. To increase utilization of MOD2 to the levels CMS intends, APG recommends CMS either provide explicit guidance identifying beneficiaries who are automatically eligible for MOD2 based on preliminary ACO assignment or have CMS's claims-processing systems automatically apply MOD2 in those circumstances once a claim is received.

Third, some APG members report that replacing a G-code with a modifier will increase administrative burden in physician compensation systems built around G-code-level compensation. APG encourages CMS to explore whether the percentage-based, ACO-differentiated payment structure it is trying to achieve could instead be implemented using two G-codes rather than a modifier, to preserve compatibility with existing compensation arrangements.

- **APG strongly supports finalizing the proposal to replace HCPCS code G2211 with the two-tiered MOD1/MOD2 structure, including the enhanced payment for ACO-affiliated and LEAD Model physicians, and recommends CMS evaluate the cumulative effect of this and other CY 2027 proposals on continuity of care.**

- **APG recommends CMS address three implementation issues with the MOD1/MOD2 proposal: creating a claim-level modifier or ACO-specific additional payment for FQHCs and RHCs, whose bundled payment systems would not otherwise reflect the new modifiers; undertaking steps — through guidance or automatic claims processing — to increase MOD2 utilization among eligible ACO-affiliated practices; and consideration of a two-G-code alternative to a modifier-based structure to preserve compatibility with existing physician compensation systems.**

Enhanced Care Management Proposals

The behavioral health integration (BHI) and psychiatric collaborative care model (CoCM) add-on codes for Advanced Primary Care Management (APCM), along with removal of their time-documentation requirement, were finalized in the CY 2026 PFS final rule. The only new CY 2027 change is a proposed work RVU revaluation for CPT code 99492 (initial psychiatric CoCM), with conforming valuation changes to G2214, G0568, and G0569. CMS is separately soliciting an RFI on restructuring the broader care management code family (CCM, PCM, TCM, and APCM) in light of persistently low uptake.

APG views the proposed upward revaluation of CPT code 99492 as a positive signal that CMS recognizes collaborative care has been undervalued relative to the clinical work involved and supports finalizing this change.

- **APG supports finalizing the proposed work RVU revaluation for CPT code 99492 and the conforming changes to G2214, G0568, and G0569.**

Medicare Shared Savings Program (MSSP)

Financial Methodology Changes

CMS proposes three changes to MSSP's benchmark financial methodology. First, CMS would raise the BASIC track Level E sharing rate from 50 percent to 60 percent beginning in 2027, narrowing the gap with the ENHANCED track's 75 percent sharing rate (the Level E shared-loss rate would remain at 50 percent). Second, CMS would reduce the maximum weight of the ENHANCED track's regional adjustment from 50 percent to 35

percent for lower-spending ACOs, while leaving the adjustment unchanged for ACOs spending above their regional benchmark. Third, CMS would increase the prior savings adjustment scaling factor (the so-called "ratchet" effect) from 50 percent to 75 percent, beginning in 2027 for new agreement periods.

APG supports raising the BASIC Level E sharing rate, which would make the highest-risk BASIC option more competitive with the ENHANCED track's shared savings opportunity. APG also supports the proposed increase in the prior savings adjustment scaling factor, which allows ACOs to retain a larger share of savings they have already generated once their benchmark is reset, though APG notes that because this change applies only at the start of a new agreement period, some ACOs will not see its benefit for up to four years and encourages CMS to explore whether the improved scaling factor could be applied sooner.

APG has significant concerns, however, with the proposed reduction in the ENHANCED track's regional adjustment weight, from 50 percent to 35 percent, for lower-spending ACOs. CMS's stated rationale is that ENHANCED track ACOs' regional adjustments are more strongly correlated with their gross savings than is true in the BASIC track, and that this correlation suggests the scale of positive regional adjustments may be partly driving ENHANCED track performance rather than reflecting genuine efficiency gains. APG believes that CMS's reasoning does not hold up, as summarized below and in APG's comments on the specialty care participation RFI later in this letter.

First, on the correlation itself: Regional adjustments were specifically designed to build ACOs' historical efficiency into their benchmarks, so some correlation between regional adjustments and gross savings is expected by construction and is not, on its own, evidence of a problem.

Second, CMS's proposal rests on an assumption that regional efficiency, once achieved, is largely passive and self-sustaining — that an ACO can coast on baseline efficiency without continued effort. APG does not believe the data support this assumption. ACOs manage constantly changing patient populations, meaning that savings achieved on an ACO's early population must continually be re-earned on new patients. Efficiency, in other words, appears to require the sustained work MSSP participation demands, not something ACOs can simply bank and coast on.

Finally, APG notes that CMS's own recent policy direction cuts against this proposal. In the Long-Term Enhanced ACO Design (LEAD) Model, CMS has eliminated periodic rebasing altogether for the model's full ten-year performance period specifically to protect ACOs' long-term savings incentive and has described LEAD as offering ACOs "a predictable window without rebasing and a pathway toward sustainable long-term benchmarks and savings." It is difficult to reconcile that policy direction with a proposal that would, in the same rule, make MSSP's regional adjustment less generous for the ACOs that have achieved the greatest regional efficiency. For all of these reasons, APG recommends CMS not finalize the proposed reduction in the ENHANCED track regional adjustment weight and instead focus on the more fundamental rebasing problem discussed immediately below.

