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Advancing Health in America

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September 12, 2025

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS–1832–P Medicare and Medicaid Programs; Calendar Year 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program

Dear Administrator Oz:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations; our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS') physician fee schedule (PFS) proposed rule for calendar year (CY) 2026.

The AHA applauds CMS' proposals to extend many telehealth regulatory flexibilities through 2026. There are, however, many statutory waivers that are scheduled to expire on Sept. 30, 2025. **As such, we urge CMS to work with Congress to extend these telehealth provisions.** Their expiration would result in a telehealth "cliff," risking reduced access to care for the millions of Americans who rely on virtual modalities to receive necessary services. As we have previously stated, making certain telehealth waivers permanent, such as the geographic and originating site restrictions, is essential for ensuring continued access to medical care and services.

We are also pleased that the agency proposes a positive payment update for physicians in CY 2026, which will be the first in several years. We remain concerned, however, about the overall inadequacy of Medicare physician payments and its potential impact on access to and quality of care. The conversion factor has declined

precipitously over the past 25 years, especially when accounting for inflation. Hospitals and health systems are currently facing the perfect storm of payment shortfalls coupled with a significant nationwide staffing shortage, additional administrative burdens and an aging beneficiary population. **Therefore, we urge CMS to work with Congress to ensure more adequate physician payment updates going forward.**

We are concerned with CMS' proposals to apply an efficiency adjustment to the work relative value units (RVUs) and to reduce by half the facility practice expense (PE) RVUs allocated based on physician work. Implementing a uniform 2.5% reduction to the work RVUs for all non-time-based services to adjust for efficiency is arbitrary and overly broad. In addition, the proposed change to the indirect PE allocation methodology would result in significant and unsustainable payment impacts for specialty physicians who frequently practice in a facility setting. **We urge CMS not to finalize these proposals and instead to consider policy options that do not impart such negative impacts.**

The AHA appreciates CMS' commitment to improving the quality of care while reducing costs through the proposed Ambulatory Specialty Model (ASM). However, we have questions and concerns regarding ASM's financial model, attribution methodology and quality performance standards. **We urge CMS to move forward with the ASM as either a voluntary model or a MIPS Value Pathway rather than requiring participation for all eligible physicians beginning in 2027.**

We appreciate your consideration of these issues. Our detailed comments are attached. Please contact me if you have questions or feel free to have a member of your team contact Joanna Hiatt Kim, AHA's vice president of payment policy at jkim@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis & Development

Enclosure

American Hospital Association
Detailed Comments on the Physician Fee Schedule Proposed Rule for Calendar Year 2026

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CONVERSION FACTOR UPDATE

As required by law, beginning in CY 2026, CMS proposes implementing two separate conversion factors: one for qualifying alternative payment model (APM) participants (QPs) and one for physicians and practitioners who are not QPs. The rule would increase the QP conversion factor by 3.83% in CY 2026 as compared to CY 2025. It would increase the non-QP conversion factor by 3.62% in CY 2026 as compared to CY 2025. These updates include statutory updates of 0.75% and 0.25% for the QP and non-QP factors, respectively; another statutory update of 2.5% as required by the One Big Beautiful Bill Act; and an increase of 0.55% that CMS states is necessary to account for proposed changes to the work RVUs.

The AHA supports CMS' proposal to provide a positive payment update for physicians. However, we note that physician payments continue to be inadequate. In fact, they are lower than they were a full 25 years ago. Specifically, the proposed conversion factors of $33.59 and $33.42 are 12% and 13% lower, respectively, than the CY 2001 conversion factor of $38.26.

The conversion factor has declined even more when considering inflation. Specifically, according to the American Medical Association (AMA), physician payment has dropped by 33% since 2001 when accounting for inflation.[1] This indicates that the impacts of inflation and rising input costs continue to outpace payments for services under the PFS. Appropriately accounting for recent and future trends in inflationary pressures and cost increases in the payment updates is essential to ensure that Medicare payments for professional services more accurately reflect the cost of providing care.

The latest Medicare Trustees report acknowledged the inadequacy of Medicare physician payments and the potential impact on quality of care. It states, "[c]ertain features of current law may result in some challenges for the Medicare program. For example, physician payment update amounts are specified for all future years. These amounts do not vary based on underlying economic conditions, and they are not expected to keep pace with the average rate of physician cost increases."[2]

Moreover, because many other payers tie their payment rates to the Medicare PFS, providers' losses under Medicare are compounded by losses from other payers. Uncertainty in year-to-year payment updates and program extensions has only exacerbated clinicians' and hospitals' financial instability. This is especially true because of the interaction of these payment shortfalls with other headwinds. Hospitals and health systems are currently facing a national staffing emergency that could jeopardize patients' and communities' access to high-quality care. Indeed, physician shortages are projected to exceed 86,000 physicians by 2036, according to the Association of

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[1] https://www.ama-assn.org/system/files/2025-medicare-updates-inflation-chart.pdf.
[2] https://www.cms.gov/oact/tr/2025.

American Medical Colleges.[3] We also have seen how increased administrative burden contributes to physician burnout and to clinicians leaving the field. The aging beneficiary population has increased demand for services, while the supply of clinicians continues to decline. More sustainable solutions are needed to ensure that updates to the PFS more accurately reflect the cost of delivering services.

Therefore, we urge CMS to work with Congress to ensure more adequate updates going forward. Doing so would help protect patients' access to care and ensure Medicare maintains a robust network of clinicians of all specialties.

EFFICIENCY ADJUSTMENT

CMS proposes to apply an efficiency adjustment to the work RVUs. It states that its proposal is based on an assumption that both the clinician's time directly providing the service to a patient as well as their work intensity would decrease as they develop expertise in performing the service. The agency expects non-time-based codes, such as those describing procedures, radiology services and diagnostic tests, to become more efficient as they become more common, professionals gain more experience, technology is improved, and other operational improvements are implemented.

To calculate the efficiency adjustment, CMS proposes using the Medicare Economic Index (MEI) productivity adjustment. This adjustment reflects the most recent historical estimate of the 10-year moving average growth of private nonfarm business total factor productivity (TFP), as calculated by the Bureau of Labor Statistics. It is substantively similar to the productivity adjustment used in other Medicare payment systems, such as the inpatient prospective payment system (PPS) and outpatient PPS (OPPS).

For CY 2026, CMS would apply the efficiency adjustment using a look-back period of five years. This methodology yields a proposed efficiency adjustment of -2.5%, which would be updated in the final rule. The agency states that, generally, specialties that bill more often for timed codes (such as family practice, clinical psychologists, clinical social workers, geriatrics and psychiatry) would see an increase in RVUs, while specialties that bill more often for procedures, diagnostic imaging and radiology services (such as radiation oncology, radiology and some surgical specialties) would see a decrease in RVUs. If finalized, CMS would update and apply the efficiency adjustment every three years.

