Vytalize

September 14, 2026

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

Submitted electronically via www.regulations.gov

RE: CY 2027 Physician Fee Schedule Proposed Rule (CMS-1848-P)

Dear Administrator Oz:

I. Introduction and Interest

Vytalize Health appreciates the opportunity to comment on the calendar year (CY) 2027 Medicare Physician Fee Schedule (PFS) proposed rule. Vytalize is a physician-led value-based care enablement company, partnering with independent primary care practices and health systems to facilitate accountability for improving care quality and managing cost. We support more than 5,000 primary care providers across 30 states, together with a specialty partner network of more than 7,000 specialists, and we participate in the Medicare Shared Savings Program (MSSP), the accountable care organization (ACO) REACH Model, and, beginning in 2027, the Long-term Enhanced ACO Design (LEAD) Model, serving over 170,000 beneficiaries in the 2026 performance year, which we anticipate growing to approximately 225,000 in 2027.

A large proportion of our partner practices are the small, independent providers that CMS most needs to reach to bring every Medicare beneficiary into an accountable care relationship by 2030. These practices often struggle to support the infrastructure, staffing and financial runway that the accountable care transition requires. Vytalize closes that gap. We advance shared savings to practices, conditioned on evidence-based actions to improve care. We also provide clinical and operational expertise, coaching, an extended care team and best-in-class shared infrastructure and technology to implement value-based care. This includes peer-to-peer clinical support from physicians experienced in value-based practice transformation, care coordination and transitional care management, virtual care, pharmacist-driven medication management, downstream specialist network management, data and analytics, quality reporting and artificial intelligence (AI) clinical decision support inside a practice's own electronic medical record.

Vytalize Health
2 Hudson Place, 6th Floor
Hoboken, NJ 07030
(844) 460-0098

www.vytalizehealth.com
info@vytalizehealth.com

Savings from the Vytalize model grow over time. Independent actuarial analysis shows that average savings among our participating practices grow more than threefold from year 1 to year 3 of participation with Vytalize. This shows the power of a longitudinal care relationship supported by clinical services and technology. For Vytalize-attributed beneficiaries, primary care visits per year go up, while hospital admissions, specialist encounters, and skilled nursing facility use are reduced, demonstrating the power of primary care centered accountable care to maintain beneficiary health while lessening reliance on higher acuity care settings.

We commend CMS for seeking information on ways to modernize primary care payment in MSSP and Original Medicare, and for recognizing the potentially transformative role that technology can play in delivery of primary care and maintaining a longitudinal care relationship. Our comments are based on our 12 years of experience as a technology-forward enabler developing tools that support value-based care transformation.

II. Physician Fee Schedule Provisions

A. CY 2027 Physician Payment and the Advanced APM Participation Incentive (CMS-1848-P, sections I.A and VII.D.1)

Vytalize supports the higher relative conversion factor for qualified physicians participating in an advanced payment model. However, the conversion factors of $33.17 and $32.84, respectively, both fall below CY 2026 levels following expiration of the temporary congressional increase. Although the update is statutory, CMS should acknowledge that physician payment that fails to keep pace with practice costs undermines the participation incentives this rule otherwise seeks to strengthen and support congressional action toward a stable update.

B. Evaluation and Management Visit Complexity Add-On: MOD2 for Medicare ACO Participants (CMS-1848-P, section II.D.3.c, item (53))

Vytalize supports the proposed MOD2 modifier, which would increase payment for qualifying E/M visits by 32 percent of the base E/M payment for practitioners in MSSP and LEAD ACOs. It recognizes the additional work of longitudinal accountable care and strengthens the participation case for independent practices. CMS should ensure consistent treatment of MOD2 in historical benchmarks, performance-year expenditures, and the fee-for-service trend so that its introduction does not reduce ACO savings relative to a pre-MOD2 baseline. We also support extending the benefit to Rural Health Clinics and Federally Qualified Health Centers.