Separately, CMS proposes to risk-adjust the existing five (5) percent cap on the regional, prior savings, and population adjustment (formerly the health equity benchmark adjustment, or HEBA) — applying the risk adjustment to whichever of the three adjustments is highest — and to introduce a new growth adjustment for ACOs that recruit new providers to value-based care, which would also be added to the highest of the three adjustments. APG members support risk-adjusting the cap but believe the five percent ceiling itself remains too low: many ACOs already exceed the cap even before risk adjustment is applied, and because the new growth adjustment is subject to the same 5 percent ceiling, it provides no additional benefit to ACOs that are already at the cap — undermining CMS's own stated goal of encouraging ACOs to bring new providers into value-based arrangements. APG members have suggested raising the cap to six (6) or seven (7) percent. APG also notes that risk-adjusting the cap and raising the cap's level are distinct policy questions, and recommends CMS consider

them separately: risk adjustment alone, without also raising the ceiling, will not resolve ACOs' concerns.

- **APG supports raising the BASIC track Level E sharing rate from 50 percent to 60 percent and increasing the prior savings adjustment scaling factor from 50 percent to 75 percent and recommends that CMS explore applying the improved scaling factor before an ACO's next agreement period begins.**
- **APG recommends that CMS not finalize the proposed reduction in the ENHANCED track regional adjustment weight from 50 percent to 35 percent for lower-spending ACOs, which risks penalizing ACOs for genuine market efficiency rather than addressing the concern CMS has identified.**
- **APG supports risk-adjusting the five (5) percent cap on the regional, prior savings, and population adjustment, but recommends CMS separately raise the cap itself — APG members have suggested six (6)to seven (7) percent — so that risk adjustment and the proposed new growth adjustment can provide meaningful benefit to ACOs that would otherwise remain at the ceiling.**

Benchmark Rebasing and the MSSP "Ratchet Effect"

Beyond the specific changes proposed for CY 2027, APG urges CMS to address the more fundamental problem underlying MSSP's benchmark methodology: the "ratchet effect," whereby an ACO's own success in lowering spending is used to lower that same ACO's future benchmark, shrinking the reward for continued high performance. CMS has itself identified this dynamic in prior rulemaking, and it has been separately documented by MedPAC and the Congressional Budget Office:

> *"…there are two ways in which the use of factors based on realized FFS spending (which reflects any ACO spending reductions) can lead to lower benchmarks, which we will refer to as 'ratchet' effects: (1) downward pressure on an individual ACO's benchmark resulting from the impact of its achieved spending reductions on its historical benchmark expenditures, regional adjustment, and update factor; and (2) downward pressure on benchmarks due to program-wide spending reductions across all ACOs." (CMS, Federal Register, 87 FR 46209)*
>
> *"Rebasing benchmarks to reflect changes in actual spending has the effect of 'ratcheting down' the benchmarks of ACOs that have succeeded in lowering their spending – thus penalizing these ACOs by giving them harder-to-beat benchmarks. Eliminating the 'ratchet effect' would give ACOs a stronger incentive to lower their spending." (MedPAC, June 2022 Report to Congress)*
>
> *"An ACO's benchmarks are empirically determined—that is, they are set and updated over time to reflect observed health care spending among that ACO's attributed beneficiaries. Because of that structure, ACOs that lower their spending are effectively penalized with lower subsequent benchmarks… The explicit reduction (known as a ratchet effect) greatly weakens ACOs' incentives to reduce their spending." (CBO, Medicare Accountable Care Organizations: Past Performance and Future Directions)*

CMS has attempted to mitigate this problem through the prior savings adjustment and the regional efficiency adjustment, and APG supports the proposed increase in the prior savings adjustment scaling factor discussed above. But both mitigation tools remain capped at five (5) percent of the benchmark, and it is that cap — not the scaling factor — that binds for the most successful ACOs. The practical effect of the five percent cap can be severe for an ACO's most successful, longest-tenured participants. APG does not believe this is a sustainable model for rewarding the ACOs whose long-term investment in accountable care CMS says it wants

to encourage.

MSSP is now in its fifteenth year, and aggregate net savings have settled at approximately 4.67 percent of total cost of care — a figure APG members do not believe is a coincidence, but rather a rational response by ACOs to a benchmark methodology that effectively caps the long-term savings opportunity at around five (5) percent regardless of how much an individual ACO actually saves. To grow total MSSP savings, as CMS states it wants to do, APG recommends that CMS look beyond the scaling-factor change proposed this year and address the five percent cap directly — both by raising the cap, as APG recommends above, and by allowing ACOs to apply the prior savings adjustment and the regional efficiency adjustment together, rather than limiting relief to whichever single adjustment is highest, so that the ACOs generating the greatest savings for the Medicare program are not the ones penalized most by rebasing.

- **APG recommends that CMS address the MSSP "ratchet effect" directly by raising or eliminating the five (5) percent cap on the regional, prior savings, and population adjustment, and by allowing ACOs to apply the prior savings adjustment and the regional efficiency adjustment together rather than limiting relief to whichever adjustment is highest, so that ACOs generating the greatest long-term savings are not penalized the most by benchmark rebasing.**

Accountable Care Prospective Trend (ACPT) Reform

The Accountable Care Prospective Trend (ACPT) is one leg of MSSP's three-way blended benchmark update factor, alongside national and regional growth. Introduced in CY 2023 to project administrative cost growth, the ACPT has underestimated actual cost growth since 2024, eroding ACOs' earned savings — by APG members' estimate, by as much as $700 million in aggregate ACO savings to date. CMS proposes three reforms: calculating the modified USPCC annualized growth rate separately for each performance year and applying the same annual rate to every ACO regardless of its agreement start date, rather than locking in a fixed five-year schedule; establishing guardrails, for agreement periods beginning in 2027 or later, that bound the modified USPCC growth rate to within one point below and 1.5 points above actual national cost growth; and a retroactive fix reopening the 2024 benchmark reconciliation (with the 2025 reconciliation to follow, delayed), which CMS anticipates will move many affected ACOs' 2024 and 2025 results from negative to neutral or positive.