The AHA opposes this proposal. While we appreciate CMS' commitment to ensuring timely and accurate valuation of the work RVUs, the proposed efficiency adjustment is arbitrary and overly broad. CMS has not explained why this adjustment should be applied uniformly to the work RVUs of *all* non-time-based services

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[3] https://www.aamc.org/news/press-releases/new-aamc-report-shows-continuing-projected-physician-shortage.

paid under the PFS. That is, rather than analyzing the wide variety and individual characteristics of physicians' services, the agency would use the blunt tool of an across-the-board reduction. This approach presumes that a base, uniform level of efficiency has accrued across all physicians' services regardless of the nature of the service or when CMS last valued it. **Such a presumption is arbitrary and unsupported by empirical evidence.**

Indeed, CMS itself acknowledges that "over time, there may be variation in the efficiencies accrued service-by-service," and cites research supporting this point. For example, there may be less potential for efficiency gains for major inpatient and longer duration surgical procedures than for minor procedures or diagnostic tests. **Notably, a recent study in the Journal of the American College of Surgeons found that CMS' proposed efficiency adjustment is not supported by empirical surgical time data.** The study concluded that "[f]or the majority of surgical procedures, operative times have stayed the same or increased from 2019 to 2023. Patient complexity also correspondingly increased. The rationale for an efficiency adjustment to the Medicare physician fee schedule for surgical procedures is not supported by objective data from a national surgical registry."[4]

In addition, as noted, CMS would apply the efficiency adjustment to all non-time-based codes regardless of how recently a code has been reviewed and revalued. The agency estimates an average of approximately 17 years between a code's introduction and its subsequent review by the AMA/Specialty Society RVS Update Committee (RUC). However, under its proposal, the same 2.5% reduction would apply to a code that was reviewed one year ago as to one that was reviewed 17 years ago. This is problematic because codes that have been reviewed recently should already reflect any efficiency gains made in the work RVUs. **As such, applying an efficiency adjustment to recently reviewed codes would be not only arbitrary but also duplicative of efficiencies already considered and accounted for.**

The efficiency adjustment would be based on the MEI productivity adjustment reflecting the most recent historical estimate of the 10-year moving average growth of private nonfarm business TFP. As we have previously commented, **this measure is not an appropriate or reliable predictor of productivity for the health care field.** First, outputs in the TFP are measured as a function of the total quantity and prices of the goods and services produced in private nonfarm businesses. For sectors that sell physical products, measuring these outputs is relatively straightforward and often standardized. However, health care quantity and prices do not operate in this way. For example, quantities such as physicians' services are not necessarily an appropriate output measure; such a measure actually may be more reflective of the disease burden

[4] https://journals.lww.com/journalacs/abstract/9900/longitudinal_trends_in_efficiency_and_complexity.1369.aspx.

of a community. More volume — thus more quantity — does not equate to more productivity in the same manner as it does for private nonfarm businesses. In addition, health care prices per unit of service often cannot be adjusted in response to changes in demand or quality; those of private nonfarm businesses can be. This is because much of health care reimbursement is through fixed payments. Hospitals and health systems cannot alter their prices in the same manner that private nonfarm businesses can. For example, prices for commercially insured patients are determined through negotiations, which often lock in rates for several years.

Second, the TFP does not reflect unique challenges that prevent health care providers from achieving productivity improvements consistent with those in the broader economy. Specifically, the private nonfarm business sector encompasses a broad range of industries with stable and predictable production processes. In contrast, health care providers operate in a complex environment characterized by unpredictable patient volumes, rising input costs and varying acuity levels, not to mention natural disasters and pandemics. Health care providers also face heavy regulatory burdens beyond those of other industries. Private nonfarm businesses rarely have such onerous challenges and requirements.

Third, the health care field is different from private nonfarm businesses because the services they provide are highly labor-intensive. As we have previously noted, it has long been theorized in the economic literature that sustained productivity gains in service-intensive industries are difficult to achieve given their heavy reliance on labor, which cannot be scaled or automated. Health care providers are, in this way, more similar to fields like education and social assistance. These industries all experience lower TFP rates. For example, the rates range from -0.4 for educational services to -0.1 for social assistance as compared to 1.9 to 4.9 for the mining, oil and gas; information; and professional services sectors, according to the Bureau of Labor Statistics.

In fact, CMS itself has acknowledged that health care providers are unable to achieve the same productivity gains as the general economy over the long run. Specifically, it found that providers can only achieve a productivity gain that is one-third of the gains seen in the private nonfarm business sector.[5] **For all these reasons, using the private nonfarm business sector TFP to adjust the work RVUs is inappropriate.**

Finally, CMS regularly revalues codes as part of its potentially misvalued codes initiative as required by section 1848(c)(2)(K) of the Social Security Act. **Therefore, instead of applying this overly broad efficiency adjustment, CMS should consider making process improvements to the potentially misvalued codes initiative or creating other narrowly tailored policy options.** For example, the agency could prioritize review of high-volume codes to ensure greater impact of the efficiency gains captured.

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[5] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/ProductivityMemo2016.pdf.

PRACTICE EXPENSE METHODOLOGY

CMS states that over the past two decades or so, there has been a steady decline in the percentage of physicians working in private practice and a corresponding rise in physician employment by hospitals, as well as growth in the percentage of physicians who practice exclusively, or almost exclusively, in the facility setting. However, when the PFS was established, the methodology for allocating indirect PE was based in part on an assumption that the physician maintained an office-based practice while also practicing in a facility setting. As such, CMS is concerned that its methodology may now overstate the indirect costs incurred by facility-based physicians.

Beginning in CY 2026, for each service valued in the facility setting under the PFS, CMS proposes to reduce the portion of the facility PE RVUs allocated based on work RVUs to half the amount allocated to non-facility (office-based) PE RVUs. The agency states that specialties that practice primarily in the facility setting would see a decrease in PE RVUs as a result of this redistribution. Specialties that perform services primarily in the non-facility (office-based) setting would see an increase in PE RVUs.

The AHA opposes this proposed change to the indirect PE allocation methodology. We are deeply concerned about the significant downward impact it would have on the payments to many physicians. Specifically, CMS estimates physician payments in the facility setting would decrease by 7%. However, the impact on certain specialties would be even worse. For example, the agency indicates that a staggering 37% of hematology/oncology physicians would see a cut of more than 10% in their total RVUs.[6] Similarly, 82% of critical care, 80% of infectious disease and 55% of general surgery and internal medicine practitioners would experience a decrease of over 5%. **Physicians cannot withstand such deep cuts in payment, especially when considering the sustained decline in the conversion factor since CY 2001. Indeed, we believe that this proposal would have the unintended consequence of further restricting beneficiary access to specialty care and exacerbating clinical workforce shortages, particularly in rural and underserved areas.** It is also deeply contrary to CMS' stated policy goal of helping ensure PFS payment stability and predictability. Payment cuts of this magnitude could undermine stability in budgeting, resource determination and staffing within physician practices and health systems.

In addition, we are concerned that the proposed change to the indirect PE allocation methodology would create inappropriate incentives. For example, it would create an even greater incentive for physicians to seek employment from non-traditional providers, such as private equity firms and commercial insurers. Indeed, a variety of factors contribute to physician practice acquisition — notably inadequate reimbursement, but also regulatory burden and commercial insurer prior

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[6] https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1832-p.

authorization policies.[7] Although disproportionate attention has been placed on hospitals' acquisition of physician practices, we note that other entities, such as commercial insurers, have collectively invested billions of dollars in physician practice acquisitions. Based on an AHA analysis of Levin Associates data, private equity, physician groups and health insurers accounted for the vast majority of physician practice acquisitions from 2019 to 2023.[8] Comparatively, hospitals and health systems accounted for only 6% of acquisitions during this period. **Significantly reducing Medicare payment rates for certain physicians would only increase the move in physician practices towards these nontraditional providers.**

This proposal also would create anomalous incentives regarding individual services and patient care. For example, nursing facility care provided by physicians is classified as non-facility, while skilled-nursing facility (SNF) care is classified as facility. However, a patient could be changed from non-skilled to skilled care overnight and still be in the same bed and the same room. Physicians who see such a patient would not see their indirect costs vary based on how the patient is classified, yet under the proposal they would be paid less for the SNF care.