Vytalize Health
2 Hudson Place, 6th Floor
Hoboken, NJ 07030
(844) 460-0098

www.vytalizehealth.com
info@vytalizehealth.com

Vytalize

III. RFI: Redesigning Primary Care to Make America Healthy Again

(CMS-1848-P, section II.E)

A. Care Management Codes and Technology-Enabled Care (CMS-1848-P, section II.E.3)

Vytalize supports simplifying care management payment and is open to new payment approaches for technology-enabled care. Payment for technology-enabled care should reflect demonstrated clinical value via contribution to better patient outcomes and reduction of total cost of care across populations to which it is deployed. Additional codes that reward activity or documentation rather than measured improvement in patient health could expand spending without improving care. Within accountable arrangements, prospective payment can support implementation of technology and care management across a population. Outside those arrangements, CMS should further develop the accountability framework before broadly implementing new payment pathways.

B. Payment Implications of Technology Enablement of Primary Care (CMS-1848-P, section II.E.4)

CMS has taken significant steps towards centering outcomes in payment, including CMS's ACCESS Model and removing low-value process measures from quality reporting. CMS should carry this principle through to its technology and prospective-payment policies. Prescribing how care must be organized or how funds must be distributed could limit innovations that achieve better results through different approaches.

Responsibility for total cost of care and quality already rests with the ACO. A technology partner's performance obligations to that ACO should be established by contract. This allows ACOs to select and pay for tools that meet their patients' needs while retaining responsibility for overall results.

When technology is paid through the PFS outside an accountable arrangement, those responsibilities require further exploration. Who will ensure that findings lead to appropriate care? Which outcomes will determine value, over what period, and what happens if they are not achieved? CMS should consider measures such as clinical improvement, avoidable hospital use, and downstream spending with safeguards for safety and access. Payment for a tool alone does not create the infrastructure or responsibility needed to manage care. If CMS does pay for technology-enabled care, the technology should strengthen the relationship between clinicians and their patients. Tools that route patients around their physician or substitute an algorithm for clinical judgment should not qualify.

Vytal Insights, our clinical decision support platform, illustrates the opportunity for technology to improve healthcare value. The platform processes claims and EHR data before a visit and presents the treating clinician with patient-specific recommendations grounded in clinical guidelines and peer-reviewed literature. Recommendations appear within the EHR with supporting evidence; the physician

Vytalize Health
2 Hudson Place, 6th Floor
Hoboken, NJ 07030
(844) 460-0098

www.vytalizehealth.com
info@vytalizehealth.com

accepts or declines them. The tool informs the clinician's judgment and the patient conversation that follows; it does not replace either. The current version of the platform, built on deterministic clinical logic, has been in production for over two years and is deployed across approximately 300 practices. In a 2024 randomized pilot, clinicians receiving recommendations acted on them at 1.9 times the rate of the control group. Internal analyses identified more than 19,000 additional clinical actions in 2025. These findings demonstrate adoption and changes in care delivery.

Building on this foundation, we have made a substantial investment in a next-generation, AI-enabled version of the platform that delivers recommendations directly into the EMR and enhances the precision and personalization of the system to drive clinical actions that help improve patient health and reduce hospitalizations.

Low marginal delivery costs can extend clinical support to more patients. However, developing, validating, integrating, and implementing these tools requires substantial investment. Vytalize supports the agency's exploration of payment options to expand the use and reach of innovative technologies. CMS should explore approaches that reward demonstrated value, while preserving incentives to invest in useful innovation.

C. Developing Prospective Primary Care Payment in MSSP (CMS-1848-P, section II.E.6)

Vytalize supports prospective primary care payment as a permanent MSSP option. We administer primary care capitation in ACO REACH today. Practices must hire, train, and optimize workflows before savings appear, while shared savings arrive well after the performance year. Prospective payment can finance that work when it is needed.