APG strongly supports this package of reforms, which its members regard as a substantial and, in some respects, overdue correction to a methodology that has materially eroded ACO savings since its introduction. Members noted the guardrails represent a meaningful, if imperfect, improvement, and APG recommends CMS continue to monitor performance under the new guardrail bounds and revisit them if experience shows further adjustment is warranted.

- **APG strongly supports finalizing the proposed ACPT reforms, including annual (rather than fixed five-year) growth-rate calculation, the new guardrails bounding ACPT to within one point below and 1.5 points above actual national growth, and the retroactive reopening of the 2024 and 2025 benchmark reconciliations. APG recommends CMS continue to monitor the guardrails' performance and adjust them if warranted in future rulemaking.**

Beneficiary Assignment

CMS proposes several changes to MSSP beneficiary assignment, beginning largely in 2028. First, CMS would exclude primary care charges billed by an ACO-participant physician under a non-ACO TIN from counting toward out-of-ACO assignment, addressing a source of beneficiary "leakage." Second, CMS would update the

definition of primary care services used for assignment purposes to include new G-codes, including two new advance care planning codes discussed further below. Third, CMS would expand the definition of an assignable beneficiary to include anyone with at least one month of Medicare Part A and B enrollment (and no Medicare Advantage enrollment in that month), replacing the current rule under which any month of A-or-B-only enrollment disqualified a beneficiary from assignment. CMS notes that only about one-third of the traditional Medicare population is currently assigned to an MSSP ACO.

APG generally supports these proposals, which are consistent with CMS's stated goal of growing meaningful ACO participation. One member, representing a large payer-affiliated ACO network, asked CMS to provide additional data on how many additional beneficiaries the expanded assignable-beneficiary definition is likely to bring into MSSP ACOs, and on how this newly eligible population may differ — in health status and otherwise — from beneficiaries assigned under current rules.

Separately, and as discussed above in APG's comments on telehealth, CMS proposes to create two new HCPCS codes describing advance care planning services furnished by clinical staff under the direct supervision of the billing physician or practitioner, incident to that practitioner's professional services: GACP1, for the first 20 minutes of clinical staff time spent explaining and discussing advance directives, including completion of standard forms; and GACP2, for each additional 20 minutes of such time. Existing CPT codes 99497 and 99498 would continue to apply only to time personally spent by the billing practitioner, and CMS also proposes adding GACP1 and GACP2 to the telehealth list. APG has no comments on these two codes themselves and is generally supportive of expanded access to advance care planning.

APG's concern is narrower and relates specifically to CMS's separate proposal to use these same two codes to revise the definition of primary care services used for beneficiary assignment, beginning with the performance year starting January 1, 2027. A member raised this concern directly during APG's member input session, noting uncertainty about how GACP1 and GACP2 will actually be used once they are broadly available, and suggesting CMS take a staged approach before relying on them for assignment purposes. APG agrees and recommends CMS first expand the availability of GACP1 and GACP2 under Original Medicare generally, and delay including the two codes in the primary-care-services definition used for assignment by one year, to give ACOs time to understand how the codes are being used in practice and how their inclusion would affect assigned populations before that inclusion takes effect.

- **APG supports the proposed changes to beneficiary assignment, including excluding out-of-ACO primary care charges from non-ACO TINs and expanding the assignable-beneficiary definition to those with at least one month of Part A/B enrollment, and recommends CMS publish additional data on the expected size and characteristics of the newly assignable beneficiary population. On the proposed new GACP1/GACP2 advance care planning codes specifically, APG has no comments on the codes themselves but recommends CMS first expand their availability under Original Medicare generally and delay their inclusion in the primary-care-services definition used for assignment by one year, to allow ACOs to better understand how the codes are used and how they would affect assigned populations.**

Beneficiary Engagement

CMS proposes to expand the Part B cost-sharing waiver so that ACOs may waive cost sharing for beneficiaries who lack supplemental insurance (or whose supplemental coverage does not cover certain services), subject to an application process, a proposed start date of April 27, 2027, exclusion of durable medical equipment and drugs, and a requirement that the ACO develop a clinical goal for the waiver — an approach similar to the Part B cost-sharing waiver already available under ACO REACH. CMS also proposes to simplify

beneficiary notification requirements, decoupling notice from a beneficiary's first primary care visit, requiring notice by a May 30 deadline, and removing the existing verbal/written follow-up requirement.

APG supports both proposals as sensible simplifications that reduce administrative burden while preserving beneficiary protections, and that bring MSSP's cost-sharing waiver framework closer to parity with ACO REACH.