Finally, CMS acknowledges in the proposed rule that the indirect PE of physicians who are solely facility-based should be accounted for in PFS payment. We agree with the agency that these indirect costs should continue to be accounted for in the PE methodology — for all physicians. When a physician performs a service or procedure in a facility setting, their practice generally continues to handle many aspects of patient care. Yet these are not allowable costs on the hospital cost report — that is, hospitals are not reimbursed for them. **As such, their full reimbursement is necessary under the PFS.** For example, these costs include patient scheduling (including pre- and post-operative visits for surgical procedures), maintaining the electronic health record, and coding and billing the claim for physicians' services. The practice needs administrative staff to perform these functions while their clinical staff perform work supporting the clinical services provided in the facility setting. Office space separate and apart from the hospital or facility is often required for the practice's administrative and clinical staff. Moreover, the practice would incur other indirect costs associated with information technology, human resources, legal, patient records and practice management. It is worth noting that these functions are not fully reflected in CMS' claims data. Global surgery codes are an example. Bundled post-operative office visits often take place in the physician's office even though the surgery was performed in a facility setting. However, this visit would not be billed as such given the global nature of the code. Indeed, it is common for surgical specialties to maintain

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[7] https://www.aha.org/fact-sheets/2023-06-07-fact-sheet-examining-real-factors-driving-physician-practice-acquisition.

[8] https://www.aha.org/system/files/media/file/2023/06/Private-Equity-and-Health-Insurers-Acquire-More-Physicians-than-Hospitals-Infographic.pdf.

offices that are open while they are performing surgery at a facility and conduct post-operative visits in these offices.

Therefore, the AHA recommends that CMS maintain the work allocator for indirect PE at 100%, as under the current methodology. We encourage CMS to consider alternative data sources that include more granular detail on indirect costs and further examine how these costs are incurred in providing physicians' services. Further consideration of these issues is needed before the agency adopts policy changes to the PE methodology, particularly with this magnitude of impact on specialists.

REVISING THE MEDICARE ECONOMIC INDEX

The MEI has long served as a measure of practice cost inflation and a mechanism to determine the proportion of RVUs, and therefore payments, attributed to physician work (time and intensity) and PEs. It measures changes in the cost of resources used in medical practices, including labor (both physician and non-physician), office space and medical supplies. These resources are grouped into cost categories, with each category assigned a weight and a price proxy. The MEI also includes an adjustment to account for improvements in the productivity of practices over time.

Historically, the MEI was based on 2006 data representing only self-employed physicians. In the CY 2023 PFS final rule, CMS rebased and revised the MEI to use publicly available data sources for 2017 input costs representing all types of physician practice ownership. However, the agency has not applied the new weights to its payment methodology. This is because while it anticipated that the revised weights would not impact overall spending for PFS services, they would impact the distribution of payments based on geography and specialty.

For CY 2026, CMS proposes to maintain the current MEI cost share weights. The agency cites its policy goal of balancing PFS payment stability and predictability with incorporating new data through routine updates to the MEI. **We share CMS' concerns about the redistributive effects of the rebased and revised MEI and therefore support a further delay in its implementation.** Specifically, its adoption would cause significant cuts for cardiac surgery, neurosurgery and emergency medicine. In addition to significant specialty redistribution, geographic redistribution would also occur. For example, a significant reduction in the weight of office rent would lead to substantial reductions in payment for urban localities. These changes would come on top of the other substantial cuts physicians have seen in recent years, including the historical decline in the conversion factor.

USE OF OUTPATIENT PPS DATA FOR PFS RATE-SETTING

For several types of services paid under the PFS, CMS proposes deviating from its historic use of AMA survey data and instead using auditable, routinely updated hospital data. Specifically, for CY 2026, the agency proposes to:

- Use the relationship between OPPS ambulatory payment classification (APC) payment rates to establish PE RVUs for radiation oncology treatment delivery and superficial radiation treatment services.
- Use OPPS cost data to establish the value for the PE portion of remote physiologic monitoring and remote therapeutic monitoring services because it believes that these cost data are more accurate than the PE inputs currently used.
- Use hospital outpatient utilization patterns to set payment rates for three categories of skin substitutes.

We appreciate CMS' efforts to reexamine these codes to ensure their accuracy. We also recognize the difficulty in maintaining relative values for services when the associated costs include capital-intensive and specialized resources that are difficult to compare to other types of resources, such as radiation treatment services. **However, the AHA opposes the use of OPPS data to set payment rates under the PFS.**

CMS has not fully analyzed whether hospital outpatient data accurately reflect the relative resource costs involved in furnishing physicians' services. And, given that significantly different methodologies and data sources are used in PFS and OPPS rate-setting, there are reasons to think they may not. For example, the PFS methodology for establishing PE RVUs takes a granular "bottom up" approach and examines the line-item costs associated with performing a service paid under the PFS. In contrast, OPPS payments are calculated based on the geometric mean cost of services in the same APC. Using the relationship between APCs or hospital outpatient cost data as a proxy for the PEs incurred in providing physicians' services has the potential to distort relativity among the services paid for under the PFS. **Instead of its proposed approach, we encourage the agency to identify alternative sources of data that are more relevant to the costs that physicians actually incur in providing these services.**

In addition, as mentioned in our comments on the CY 2026 OPPS proposed rule, we have concerns about CMS' proposals regarding APC assignment for two of the newly revised CPT codes for radiation treatment delivery services. We recommend that:

- CPT code 77407 be assigned to APC 5623 (Level 3 Radiation Therapy), which has a proposed payment of $600.14, rather than the proposed assignment into APC 5622 (Level 2 Radiation Therapy) with a proposed payment of $275.34.
- CPT code 77412 be assigned to APC 5624 (Level 4 Radiation Therapy), which has a proposed payment of $715.83, rather than the proposed assignment into APC 5622 (Level 2 Radiation Therapy) with a proposed payment of $275.34.

We note there are both clinical and cost rationales for including CPT codes 77407 and 77412 in the higher-level APCs, as discussed in our comments on the CY 2026 OPPS proposed rule.

CHANGES TO PAYMENT FOR TELEHEALTH SERVICES

The AHA and our members continue to applaud the Administration's support of telehealth and ongoing efforts to develop a long-term structure for the efficient delivery of telehealth services. **We appreciate CMS' proposals to extend or make permanent several telehealth flexibilities. However, we cannot emphasize enough the need to permanently waive additional statutory and regulatory restrictions on telehealth services.**

The telehealth flexibilities granted because of the COVID-19 public health emergency (PHE) resulted in significant benefits to patient care. Their continuance is needed now, more than ever, to ensure patients' continued access to high-quality care. The expansion of telehealth services has transformed care delivery, expanded access for millions of Americans and increased convenience in caring for patients, especially those with transportation or mobility limitations. Given current health care challenges, including major clinician shortages nationwide, telehealth holds tremendous potential to leverage geographically dispersed provider capacity to support patient demand.

However, barring further action by Congress, the current patchwork of temporary statutory flexibilities for telehealth services will expire on Sept. 30, 2025. If this occurs, we risk a telehealth "cliff" that would negatively impact patient access in all communities. **Recognizing both the immediate and potential long-term benefits of telehealth, we urge CMS to work with Congress to ensure that statutory restrictions are lifted, including:**

- Permanently eliminating originating- and geographic-site restrictions, which would allow telehealth visits to occur at any site where the patient is located, including urban areas and the patient's home.
- Permanently eliminating in-person visit requirements for behavioral telehealth services, which would ensure that patients do not need an in-person visit before initiating virtual treatment.
- Permanently removing distant site restrictions on federally qualified health centers and rural health clinics, which would ensure that they can continue to provide telehealth services.
- Permanently allowing payment and coverage for audio-only telehealth services.
- Permanently expanding eligible telehealth provider types to include physical therapists, occupational therapists, speech-language pathologists and audiologists.