Prospective payments should flow to the ACO for distribution under its written participant agreements. As the entity accountable for quality and total cost of care, the ACO is best positioned to align payments with practice needs and transformation priorities while funding shared infrastructure, including team-based care support, EHR integration, analytics, beneficiary engagement, and technology, that benefits multiple practices. Requiring a fixed pass-through percentage to providers could inadvertently limit innovations. CMS should allow room for innovation in payment arrangements between ACOs and practices and gather data to evaluate how such arrangements improve outcomes.

For enhanced primary care capitation, CMS should permit repayment over the agreement period rather than requiring annual repayment. Annual recoupment makes investments with multiyear returns in care improvement and cost reduction harder to finance and favors activities with quicker paybacks. Providing a longer repayment period would better match the time needed to build infrastructure and improve care.

Vytalize Health
2 Hudson Place, 6th Floor
Hoboken, NJ 07030
(844) 460-0098

www.vytalizehealth.com
info@vytalizehealth.com

Extending primary care capitation more broadly through the PFS raises the same accountability questions as direct technology payment. Before doing so, CMS should further develop who would be responsible for outcomes, coordination, and downstream costs, and how practices would obtain the necessary support.

IV. Medicare Shared Savings Program

A. Quality Reporting: Medicare CQM Population and Participant TIN Exclusions (CMS-1848-P, sections III.G.3.c and III.G.3.d)

Vytalize Health supports the proposed ACO participant TIN exclusions at § 425.508(c), the use of flat benchmarks for the new Medicare eCQMs collection type, and the alignment of the Medicare CQM reporting population with the ACO's assigned beneficiaries. We ask CMS to apply the revised definition of "beneficiary eligible for Medicare CQMs" at § 425.20 beginning in PY 2026 rather than PY 2027.

The TIN exclusion, though helpful for practice-level circumstances outside an ACO's control, does not address the PY 2026 mismatch between the Medicare CQM reporting population and the ACO's assigned population because the exclusion is limited to enumerated circumstances, and it operates at the TIN level. Based on Vytalize's latest Medicare CQM list, almost 20 percent of beneficiaries on whom we would need to report under the current definition are not assigned to our ACO.

The public-interest determination CMS has proposed under section 1871(e)(1)(A) to support retrospective application for § 425.508 applies equally to the revised definition: PY 2026 quality data are not submitted until 2027, CMS already produces quarterly assigned-beneficiary lists, and no ACO is harmed by reporting on a narrower population. If CMS is concerned about reliance on the current definition, we ask in the alternative that ACOs be permitted to elect either population for PY 2026.

B. Certified Electronic Health Record Technology (CEHRT) Use (CMS-1848-P, sections III.G.3.d and III.G.4.b)

Vytalize supports the proposed quality-reporting flexibilities and simplification of CEHRT use requirements. However, CMS should also extend enforcement discretion through performance year 2027 and retain appropriate small-practice exclusions. Final requirements will arrive after ACOs have contracted with practices and planned implementation, and ACOs need sufficient time to ensure compliance.

C. Shared Savings Program Financial Methodology (CMS-1848-P, section III.G.5)

1. Regional Adjustment for Lower-Spending ENHANCED Track ACOs

We disagree with CMS's proposal to reduce the maximum positive regional adjustment weight for lower spending ENHANCED track ACOs to 35 percent, which would weaken incentives for ACOs that

Vytalize Health
2 Hudson Place, 6th Floor
Hoboken, NJ 07030
(844) 460-0098

www.vytalizehealth.com
info@vytalizehealth.com

sustain lower spending while meeting quality requirements and investing in primary care, including care for beneficiaries with complex conditions. CMS should retain the 50 percent maximum positive regional adjustment weight for lower-spending ENHANCED track ACOs. We support the proposed increase in the prior savings adjustment scaling factor to 75 percent, but that increase cannot be assumed to offset the reduction for ACOs whose regional adjustment remains larger.