- **APG supports finalizing the proposed Part B cost-sharing waiver expansion and the simplified beneficiary notification requirements.**

Quality Reporting Changes

CMS proposes a two-year phased transition to FHIR-based digital quality measurement (dQM) beginning with the 2028 performance period, subject to future rulemaking. In the interim, CMS proposes to extend MIPS CQM reporting, with sunset now expected around 2028 rather than 2027 as previously scheduled, and to extend Medicare CQM reporting, with sunset expected around 2030. CMS also proposes to extend flat benchmarking to all five applicable Medicare CQM quality measures (up from two), applying the flat benchmark retroactively for 2025 to measures 001 (Hemoglobin A1c), 134 (Depression), and 236 (Controlling High Blood Pressure); to establish a new Medicare eCQM collection type for performance year 2027 covering only ACO-assigned beneficiaries (rather than all traditional Medicare beneficiaries, as under current Medicare CQM); and to allow ACOs to exclude one or more participant TINs from a measure's data collection for unforeseen events, specialty-use certified EHR technology (CEHRT) that cannot support a given measure, or other CMS-determined circumstances, provided the ACO's reporting still covers at least 95 percent of assigned beneficiaries. Separately, CMS proposes to eliminate two quality measures — Quality 305 (substance use disorder) and Quality 493 (adult immunization) — from the APP Plus measure set.

APG strongly supports these proposals, several of which directly respond to concerns APG has raised in prior comment letters. In particular, APG appreciates CMS's decision to extend the MIPS CQM sunset date and to eliminate two measures added only last year, after APG and other stakeholders objected that adding new measures worked at cross purposes with CMS's own stated goal of reducing reporting burden. APG also supports allowing ACOs to exclude specialty-use TINs — for example, dermatology or ophthalmology practices whose certified EHR cannot support a given measure — from a measure's data collection, which will reduce reporting burden without compromising the integrity of ACO-level quality results.

CMS also proposes to eliminate the Promoting Interoperability (PI) measure category for ACOs beginning in 2027, but would require ACOs to complete one of three alternative compliance options: reporting at least one of the five ACO-reported APP Plus measures through the eCQM or Medicare eCQM collection type; using CEHRT to fully report at least one of the five measures and attesting to using FHIR-based data; or selecting and attesting to one CEHRT-use metric from an annual list CMS will establish (for example, e-prescribing, health information exchange, or provider-to-patient exchange). APG members do not object to any of the three options but requested that CMS clarify, in the final rule, that these options are offered in the alternative to — rather than in addition to — an ACO's ability to simply document that its practices are using certified EHR technology on the Certified Health IT Product List (CHPL), consistent with current practice.

APG's support for continuing MIPS CQM and Medicare CQM reporting rests in part on accuracy grounds that APG believes CMS should weigh carefully as it designs the eventual FHIR-based dQM framework. One APG member's own testing found that moving the same underlying patient data from chart-validated abstraction to pure electronic capture changed blood pressure control scores by 7.96 points, HbA1c control scores by 27.64 points, and depression screening scores by 53.33 points, with no actual change in the care delivered — a swing

of two to four deciles in relative performance driven entirely by how completely a given EHR configuration captures structured data, not by quality of care. This is consistent with the broader clinical-measurement literature: a 2022 study in the Journal of the American Medical Informatics Association comparing electronic and manual abstraction for two standardized perinatal care measures found the same pattern of systematic divergence between electronic and chart-validated data. APG believes this accuracy gap is precisely why CMS has historically applied different, lower performance thresholds (the 40th and 10th percentile, for example) to eCQM and MIPS CQM reporting types, and recommends CMS continue to calibrate thresholds to account for this trade-off as it moves toward FHIR-based measurement.

Relatedly, as health care data become increasingly federated across multiple systems and exchanged through APIs, TEFCA, and CMS's own Health Technology Ecosystem, APG believes CMS's longstanding policy of requiring quality-reporting data to reside within a single instance of certified EHR technology has become outdated. The National Committee for Quality Assurance has already recognized this shift in its Electronic Clinical Data Systems (ECDS) reporting standard, which is not limited to data drawn from a single EHR. APG recommends CMS apply the same principle across its own quality-reporting policies — including the eventual FHIR-based dQM framework — so that ACOs and clinicians can report using all of the data available to them, rather than data siloed in one system. APG also recommends CMS allow ACOs to receive and aggregate QRDA Category III reports from their participants, so that ACOs are not required to obtain and manage individually identifiable, all-patient data merely to report eCQMs on participants' behalf. Finally, on the proposed 95 percent assigned-beneficiary reporting threshold for TIN exclusions discussed above, APG recommends CMS expand the third proposed exclusion criterion — "other circumstances CMS determines" — to make clear that CMS may also adjust the 95 percent threshold itself on a case-by-case basis, for the same reason CMS included that catch-all criterion for exclusions in the first place: future circumstances cannot all be anticipated in advance.

- **APG supports finalizing the proposed two-year phased transition to FHIR-based digital quality measurement beginning in the 2028 performance period, the extension of MIPS CQM and Medicare CQM reporting, the expansion of flat benchmarking to all five applicable measures, the new Medicare eCQM collection type limited to assigned beneficiaries, the ability to exclude specialty-use TINs that lack EHR support for a measure, and the elimination of Quality 305 and Quality 493 from the APP Plus measure set.**

- **APG recommends CMS continue to calibrate performance thresholds to account for the demonstrated accuracy differences between chart-validated and electronic-only quality reporting as it develops FHIR-based digital quality measurement, allow ACOs to receive and aggregate QRDA Category III reports from participants, and expand the proposed "other circumstances CMS determines" exclusion criterion to include the ability to adjust the 95 percent assigned-beneficiary reporting threshold on a case-by-case basis.**

- **APG supports eliminating the Promoting Interoperability measure category for ACOs, and recommends CMS clarify in the final rule that the three proposed compliance options are offered in the alternative, preserving ACOs' existing ability to document certified EHR use through the Certified Health IT Product List.**

Ambulatory Specialty Model (ASM)