While the temporary extensions have been much appreciated, they have also created uncertainty for patients, caregivers and providers. Operationally, many providers are scheduling appointments several months out (especially in provider shortage areas), and the lack of stability has left both providers and patients concerned about the ability to continue vital services.

Our comments on CMS' specific telehealth proposals are as follows.

Changes to Medicare Telehealth Services List

CMS proposes to revise the five-step review process for requests to add services to the Medicare Telehealth Services List by removing two steps. In addition, services on the list would no longer be designated as "permanent" or "provisional;" instead, all services would be considered permanent. The agency states that its proposal would simplify and reduce the administrative burden of submission and review of services to the list.

We support CMS' proposal. As technology and consumer preferences have evolved, more care can safely be delivered via telehealth. However, numerous regulations have inappropriately restricted the use of virtual care. The agency's proposal would reduce some of these restrictions. **In fact, we urge CMS to go a step further in reducing burden by including all Medicare-covered services as eligible telehealth services. They could then be removed on a case-by-case basis.**

If the proposal to eliminate the "provisional" and "permanent" designations is not finalized, CMS states that it would complete an analysis of all provisional codes before determining whether individual provisional codes should be made permanent. **We request that, if this becomes the case, CMS complete this evaluation in a comprehensive, timely and transparent manner.**

In this rule, CMS proposes to add four services to the Medicare Telehealth Services List for CY 2026:

- Multiple-Family Group Psychotherapy (CPT code 90849)
- Group Behavioral Counseling for Obesity (HCPCS code G0473)
- Infectious Disease Add-On (HCPCS code G0545)
- Auditory Osseointegrated Sound Processor (CPT codes 92622 and 92623)

The AHA supports adding these services to the Medicare Telehealth Services List, which will add to the tools providers can use to care for patients.

In response to questions received, CMS clarified that digital mental health treatment, remote physiological monitoring (RPM), and remote therapeutic monitoring (RTM) services do not meet the definition of telehealth services under section 1834(m) of the Social Security Act. While we recognize that certain services may not meet the statutory definition of telehealth, evaluation of virtual services outside the definition is still worthwhile. Indeed, CMS has already adopted, on a case-by-case basis, certain non-face-to-face codes for RPM, RTM, artificial intelligence and e-visits, and virtual check-ins. As technology advances, applications of digital care delivery will become broader than audio-visual visits. **To support innovative applications, we encourage CMS to**

define a parallel process to review virtual services that may not meet the statutory definition of telehealth services.

Frequency Limitations on Subsequent Care Services in Inpatient and Nursing Facilities and Critical Care Consultations

Historically, certain telehealth-eligible services had frequency limitations. For CY 2026, CMS proposes to permanently remove telehealth frequency limitations for:

- Subsequent inpatient visits (CPT codes 99231, 99232, 99233)
- Subsequent nursing facility visits (CPT codes 99307, 99308, 99309, 99310)
- Critical care consultation services (HCPCS codes G0508, G0509)

The AHA supports this proposal for the services listed above. We support the permanent removal of frequency limitations, as when and how patients receive care should be left to clinical judgment so long as the standard of care is met.

Provider Home Address

During the COVID-19 PHE, CMS allowed practitioners to render telehealth services from their homes without reporting their home address on their Medicare enrollment while continuing to bill from their currently enrolled location. CMS subsequently extended these flexibilities through CY 2025. However, in this rule, the agency has not addressed this topic.

We are deeply concerned that, absent additional CMS action, this requirement would go into effect Jan. 1, 2026. Doing so would pose substantial privacy issues since home addresses may be publicly available on sites like Medicare Care Compare without providers' knowledge or consent. Given the experience with the COVID-19 pandemic, many hospitals, health systems and clinicians have moved to hybrid schedules where some physicians and staff are working remotely. This flexibility fosters improved retention, which is especially important in light of the significant staffing shortages nationwide. Requiring clinicians to list their home addresses on enrollment and claims forms, which patients or others in the public can access, poses privacy and safety risks. This is a particular concern given the increased incidence of violence against health care workers. Recent studies indicate, for example, that 44% of nurses reported experiencing physical violence and 68% reported experiencing verbal abuse during the COVID-19 pandemic.[9] Regulatory requirements such as these lead to clinicians experiencing burn out and leaving the profession, something we cannot afford.

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[9] https://www.aha.org/system/files/media/file/2022/09/Fact-Sheet-Workplace-Violence-and-Intimidation-and-the-Need-for-a-Federal-Legislative-Response.pdf.

In addition, the guidance is not clear on the appropriate reporting of the home address if this requirement were to take effect. For example, it is unclear if it is required only for practitioners providing 100% of encounters from their homes, or whether this policy would result in audits and inspections of clinicians' homes. There is also concern about the operational and administrative burden of tracking and reporting changes in clinicians' home addresses if and when they move. **As such, we urge CMS to include a provision in the final rule *permanently* allowing clinicians to continue billing from their currently enrolled practice location instead of their home address when providing services from their home.**

Direct Supervision

During the COVID-19 PHE, CMS allowed clinicians to satisfy direct supervision requirements for diagnostic tests, services furnished incident to a physician's services and some hospital outpatient services through virtual presence using real-time audio-video technology. The agency then continued allowing virtual presence to satisfy direct supervision requirements through the end of CY 2025. In this rule, it proposes to *permanently* adopt this definition of direct supervision for all services except those with a 010 or 090 global surgery indicator. **The AHA strongly supports this proposal.** This critical flexibility has supported improved access to care for patients in underserved areas, and we agree it should be made permanent.

Supervising Residents in Teaching Settings

After the COVID-19 PHE, CMS temporarily allowed (through CY 2025) teaching physicians to meet requirements to be present for key or critical portions of services involving residents through virtual presence (real-time audio-visual communications technology) in all teaching settings, but only when the service is furnished virtually (for example, a three-way telehealth visit, with the patient, resident and teaching physician in separate locations). However, in this rule, CMS proposes to end this flexibility and allow virtual presence only for services furnished in residency training sites located outside of Metropolitan Statistical Areas (MSAs).

The AHA does not support this proposal. Instead, we urge CMS to extend the virtual presence flexibilities for MSAs as well as non-MSAs, and in a permanent fashion. The existing flexibilities to allow the virtual presence of teaching physicians across geographic settings have enabled improved patient access and maximized limited teaching physician capacity given prevalent staffing shortages. It has also provided real-world telehealth experience for residents across geographies, with teaching physicians able to provide virtual personal oversight and management safely and effectively. This will be an essential real-world experience to train the next generation of clinicians. In addition, health care provider shortage areas and staffing challenges are not limited to non-MSAs, particularly in areas like behavioral health.