2. Cap on Upward Benchmark Adjustments

Vytalize supports risk adjusting the cap on positive regional, prior savings, and population adjustments, with a floor of 1.0 on the risk multiplier to prevent a lower cap. We also urge CMS to raise the cap from 5 to at least 7 percent of risk-adjusted national per-capita expenditures. ACOs that sustain lower spending should have room to retain returns from their performance, reinvest in primary care and support continued participation in downside-risk arrangements.

3. Growth Adjustment

Vytalize supports the proposed growth adjustment to the historical benchmark. We disagree, however, with the proposal to count only beneficiaries new to a shared savings initiative who are assigned to an ACO professional who is also new. That pairing excludes practices already participating in an ACO that expand their Medicare fee-for-service panels or add clinicians. To achieve CMS's stated intent to "target those ACOs that are actively engaged in expanding their beneficiary population," CMS should drop the requirement that the ACO professional be new. The minimum growth thresholds, cap on new growth at overall growth, and the measurement of beneficiary experience against the BY3-year assignment already ensure that new beneficiary growth represents active efforts to bring in new beneficiaries.

4. BASIC Level E Sharing Rate

Vytalize supports increasing the BASIC Level E shared savings rate from 50 to 60 percent. Allowing ACOs and their participating practices to retain more shared savings strengthens the ability to invest in care transformation and build experience with financial risk.

5. Accountable Care Prospective Trend

Vytalize supports performance-year-specific trend rates, the proposed Accountable Care Prospective Trend (ACPT) guardrails, and retroactive application of the lower guardrail for affected ACOs. However, the delay in settlement payments may create hardships for the independent practices we serve. CMS should therefore issue provisional performance year 2025 payments under the existing methodology as soon as other reconciliation inputs are complete, then make supplemental payments in December 2026 after applying the finalized guardrail. This approach would preserve the benefit of the reform while reducing disruption to practice distributions and clinical investments.

Vytalize Health
2 Hudson Place, 6th Floor
Hoboken, NJ 07030
(844) 460-0098

www.vytalizehealth.com
info@vytalizehealth.com

Vytalize

D. Program Integrity and ACO Performance (CMS-1848-P, section II.D.3.c, item (49), and section III.G.5.g; 42 CFR § 425.315)

This rule's proposals to nationally price non-sheet skin substitutes continue CMS's response to improper billing that has also reached ACO expenditures, and the retroactive application of the ACPT guardrail shows CMS's willingness to revisit settled performance years when methodology produced inaccurate results. Consistent with the compliance obligations that apply to all ACOs, Vytalize reports suspicious billing patterns identified through claims analytics. CMS should address confirmed improper payments consistently in ACO financial calculations. Where those payments materially distort prior ACO results, CMS should review the affected determinations and apply its reopening authority under 42 CFR § 425.315, so that improper payments do not reduce resources available for patient care. Greater transparency on CMS's thresholds and process for reopening would give ACOs more certainty that they will not bear the cost of improper billing outside their control.

V. Conclusion

Vytalize Health appreciates CMS's continued commitment to accountable care. The proposed rule takes significant steps to improve viability for primary care practice participation in value-based care and demonstrates CMS's commitment to leveraging innovative technologies for sustained care improvement. Vytalize would welcome further opportunities for discussion and data sharing to inform CMS's direction on value-based care transformation. For follow up on any of the comments outlined above, please contact Vice President of Policy and Program Strategy Steve Bloom at steve.bloom@vytalizehealth.com.

Sincerely,

Faris Ghawi

Faris Ghawi
Chief Executive Officer

Amer Alnajar

Amer Alnajar, MD
Chief Medical Officer

Vytalize Health
2 Hudson Place, 6th Floor
Hoboken, NJ 07030
(844) 460-0098

www.vytalizehealth.com
info@vytalizehealth.com