CMS's mandatory Ambulatory Specialty Model (ASM), for specialists treating low back pain and congestive heart failure, is scheduled to run for five years beginning January 2027, with roughly one-quarter of core-based statistical areas and metropolitan divisions selected for participation, individual-level performance assessment, and risk growing from 9 percent in the model's first year to 12 percent by its fifth. In the CY 2027 proposed rule,

CMS proposes a series of refinements to the model as it prepares to launch: permitting Improvement Activities data to be submitted at either the individual or group level; replacing the prior patient-reported outcome (PRO) measure for low back pain with a new administrative-claims-based imaging measure and a functional-status process measure, alongside a new scoring incentive for voluntary PRO data submission intended to seed future PRO-based measures; realigning the Promoting Interoperability category with proposed MIPS PI changes and adding a new measure-suppression policy; adding a rural scoring adjustment of five points for qualifying rural clinicians; clarifying Collaborative Care Arrangement (CCA) terms and TIN-change and cardiology-redesignation exceptions; removing participants' right to withdraw once selected while granting CMS new authority to terminate participants for program-integrity or non-compliance reasons; and reaffirming CMS's estimate of $177 million in net Medicare savings from ASM between 2029 and 2033. CMS characterizes these as technical refinements rather than a redesign of the model.

APG members support the rural scoring adjustment, the added flexibility for Improvement Activities reporting, and the new low back pain imaging measure. Members raised two broader concerns during APG's member input session. First, several APG members participate in Advanced Alternative Payment Models — including MSSP ACOs and the LEAD Model — and asked whether providers already accountable for total cost of care through an Advanced APM should be exempt from separately mandatory participation in ASM, since the two sets of incentives can work at cross purposes for the same clinician. Second, members reiterated a concern raised elsewhere in these comments regarding quality measure interoperability: ASM's reliance on CEHRT-based measures assumes a level of EHR standardization that does not reflect the reality many practices face, particularly as practices change ownership or switch EHR vendors. Members urged CMS to use its full range of authority to press EHR vendors toward greater standardization, since burden falls disproportionately on practices navigating multiple, inconsistent systems.

- **APG recommends that CMS exempt clinicians who participate in an Advanced Alternative Payment Model, including MSSP ACOs and the LEAD Model, from mandatory participation in the Ambulatory Specialty Model.**
- **APG supports the proposed rural scoring adjustment, the flexibility to submit Improvement Activities data at the individual or group level, and the new low back pain imaging and functional-status measures, and recommends CMS use its authority to advance greater EHR standardization across vendors to reduce the reporting burden ASM and other value-based models place on practices.**

Quality Payment Program (QPP)

CMS's CY 2027 proposals for the Quality Payment Program (QPP) continue the agency's multi-year plan to sunset traditional MIPS into MIPS Value Pathways (MVPs), with full transition expected by the 2029 performance year. For performance year 2026, the Qualifying APM Participant (QP) payment and patient-count thresholds are 50 percent and 35 percent respectively, reflecting an extension enacted by Congress; without further congressional action, these thresholds would revert to 75 percent and 50 percent. Congress also extended the 3.1 percent Advanced APM incentive payment for performance year 2026; neither of these congressional actions involves CMS discretion.

The one QPP proposal squarely within CMS's authority that most concerns APG members is a proposed change to how Advanced APM qualification is determined. Under current policy, when a specialist's Taxpayer Identification Number (TIN) sits outside an ACO, but the ACO nonetheless qualifies as an Advanced APM, that specialist can receive the Advanced APM incentive payment for all of their patients, whether or not those patients are in the ACO. CMS observes that NPIs billing under a TIN outside the ACO tend to be associated with

higher-cost, sicker beneficiaries, and proposes to move Advanced APM qualification — for both qualification and payment purposes — to the individual NPI/TIN level, so that only an NPI billing within the ACO's TIN structure would qualify.

APG members are divided on this proposal. Some members agreed that CMS's underlying fairness concern has merit, particularly for larger, multi-specialty health systems whose complex TIN structures were not designed with ACO participation in mind and suggested that if CMS addresses this cost-leakage concern through the NPI-level approach, the agency might also consider reverting the broader QP determination to a 50 percent/35 percent threshold test. Other members cautioned that an NPI/TIN-level requirement risks unintended consequences: a physician who changes practices, or whose employer restructures TINs, could lose Advanced APM qualification or incentive payments through no fault of their own or the ACO's; fee schedule administration, which is generally organized at the TIN level, would become more complex at the NPI level; and the policy could significantly reduce the total incentive payments flowing to Advanced APM participants — potentially undermining the very participation CMS is otherwise trying to encourage elsewhere in this rule.

- **APG appreciates Congress's extension of the QP payment and patient-count thresholds (50 percent/35 percent) and the 3.1 percent Advanced APM incentive payment for performance year 2026 and urges Congress to act again to prevent these provisions from reverting to less favorable terms.**
- **While APG appreciates CMS's goal of addressing potential gaming through TIN separation, APG recommends CMS consider narrower alternatives — such as more targeted safeguards against TIN separation, potentially paired with a return to a 50 percent/35 percent QP threshold test — that address CMS's program-integrity concern without risking unintended reductions in Advanced APM participation and incentive payments.**

Requests for Information (RFIs)

CMS's CY 2027 proposed rule includes several Requests for Information (RFIs) previewing the agency's thinking for performance years 2028 through 2030 and beyond. APG appreciates the opportunity these RFIs provide for early stakeholder input, before CMS's thinking on these issues becomes further set in the course of formal rulemaking.