The current temporary policy applies only in clinical instances when the service is

furnished completely virtually, with no in-person component. However, for many hospitals and health systems, teaching physicians may be geographically dispersed or balancing supervisory functions with care delivery and administrative tasks. We encourage flexibility to maximize the benefit of virtual modalities (i.e., to connect geographically dispersed supply with demand). For example, there may be instances where the resident is physically with the patient and the teaching physician is at a different location. The resident should be able to "dial in" the teaching physician in these instances. **As such, we urge CMS to also extend flexibilities for instances where the resident and patient may be in the same location and the teaching physician is remote.**

Federally Qualified Health Center- and Rural Health Center- Specific Provisions

CMS proposes extending payment to federally qualified health centers (FQHCs) and rural health centers (RHCs) for non-behavioral health telehealth services (including audio only) through CY 2026. FQHCs and RHCs would continue to bill these services using the G2025 HCPCS code. **We support continued telehealth services payment for FQHCs and RHCs. We encourage CMS to adopt these provisions permanently.**

Place of Service for Medicare Telehealth Services

In CY 2020, CMS finalized policies for telehealth modifiers and place of service (POS) codes on an interim basis. Specifically, CMS finalized that providers should use the modifier "95" for telehealth claims for the duration of the COVID-19 PHE and report the POS based on where the service would have occurred if it were in person. This ensured payment at the same rate that would have been paid if the services were furnished in person (facility rate or non-facility rate).

In CY 2023, CMS finalized that by the end of the calendar year in which the COVID-19 PHE ends, telehealth claims would no longer use the 95 modifier and would instead report the following POS codes:

- 02 (Telehealth provided to a location other than the patient's home)
- 10 (Telehealth provided to a patient's home)

Beginning in CY 2024, CMS finalized that claims billed with a POS 10 would be paid at the non-facility rate, but claims billed with a POS 02 would be paid at the lower facility rate.

The AHA urges CMS to pay at the non-facility rate for all telehealth visits, including those billed with POS 02 or 10. Prior to the COVID-19 PHE, CMS paid for telehealth visits at the facility rate regardless of whether the clinician was performing the visit from a facility or non-facility setting. However, this did not account for practice-related expenses, such as support staff to assist patients in connecting with physicians or following up if connections failed. This was a challenge for clinicians who delivered

the same level of work and quality of care as in-person visits but received lower payments. As noted above, during the PHE, CMS updated guidance to pay clinicians at the rate they would normally receive if the patient were seen in person, which provided much more adequate reimbursement and therefore facilitated patient access to care.

In addition, as a matter of course, PFS payment should compensate for physician work, malpractice expense and practice expense-related costs; these expenses are generally the same regardless of whether the encounter was in person or virtual. For example, malpractice expenses, which include professional liability insurance premiums, are the same regardless of the method by which care is delivered. In addition, virtual encounters may reduce practice expenses (which include clinical staff, supplies and equipment) and supply expenses (like exam gloves or paper for exam tables) but increase technology expenses (like software licenses and hardware). Also, per statute, CMS must pay physicians for telehealth at an "amount equal to the amount that such physician or practitioner would have been paid under this title had such service been furnished without the use of a telecommunications system."

Clarification for Remote Monitoring Services

In prior rulemaking, CMS established a set of codes for RPM and RTM services for new and established patients. While these services are not addressed in the proposed rule, we would like to reinforce our previous comments regarding the applicability of RPM for new patients. In CY 2021, CMS established that following the end of the COVID-19 PHE, RPM services may only be furnished to established patients. As such, in CY 2024, CMS returned to the CY 2021 guidance and pre-COVID-19 pandemic rules to require that RPM and RTM services only be administered to established patients.

We disagree that RPM and RTM services should be limited to established patients. RPM and RTM have been critical capabilities to safely discharge patients with chronic conditions from the hospital, transition patients to better self-manage conditions and reduce readmissions. During the COVID-19 pandemic, the flexibility to provide these services to both new and established patients meant that patients were able to start monitoring services earlier (in many cases enrolling prior to discharge), which provided critical support in the immediate timeframe after discharge. There is concern that requiring an established relationship will create a barrier for patients to access services in a timely manner. Furthermore, there is precedent within evaluation and management (E/M) coding structure for new versus established relationships (E/M codes are separated based on new versus established). **As such, we urge CMS to reinstate flexibilities to allow for both new and established patients to access RPM and RTM services.**

PAYMENT FOR EVALUATION AND MANAGEMENT SERVICES

E/M Visit Complexity Add-On Code

In CY 2024, CMS implemented a new E/M add-on code (G2211) to account for intensity and clinical complexity. This was intended to account for additional costs in treating a patient's single, serious or complex condition. The code reflects the resource costs involved in building longitudinal relationships with patients when the practitioner is the continuing focal point for all the patient's health care services. The add-on code was originally scheduled for implementation in CY 2021; however, the Continuing Appropriations Act, 2021 established a moratorium that expired at the end of CY 2023.

For CY 2026, CMS proposes extending the complexity add-on code to home and residence E/M visits. **We support this proposal and agree that building trust as part of a long-term practitioner-patient relationship may be particularly significant in the context of home and residence E/M visits.**

Payment for Services in Urgent Care Centers

Last year, CMS sought comment on urgent care center services, noting that hospital emergency departments (EDs) are often used to address non-emergent, common conditions that can be treated in less acute settings. The agency stated that it was interested in how urgent care centers could play a role in mitigating system capacity and workforce issues in EDs.

For CY 2026, CMS seeks comments on whether separate coding and payment is needed for E/M visits at urgent care centers. It states that an interested party has requested a new POS code for ''enhanced" urgent care centers and an add-on code for services furnished in such centers that offer extended hours and certain diagnostic and therapeutic services.

We directionally support coding and payment policies for urgent care centers that would relieve burden on hospital EDs. Hospital EDs are overcapacity due to many factors, such as the ongoing shortage of nursing and ancillary staff, increased demand from an aging and more complex patient population, and limited access to outpatient primary care and specialists for many patients. Urgent care centers can play a role in addressing system capacity limits by diagnosing and treating non-emergent conditions, such as sprains, minor fractures and common respiratory illnesses, which often present to EDs. Nurse triage lines, enhanced digital tools and patient education on where to go for care can help with appropriate site selection for unscheduled care needs.

ADVANCING ACCESS TO BEHAVIORAL HEALTH SERVICES

CMS proposes to clarify that marriage and family therapists and mental health counselors can bill Medicare directly for Community Health Integration and Principal Illness Navigation services. The agency also proposes creating add-on codes for Advanced Primary Care Management services that complement previously established Behavioral Health Integration or psychiatric Collaborative Care Model services. **The AHA supports these proposals.** It has long been established that integrating

behavioral health care with physical health care is an effective and efficient approach to managing whole-person health, and we appreciate that CMS is working to advance how it pays for care to facilitate this valuable clinical care.

CMS also proposes updates to previously established payment codes for services provided using digital mental health treatment (DMHT) devices, including expanding payment for use of DMHT for attention deficit hyperactivity disorder. **The AHA supports this proposal and appreciates the continued investment in technology-driven care for behavioral health conditions.**

COMMENT SOLICITATION ON PAYMENT POLICY FOR SOFTWARE AS A SERVICE

The AHA recognizes the pivotal role that health technology plays in care delivery today and its potential to transform the patient and provider experience in the future. From artificial intelligence (AI) to mobile apps, software as a service (SaaS) technology can reduce administrative burden and improve efficiency for patients, caregivers and providers. Moreover, we believe that this technology has the potential to address some of the prevalent challenges confronting the health care ecosystem, such as provider burnout and staffing shortages driven by administrative burdens.

The use cases and approved SaaS applications continue to expand over time. The Food and Drug Administration (FDA) has approved over 1,200 AI-enabled medical devices, including over 140 in 2025 alone.[10] Recognizing the benefits of certain AI tools to improve patient experience and drive efficiencies, providers have adopted tools in new and innovative ways. For example, AI is augmenting the accuracy and efficiency of X-ray and MRI reviews in hospital outpatient settings. AI can detect and alert clinicians to subtle changes in tissue images, which is crucial for early disease detection.

We applaud CMS for acknowledging the continued evolution of new software-based technologies, like AI applied in physician settings, and the desire to consider updated methodologies to appropriately reimburse for these services.

Factors to Consider When Setting Payment Rates

Implementing new technologies and standards often requires significant financial investment and workflow changes for health care providers. Ensuring appropriate reimbursement can support wider adoption of these tools and ultimately improve access to services. **While we have appreciated the efforts to update reimbursement for new technologies, historical payment within PFS has not fully accounted for the**

[10] https://www.fda.gov/medical-devices/software-medical-device-samd/artificial-intelligence-enabled-medical-devices

costs of these services. This includes payment for certain CPT codes for AI, as well as bundled payment in risk-based arrangements.

In general, reimbursement for physician payment has been woefully inadequate. Furthermore, the budget-neutral aspect of payment increases has meant that increases in certain services have resulted in cuts in others. While we support "rightsizing" of payment for SaaS, this should not come at the expense of other services. Also, geographic differences must be accounted for as certain areas (like rural areas) may have additional infrastructure barriers to implementing SaaS tools. Updates to payment should not exacerbate the "digital divide," where rural and other underserved areas have less access to digital services.

There are specific factors that CMS should consider when setting payment rates for SaaS, since the costs associated with developing, deploying and maintaining SaaS tools like AI extend beyond the software. Examples of cost factors that should be considered include:

- **Clinical time for validation.** AI-enabled tools are used to augment — not replace — human capacity. In fact, these tools still require a significant amount of human direction, such as when developing treatment plans and supervising outcomes. For example, while an AI-enabled tool may recommend a particular course of treatment, ultimately, a clinician is still making the final decision in consultation with patients and their caregivers. Reimbursement should account for the time required to validate AI outputs.
- **Maintenance.** SaaS tools require stakeholders to engage in routine maintenance and post-deployment testing to ensure ongoing integrity of the tools. Maintenance may include technology vendors, developers and providers.
- **Cybersecurity insurance.** While the expansion of SaaS offerings holds tremendous promise, there are also potential cybersecurity risks. According to U.S. government reporting, the most significant cyber threats targeting U.S. critical infrastructure, including health care, originate from noncooperative foreign jurisdictions.[11],[12],[13],[14] Cross-border hacking incidents, which result in the theft of protected health information (PHI), and ransomware attacks targeting health care have increased dramatically, rising nearly tenfold since 2020. Most PHI data breaches reported to the Office for Civil Rights (OCR) were the result of hacking incidents targeting health care providers who were not in hospitals, including third-party service and software providers. The rise in frequency and severity of cyberattacks accompanying the expansion of SaaS tools has driven increased

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[11] https://www.dni.gov/files/ODNI/documents/assessments/ATA-2025-Unclassified-Report.pdf

[12] https://www.ic3.gov/AnnualReport/Reports/2024_IC3Report.pdf

[13] https://usun.usmission.gov/remarks-at-a-un-security-council-briefing-on-ransomware-attacks-against-hospitals-and-other-healthcare-facilities-and-services/

[14] https://www.cisa.gov/topics/cyber-threats-and-advisories/nation-state-cyber-actors

cybersecurity insurance premiums. Reimbursement models should account for this. Just as malpractice is factored into payment (e.g., malpractice RVUs in the PFS), rising cybersecurity costs should also be considered.

- **Software and storage fees.** These costs also include software licenses, as well as costs for data storage. SaaS offerings generally rely on large data sets, which also require servers. We encourage CMS to consider the costs for maintaining this underlying data infrastructure.

Quality and Efficacy of SaaS

Patient safety is a hospital's top priority, and hospitals and health systems are committed to ensuring the quality and efficacy of tools impacting patient care. The AHA has several recommendations regarding evaluation of quality and efficacy of SaaS tools.

First, the AHA encourages payment for maintenance of SaaS tools to support the time required for ongoing evaluation of efficacy. We recognize the importance of ongoing testing to ensure the integrity of such services. As mentioned above, that is why we encourage CMS to account for maintenance when calculating reimbursement rates for SaaS, which can support execution of post-market testing.

To support ongoing maintenance, we also encourage the agency to work with other agencies (like the FDA, ONC and OCR) to develop policies to promote transparency of data sources and weights. The closed source (or "black box") nature of many AI systems makes it hard for hospitals and health systems to identify flaws in the models that might produce incorrect analyses and recommendations.

Second, we encourage appropriate payment for clinical validation to account for clinical time needed to review AI recommendations. AI-enabled tools should not make final decisions that would deny or otherwise restrict access to care or coverage. The clinical time required to validate AI outputs should be accounted for.

Finally, we encourage the agency to work with other agencies like the FDA to streamline the evaluation of quality and safety of SaMD. The FDA's SaMD regulations require testing of safety and efficacy of AI-enabled medical devices through a pre-market submission program. As the Administration considers approaches to streamlining this evaluation, we encourage the agency to consider end-user burden and take steps to minimize it.

AMBULATORY SPECIALTY MODEL

CMS proposes the new ASM, a five-year mandatory payment model that would begin January 2027. The model's aims are to enhance the quality of care and reduce low-value care by improving upstream chronic disease management for patients with low back pain (LBP) and heart failure (HF). Certain specialists in select core-based

statistical areas and metropolitan divisions would be required to participate in the two-sided ASM instead of the Merit-based Incentive Payment System (MIPS). While the general framework of the ASM borrows heavily from that of the MIPS Value Pathways (MVPs) in that it assesses performance on quality, cost, improvement activities and promoting interoperability, as well as adjusts Medicare Part B payments based on this performance, the methodology for determining the percentage change in a physician's payments differs from that of MIPS.

The AHA appreciates that CMS and the Center for Medicare and Medicaid Innovation (CMMI) continue to investigate ways to improve quality of care while reducing costs to patients and providers, and we agree that physicians can help prevent certain chronic diseases through upstream focus. However, we have several questions and areas of concern regarding ASM's financial model, attribution methodology and quality performance standards; because of these outstanding questions, **we urge CMS to move forward with the ASM as either a voluntary model or an MVP rather than requiring participation for all eligible physicians beginning in 2027.**

Financial Model

Our primary concerns with the ASM relate to the potential for substantial payment adjustments coupled with the level of administrative requirements; in short, we worry that this mandatory model would result in too much financial and administrative burden on physicians too soon.

In general, the model is similar to the SNF Value-based Purchasing (VBP) program in that it would save CMS money by withholding a certain percentage of payments across the board. The ASM includes a "redistribution percentage" of 85% that is designed to reduce the aggregate Part B payments to the participating physicians in each cohort by 1.35% in the first two payment years and 1.5% in the last three to ensure savings. **This means that the majority of physicians would receive payment reductions under the model, and even if all participants received the highest possible performance score, they would still be penalized financially.** In addition, ASM does not provide any additional payments (other than fees for normal services) that would encourage delivery of high-value services, such as home blood pressure cuffs or therapy equipment. The SNF VBP program was directed by statute to distribute just 60-80% of withheld funds; ASM is under no such obligation. If the proposed model's framework truly encourages physicians to deliver higher-quality, lower-cost care, as CMS purports it to do, then CMS should achieve net savings without reducing overall physician payments. **The AHA recommends that CMS eliminate this aspect of the model and instead implement it in a budget-neutral fashion.**

The redistributive properties of the model also are due to the methodology CMS proposes to use to calculate payment adjustments, and it likely would result in unfair outcomes for many participants. Similar to the SNF VBP program, CMS proposes to use a logistic exchange function to translate total performance scores into payment

adjustment percentages. This means that performance — and thus payment adjustments — are made relative to the performance of other providers rather than in comparison to objective benchmarks. As a result, differences in payment changes would not be directly proportional to the differences in performance scores. Unlike a linear exchange function, an "S-shaped" logistic exchange function gives much higher weights to small differences from the median than large ones; thus, a physician with a score close to the median score of all participants would receive a payment adjustment nearly as large as physicians with scores much higher or much lower than the median.