FHIR and Digital Quality Measurement

CMS is moving toward FHIR-enabled data use for risk adjustment and quality measurement, and requests stakeholder input on the obstacles to digital quality measurement in the near term as the industry converts to FHIR-based systems. This request for information (RFI) connects directly to the MSSP quality proposals discussed above, where CMS signals that FHIR-based digital quality measures would become available in 2028 and mandatory by 2030.

APG members emphasized that the goal of any transition should be ensuring that clinicians and ACOs can use all of the data available to them to capture a comprehensive set of quality metrics for their patients — regardless of the specific technical standard used to exchange that data. Every standard, policy, and technical requirement that CMS adopts in this transition should be measured against a single test: Does it help or hinder the data reporters' ability to use all of the data available to them? Members cautioned that the term "FHIR" means different things to different stakeholders: Some in the quality measurement community treat FHIR-based digital quality measures (dQMs) as functionally identical to existing eCQMs using the same specifications, while others understand FHIR as a broader technical transformation. APG recommends that CMS use precise,

consistent terminology as it develops this policy, and ensure that any transition accommodates the reality that clinical data are stored in many different systems and formats across the industry.

APG members also cautioned CMS against assuming that publishing a standard, or setting a policy deadline, is sufficient to make that standard operationally reliable. The eCQM specifications themselves have never required that quality data be stored within certified EHR technology; that limitation has been a CMS policy choice, not a feature of the underlying standard. Separately, QRDA Category I reporting has existed as a standard for over a decade, longer than QRDA Category III, and has long been required by certification policy — yet vendors and providers had little real experience with it until ACOs began requesting Category I reports only in the last few years, at which point many vendors struggled to produce them. APG expects the same pattern with FHIR-based digital quality measurement: operational reliability will come only from sustained, real-world use, not from advance notice that a standard exists. APG recommends that CMS build a defined post-go-live correction period into the FHIR transition, during which reporting issues can be identified and corrected without penalty, and recommends that CMS not treat a longer pre-go-live lead time as a substitute for that correction period.

On timing specifically, APG recommends CMS anchor the FHIR transition timeline to CMS's own demonstrated capability to receive and process FHIR-based submissions, rather than to a fixed calendar date. Because API-based transmission requires both the sender and the receiver to be available at the same time, CMS's own receiving infrastructure — not a provider-facing deadline — is the binding constraint on a successful transition. If CMS's systems are ready to receive FHIR-based submissions before CY 2028, APG sees no reason to delay voluntary reporting until that date. Conversely, if CMS's systems are not demonstrably ready, a CY 2030 mandatory date would create risk for data reporters without a corresponding benefit. APG recommends CMS commit to a specific date for its own receiving capability, publicly report progress against it, and set provider-facing voluntary and mandatory dates — along with the post-go-live correction period discussed above — as a function of that capability rather than as independent milestones.

Finally, APG urges CMS to ensure that measure specifications and Medicare payment policy remain consistent as the agency develops new digital quality measures. As one example, the depression screening quality measure's denominator can operationally require multiple depression screenings a year for the same patient, while Medicare payment policy covers only one depression screening per twelve-month period. APG recommends CMS avoid replicating this kind of mismatch — where quality reporting policy effectively requires a service at a frequency Medicare's own payment policy does not cover — as it develops future digital quality measures.

- **APG recommends that CMS's approach to FHIR-based digital quality measurement explicitly accommodate the reality that clinical data is stored in many different systems and formats, use precise and consistent terminology, and recognize that the eCQM standard itself has never required CEHRT-only data — that limitation has been a CMS policy choice, not a feature of the standard.**

- **APG recommends that CMS anchor the FHIR transition timeline to CMS's own demonstrated capability to receive and process FHIR-based submissions rather than to a fixed calendar date, build a defined post-go-live correction period into the transition given the operational adoption lag CMS experienced with QRDA Category I reporting, and avoid measure-specification and payment-policy mismatches such as the depression-screening frequency example discussed above.**

Redesigning Primary Care Payment: Prospective and Hybrid Models

CMS requests comment on redesigning Medicare primary care payment more broadly, including prospective and hybrid (for example, capitated) payment models, and specifically asks how such models might begin within the Shared Savings Program. CMS separately asks how future rulemaking might categorize evaluation and management visits — for example, as longitudinal, acute, or consultative — so that payment better reflects the resource costs of longitudinal care, the same conceptual foundation underlying this year's MOD1/MOD2 proposal.

APG members regard this as one of the most consequential RFIs in the proposed rule, since it could open the door to a genuinely prospective primary care payment option anchored in accountable care. APG's central recommendation is that any new pathway in MSSP remain strictly voluntary, as ACO PC Flex is today. Practice operations and patient panels vary widely across APG's membership and other potential MSSP participants, and no single mandatory pathway would work for all of them.

APG also recommends that any prospective primary care payment model remain tightly anchored within an ACO or total-cost-of-care framework. Operating prospective payments outside of an ACO's guardrails invites unmanaged fee-for-service leakage and program-integrity risk. CMMI's own evaluation of the Comprehensive Primary Care Plus (CPC+) model found that independent practices participating in both CPC+ and MSSP achieved meaningfully better spending and quality results than practices receiving hybrid payments outside of an ACO, and CMS's own data show that MSSP ACOs with a high proportion of primary care clinicians (75 percent or more) generate net per-capita savings nearly double the program average ($403 versus $224 in performance year 2024). Anchoring any new payment model within MSSP ensures the resulting resources are managed by the entity best positioned to oversee quality, risk stratification, and downstream care coordination.