Additionally, physicians would not be able to predict whether they would receive a bonus or payment, as adjustments would be made based on performance relative to the median scores; quality measure performance and total Part B payments for each physician are typically not available to participants until well after the end of the performance year. Unlike other VBP programs, ASM assesses physicians' work only during the performance year and not improvement versus a baseline. Thus, the majority of physicians in the model would receive a payment reduction even if they significantly improved their performance from the previous year or perform at a level above the median of all practitioners and not just those participating in the model.

Eligibility and Attribution

Under the proposal, practitioners would be required to participate in the ASM if they specialize in general cardiology (for the HF cohort) or anesthesiology, pain management, interventional pain management, neurosurgery, orthopedic surgery or physician medicine and rehabilitation (for the LBP cohort) and have historically treated at least 20 HF or LBP episodes per year as identified by the episode-based cost measure (EBCM) methodology. **The AHA questions whether this attribution method would identify the clinicians most appropriate to participate in the ASM.**

First, it is unclear precisely how CMS would determine patient attribution and subsequent eligibility to participate in the ASM given the broad definition of these cohorts. The specialists described above often work with partners or as part of a larger practice, meaning that multiple practitioners under the same taxpayer identification number (TIN) would be treating the same patient — and perhaps not treating HF or LBP. In other words, physicians could be required to participate in the model even if they were not managing the HF or LBP care for a patient because they delivered *other* services to the patient, while their clinician partners actually were managing the patients' HF or LBP. Due to the nuances in the EBCM methodology, it is conceivable that eligibility based on episode attribution could change frequently — that is, a clinician might be attributed 20 episodes in one year, but 18 the next, then 22 in the year after that. Even more complex, eligibility is based upon the number of episodes attributed to the physician two years earlier; thus, adjustments could be made to payments in a performance year during which a physician treated zero patients for HF or LBP. At best this would be confusing; at worst, it might deter physicians on the cusp of participation from taking on more Medicare beneficiaries with HF or LBP.

For many physicians, 20 patients might represent a vast minority of all patients treated; that means that physicians who are in the aforementioned specialties might still be required to participate even if they treat most of their patients for other conditions. Indeed, CMS notes in the proposed rule that 43% of the cardiologists who would be required to participate in the ASM had only 20-29 attributed HF episodes according to the EBCM, and 35% of the specialists in the LBP cohort had only 20-29 relevant episodes. Further, in the EBCM, a patient may be attributed to a specialist if a diagnosis code representing HF or LBP appears on the claim forms for multiple services delivered by the physician even if HF or LBP is not the primary problem being treated; this could mean that physicians who do not substantially treat HF or LBP could be required to participate in the model.

The attribution methods in the ASM would also be complex in group practice environments. Many patients receive treatment for HF and LBP from either non-physician practitioners (like nurse practitioners or physical therapists) or from specialists other than those listed above as part of a group practice. Thus, we are concerned that the definitions of the cohort specialties would exclude a significant number of Medicare beneficiaries from the model. Further, some physicians in a group practice may be required to participate in the model while others would not be, even if they have the same specialty and treat the same kinds of patients. Because of the intricacies of patient attribution for HF and LBP, **we recommend that CMS instead allow specialists, including non-physician clinicians, to choose whether to participate in the ASM based on whether their practice focuses on treating patients in that cohort.** This could be defined as treating at least 50 patients for HF or LBP.

Performance and Measures

Like the MIPS MVPs, physician performance is assessed based on measures in four categories: quality, cost, improvement activities, and promoting interoperability. However, under the ASM, performance would be assessed on a limited set of measures in these categories, and participants would not be able to choose measures and activities tailored to their practices. It is unclear whether the measures and activities CMS has included in the model are those most likely to result in quality improvement and cost savings, and physicians would not have flexibility to use other metrics to better drive performance.

For example, one of the two improvement activities upon which physicians in the ASM would be assessed is Establishing Communication and Collaboration Expectations with Primary Care Using Collaborative Care Arrangements (CCA). The CCA is required to include elements such as data sharing, protocols for co-management of patients and transitions of care, processes for referral, and documentation of care coordination activities. ASM participants will likely treat patients who see several different primary care providers (PCPs) from many different practices; executing formal CCAs with each would be burdensome for both PCPs and specialists. We also are unaware of any

requirement for PCPs to engage with CCAs. The other improvement activity is Connecting to Primary Care and Ensuring Completion of Health-related Social Needs Screening; some patients may not have a PCP or may not want their physicians to share their health-related social needs information with other providers.

In the Cost Performance category, physicians would be assessed on the same EBCMs used to determine patient attribution. These measures have inherent limitations, such as the inability to distinguish between necessary and avoidable spending or factors affecting spending that are within the provider's control (such as drug prices). The measures are also not adjusted for many social and economic factors that affect the number and types of services patients receive and their outcomes; the risk adjustment in the HF EBCM only includes a variable for dual eligible status, and the LBP EBCM has no adjustments to capture differences in access to care that could result in higher costs. Using these measures — and weighing performance in the Cost category at 50% — could significantly disadvantage physicians serving patients from communities with lower incomes or other upstream influences on their health.

We also have several concerns about the measures proposed for the Quality Performance category. In general, the measure populations specified in the quality measures do not align with those in the EBCM; quality measures assess care for patients of all ages, whereas the EBCMs are focused on Medicare beneficiaries. The particular measures in each cohort apply only to a subset of patients within the cohort (for example, in the HF cohort, measures on Beta Blocker Therapy for LVSD and ACE/ARB/ARNI for LVSD apply only to patients with reduced, rather than preserved, ejection fraction; in the LBP cohort, the Functional Status Change for Patients with Low Back Impairments measure is specified for a different set of diagnosis codes than the ones used for the LBP EBCM).

In particular, the AHA does not believe the measure set proposed for the LBP cohort would accurately and meaningfully assess quality of care for these patients. Several of the measures are specified for larger patient populations than just LBP patients; Use of High-Risk Medications, Screening for Depression and BMI are indicators for patients who have a wide range of diagnoses and should be interpreted based on specific conditions. The MRI Lumbar Spine for Low Back Pain measure was removed from the Outpatient Quality Reporting Program as it no longer aligned with clinical guidelines; while CMS proposes that this measure would be newly specified to be relevant to the ASM, we have yet to see the specifications and thus cannot determine whether the measure would be appropriate for use in this model.

The AHA appreciates that CMS and CMMI are working to refine physician payment programs to tie payment to performance in ways that are relevant and meaningful for the various physician specialties. We also understand why the agency wants to focus on the widespread issues of HF and LBP as part of larger initiatives to manage and prevent chronic disease. However, we question whether creating the separate ASM for these cohorts is the best approach. **Instead, we recommend that CMS pilot the ASM**

to gather data and feedback on the various aspects of the model to inform future work, or to offer an optional track for physicians who treat HF and LBP based on the design of the ASM.

Proposed Promoting Interoperability ASM Performance Category

CMS includes several proposals for performance year Promoting Interoperability (PI) measures, use of certified electronic health record technology (CEHRT) and related attestations, data submission criteria, and scoring for a proposed ASM Promoting Interoperability performance category. Below are our detailed comments on these proposals.