APG recommends that CMS offer ACOs a choice among multiple voluntary options, each sharing three characteristics: a simple, known payment amount that flows through the ACO without within-year retrospective adjustment; no requirement for dollar-for-dollar spend-plan accounting; and full accountability through inclusion of the payment in the ACO's total cost of care. Specifically, APG recommends that CMS consider: (1) a full primary care capitation option modeled on the REACH Enhanced Primary Care Capitation, which sets a known payment (7 percent of benchmark under REACH) with no spend-plan tracking; (2) a hybrid option, modeled on Comprehensive Primary Care Plus, that preserves each practice's existing fee-for-service revenue as a baseline and layers a prospective, monthly, non-recoupable enhanced payment on top, allowing fee-for-service to continue doing what it does well while filling gaps for longitudinal, accountable care; and (3) the option to remain in the existing ACO/fee-for-service combination with no new prospective payment at all, since for practices that already succeed under that model, preserving the choice not to change is as important as offering new options to those that want them.

On the related question of categorizing E&M visits by function, APG agrees that the clinical purpose and resource inputs of a longitudinal visit differ fundamentally from a discrete acute or consultative visit, and that valuing longitudinal care to reflect both the visit itself and the coordination that happens between visits is a logical evolution of the fee schedule. However, APG strongly recommends against creating a new, complex family of longitudinal and acute G-codes to operationalize this distinction, which would fragment E&M billing, increase audit complexity, and burden practices already managing substantial billing requirements. Instead, APG recommends that CMS build on the MOD1/MOD2 framework proposed this year as the permanent mechanism for this distinction, since modifiers applied to existing E&M codes can adjust payment based on the relationship and accountable environment of a visit without requiring an entirely new coding architecture.

- **APG recommends that any new prospective or hybrid primary care payment model in MSSP remain strictly voluntary and tightly anchored within an ACO or total-cost-of-care framework, that CMS offer ACOs a choice among a full-capitation option, a hybrid FFS-plus-enhanced-payment option, and the choice to remain in the existing model, and that CMS build on the proposed MOD1/MOD2 modifier framework — rather than a new family of G-codes — for any future longitudinal-versus-acute E&M categorization.**

Specialty Care Participation in the Medicare Shared Savings Program

CMS seeks comment on strengthening specialty care participation and integration within MSSP, including how to better involve specialists in ACOs and align their incentives with total-cost-of-care accountability.

Many APG members have invested in attempts to collaborate with specialist physicians across a variety of states and payment models. Based on their experience, they report three principal obstacles to integrating specialty care into ACOs: specialists generally do well under existing fee-for-service payment and have little incentive to shift into risk-based arrangements that would align them financially with an ACO; patient overlap between ACOs and many specialty groups is often too small to construct stable, accurate spending benchmarks; and MSSP's financial model — particularly the periodic rebasing of benchmarks discussed elsewhere in this letter — is not conducive to forming the kind of long-term financial partnerships that require predictable cash flow. APG recognizes that the first two obstacles are real constraints inherent to specialty integration but believes the third is a policy choice CMS can fix directly and is the same rebasing problem APG addresses at length above: Without addressing the five percent cap on the prior savings and regional efficiency adjustments, low-revenue ACOs simply do not generate a large enough or predictable enough long-term savings opportunity to fund meaningful financial partnerships with specialists.

Separately from the financial model, APG recommends that CMS pursue several administrative changes that would reduce friction in specialist collaboration even short of full financial integration. On data sharing, APG supports continued expansion of CEHRT Direct messaging, the Trusted Exchange Framework and Common Agreement (TEFCA), and CMS's Health Technology Ecosystem initiative, all of which are already improving the availability of clinical data across specialties.

On quality measurement, APG recommends that CMS recognize that integrating a specialist practice into an ACO can create measurement obligations disconnected from that specialist's actual scope of care — for example, integrating a dermatology practice can add thousands of patients to an ACO's depression-screening denominator whose primary care relationship sits with a different ACO entirely — and calibrate quality measure scope accordingly as ACOs expand specialty participation. On billing, APG recommends that CMS address the counterproductive competition that arises when a hospital, a specialist, and a primary care practice each seek to bill for the same transitional care management (TCM) service following a hospitalization, by reserving an enhanced payment comparable to MOD2 for the ACO-participant practice, consistent with the ACO's accountability for total cost of care. Finally, APG recommends that CMS expand the data available through the 835/837 eligibility system — for example, current primary care assignment and date of last visit with any provider — and broaden access to that data, since eligibility data remains an underused tool for supporting specialty collaboration.

- **APG recommends that CMS (1) address the financial obstacles to specialty care integration in MSSP by fixing the rebasing problems discussed elsewhere in this letter, and separately (2) reduce administrative friction to specialist collaboration by continuing to expand data-sharing infrastructure such as CEHRT Direct and TEFCA, calibrating quality measurement scope to a specialist's actual role in an ACO, reserving an enhanced payment for ACO-participant practices**

providing transitional care management, and expanding the data available through the 835/837 eligibility system.

Disease Treatment

CMS is interested in stakeholder input on incorporating preventive services into Advanced Primary Care Management (APCM), supporting chronic disease prevention and management more broadly (including primary, secondary, and tertiary prevention), and incorporating well-being and nutrition measures into the QPP in future years, consistent with the administration's Make America Healthy Again (MAHA) priorities.

APG welcomes CMS's continued interest in supporting chronic disease prevention through APCM and other primary-care-focused payment models, which are well aligned with APG members' focus on accountable, coordinated care. APG encourages CMS to continue soliciting detailed stakeholder input as these concepts mature into specific measure proposals in future rulemaking.

- **APG welcomes CMS's RFI on disease treatment and encourages the agency to continue engaging stakeholders as it develops specific proposals to support chronic disease prevention and incorporate well-being measures into QPP in future years.**

Query of Prescription Drug Monitoring Program (PDMP)

CMS is considering whether to convert the existing Query of PDMP measure — currently attestation-based and limited to Schedule II opioids — to a performance-based measure, and whether to expand its scope to other Schedule II drugs.

The PDMP is not a core focus for APG members, but APG encourages CMS to proceed cautiously before converting an attestation-based measure to a performance-based one, given the significant additional reporting burden a performance-based measure would create.

- **APG has no strong position on the Query of PDMP RFI but cautions CMS against converting the measure from attestation-based to performance-based without a clear evidentiary basis and careful attention to added reporting burden.**

Performance-Based Measures and Data Quality

CMS is interested in new measure concepts for public health reporting and data quality, potential revisions to scoring for the public health and clinical data exchange objective measures, and opportunities to take advantage of FHIR-based capabilities within CEHRT, with a stated goal of encouraging MIPS-eligible clinicians to adopt modern technology and standards.

As APG members emphasized repeatedly during APG's member input session — in the context of ASM, MSSP quality reporting, and this RFI alike — not every practice has access to the most current electronic health record technology, and even state-of-the-art EHR systems do not yet support all of the functionality that CMS's proposals sometimes assume. APG urges CMS to factor these real-world limitations into any new measure concepts or scoring changes it develops, and to continue pressing EHR vendors toward greater standardization as a complement to any new CMS reporting requirements.

- **APG urges CMS to account for real-world variation in EHR capability and adoption as it develops new performance-based measures and data-quality scoring changes, and to continue encouraging greater standardization among EHR vendors.**

Transforming MIPS: The MIPS Value Pathways (MVP) Strategy

This RFI addresses the future pathway for CMS's transition from traditional MIPS to MIPS Value Pathways (MVPs), including the use of FHIR-based eCQMs in quality reporting and payment programs.

APG's comments have traditionally focused on our members' experience in Advanced APMs and other value-based, accountable care arrangements rather than traditional MIPS, which is more directly relevant to non-APM participants. APG believes that MVPs should serve as step on the pathway to Advanced APMs rather than the destination. APG welcomes the opportunity to provide more detailed comments as this RFI matures into specific rulemaking proposals in future years.

- **APG welcomes the opportunity to provide more detailed input on the MIPS-to-MVP transition as this RFI develops into specific rulemaking proposals.**

MVP Scoring Methodology Within the Same MVP

CMS asks how the agency should adjust MVP scoring methodology so that clinicians reporting within the same MIPS Value Pathway are compared fairly to one another.

Most primary care clinicians in APG members' ACOs already have a working comparability mechanism: under MSSP, they are scored as a group through the APP Plus quality measure set rather than individually through an MVP. MVP scoring normalization is therefore more directly relevant to specialists and other MIPS-eligible clinicians in APG members' participating TINs who report individually. APG recommends CMS clarify, before finalizing any normalization approach, how MVP-level scoring changes would interact with ACO-level APP Plus scoring for clinicians who touch both systems, so that ACOs are not left managing two separate, potentially conflicting comparability frameworks for the same clinicians. APG also recommends that whatever normalization method CMS adopts, it publish the MVP benchmark and the specific normalization methodology before the performance period begins, not after, so that clinicians know what target they are being measured against while they are still delivering care.

On timing, APG recommends that CMS test any new scoring methodology through an earlier pilot rather than introducing it for the first time in the same performance year full MVP implementation becomes mandatory, since a new scoring approach — like a new reporting standard — surfaces real problems only once clinicians are actually scored under it, and a pilot allows those problems to be found while traditional MIPS remains available as a fallback. APG also shares a narrower version of a concern raised elsewhere in these comments regarding measure availability: Some specialists within APG members' multi-specialty ACOs have no clinically relevant MVP, or one offering a much smaller measure set than the traditional MIPS specialty set, and a within-MVP normalization approach cannot fix a comparison built on a thin or mismatched measure set. If CMS moves forward with within-MVP normalization, APG recommends that CMS pair it with continued investment in specialty and subspecialty MVP development.

Finally, as APG discusses in greater detail in its comments on MSSP quality reporting above, data assembled across a multi-TIN, multi-EHR ACO reporting on an all-payer, all-patient basis is measurably less accurate than the same data reported through sampling-based methodologies. Because CMS's own reporting requirements create this accuracy discrepancy, APG recommends that CMS account for it in any MVP normalization methodology, at minimum by weighting performance to account for patient panel size — the performance of a thousand-patient practice should not be weighted the same as an ACO reporting on a million-patient population.

- **APG recommends that CMS clarify how any MVP scoring normalization would interact with ACO-level APP Plus scoring, publish MVP benchmarks and normalization methodology before each performance period begins, test new scoring methodology through a pilot before full implementation, pair any within-MVP normalization with continued investment in specialty and subspecialty MVP development, and account for data-accuracy and patient-panel-size differences when weighting performance.**

Conclusion

APG thanks CMS for the agency's ongoing commitment to ensuring that the Medicare program continues to address stakeholder concerns and meet the needs of all beneficiaries. APG looks forward to working with CMS as the proposals in this proposed rule are refined and finalized and stands ready to provide additional data and member perspectives — including in response to the several Requests for Information addressed above — as CMS's thinking on these issues develops.

Sincerely,

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