ASM Performance Year for the Promoting Interoperability Performance Category. Beginning in the 2029 payment year, CMS proposes that the performance year for PI measures would be the minimum of a continuous 180-day period within the calendar year that occurs two years prior to the applicable ASM payment year, up to and including the full calendar year.

First, we support the 180-day reporting period, which would align an ASM PI performance category with the hospital promoting interoperability program (PIP) and MIPS PI performance category reporting. To the extent possible, we have encouraged consistent measure methodology and timelines across programs to minimize administrative burden for providers.

Second, as we highlighted in our comments regarding the FY 2026 IPPS[15], we believe lengthening the reporting period beyond 180 days could pose significant challenges to the field. CMS has previously established reporting periods of less than a full calendar year in recognition that electronic health records (EHRs) are far from static tools. EHRs are continually undergoing software upgrades, system downtime, expansions to other sites with the system and a variety of other improvement and maintenance activities. When CMS makes changes to the requirements of the PIP or MIPS PI performance category, these changes affect the multitude of providers that are participating in these programs. Yet, to make the changes and upgrades needed to comply with the PI requirements, providers are drawing on the same EHR vendors simultaneously, and the capacity of those vendors is finite. In some cases, vendors are simply not available to perform the needed work because they are working with multiple other facilities. Providers also need sufficient time for testing and implementation, which is necessary to identify and resolve problems with the software and provide essential training to end users. Ultimately, these activities are crucial to ensuring EHRs do not inadvertently compromise the safe delivery of care. We urge CMS to carefully consider these issues in assessing any lengthening of the reporting period in future rulemaking.

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[15] https://www.aha.org/system/files/media/file/2025/06/aha-comments-on-cms-fy-2026-inpatient-prospective-payment-system-proposed-rule-letter-6-10-2025.pdf

Reporting for the PI ASM Performance Category. In the proposed rule, CMS also proposes for the PI performance category to be reported at the TIN/NPI level or individual physician level. This may not align with an organization's reporting for other PI programs. For example, providers may be reporting for other programs at the TIN, group practice or APM entity level. **Providers should be given flexibility to report at a level to maintain consistency across programs, and as such should be given the option to report at the TIN, group practice or APM entity level.**

Adding, Removing and Modifying PI Measures. CMS indicates its intent to avoid making significant changes to PI measure sets over the period of the model. **We applaud the agency for explicitly stating its intent to maintain the same measure set over the course of the model.** We have previously stated that maintaining consistent measure methodology over the course of the model can minimize the administrative burden for participants in adjusting measures partway through a model and can also help strengthen the reliability of longitudinal assessment (since the measure methodology would be consistent to allow for comparisons year to year).

However, the agency also proposes that any adjustments CMS applies to the PI measures within MIPS would be automatically incorporated into the PI ASM measure sets without notice and rulemaking. **We urge the agency to instead propose any changes via notice and rulemaking.** While in general we support consistency in methodology across programs, there may be certain circumstances that would warrant differences in policy across programs. At a minimum, notice and rulemaking would provide the appropriate awareness for model participants to know in advance which changes may be made year to year in methodology. For example, CMS did not include the Public Health Reporting Using Trusted Exchange Framework and Common Agreement® (TEFCA) measure that was proposed for the Public Health and Clinical Data Exchange objective in MIPS in the proposed PI ASM Performance Category measure set. It is unclear if this was intentionally left off the list since CMS does not intend to add this measure or whether it would automatically be added if it is finalized for MIPS. To avoid confusion, any proposed additions, removals or modifications to PI ASM measures (including those that align with MIPS) should be done through notice and rulemaking.

PI ASM Scoring. In Table 41 of the proposed rule, CMS outlines the proposed measures for the PI ASM performance category.

While CMS aligns scoring with MIPS methodology, CMS proposes to not allocate bonus points for the optional public health agency or clinical data registry measures. CMS' stated rationale is that these measures may not be as relevant for the ASM. However, for patients with chronic disease like CHF, reporting to public health agencies or clinical data registries may be of relevance given that patients may be immunocompromised. **Given that public health agency or clinical data registry measures are optional to**

begin with, the AHA recommends that CMS make ASM participants eligible for the same bonus (five points) for these measures as in the regular MIPS program.

The AHA also is concerned that CMS does not propose any exceptions for the PI ASM performance category requirements. This is a departure from MIPS, which has established automatic reweighting criteria of the PI category for certain MIPS-eligible clinicians, such as hospital-based clinicians and ambulatory surgical center-based clinicians, and clinicians in small practices. The MIPS reweighting policy generally excludes the PI performance category from the MIPS final score if the applicable clinician or group practice does not submit PI data. CMS' stated rationale for not proposing any exceptions — that relatively few ASM providers would meet MIPS exclusion criteria and that the complexity would outweigh benefit — is not sufficient to justify the lack of alignment with the traditional MIPS. **We urge CMS to apply the same exclusion criteria as MIPS.**

MEDICARE PRESCRIPTION DRUG INFLATION REBATE PROGRAM

The AHA acknowledges CMS' statutory obligations under the Inflation Reduction Act (IRA) to exclude all Medicare Part D drug units purchased under the 340B Drug Pricing Program from the calculation of Medicare Part D inflationary rebates. To fulfill this statutory obligation, we appreciate the agency's recognition that it is infeasible to identify the 340B status of Medicare Part D drugs at the point-of-sale and requires an alternate process. **Therefore, we support the agency's proposal to establish a 340B claims data repository.**

Further, we recognize that it will take time for both CMS and 340B covered entities to operationalize this repository. **In the interim, we strongly encourage the agency to use the estimation percentage methodology it had *originally* proposed in the CY 2025 Physician Fee Schedule Rule instead of the agency's current proposal of a claims-based methodology to identify Part D drug units purchased under the 340B program.**

We have several concerns with a claims-based approach because, as CMS acknowledges in the proposed rule, the claims-based methodology to identify 340B drug units "may overestimate the number of units that are potentially 340B-eligible."

- First, the claims-based methodology is limited by its reliance on complex, untested and unreliable matching algorithms that are known to be deeply flawed, particularly when applied to large data sets.[16]

[16] https://dataladder.com/fuzzy-matching-101/#:~:text=False%20negative%20%E2%80%93%20These%20are%20pairs,character%20count%20and%20phonetic%20match.

- Second, overestimating the number of 340B drug units could result in an inaccurate measure of 340B sales volume, which could be used by program critics to falsely portray the 340B program as larger in scope than it is. Moreover, imprecise data could be used to advocate additional limits on the 340B program and the benefits it provides vulnerable populations across the country.
- Third, given the Health Resources and Services Administration's (HRSA) recent notice of the 340B rebate model pilot program beginning Jan. 1, 2026, and applying to the 10 Medicare Part D drugs selected for negotiation under the IRA, the claims-based methodology may not adequately account for denied or delayed rebates, resulting in an inaccurate calculation of 340B drug units.[17]

For all these reasons, the agency should not move forward with its proposed claims-based methodology.

Instead, the agency should finalize its proposal to establish a 340B claims data repository. We appreciate the agency's proposal to allow 340B hospitals to voluntarily submit data to the repository during the testing period. This will be important to give 340B hospitals and their third-party administrators sufficient time to develop and tweak the systems and data flows to submit the required data elements to the repository. The AHA also agrees with the limited claims data elements that the agency proposes to collect. These data elements represent the necessary information the agency would need to accurately identify the 340B status of a Part D drug retrospectively.

We also appreciate the agency's commitment to protect the privacy of the claims data submitted and ensure that manufacturers and Part D plan sponsors do not have access to this data. It is critical that CMS and the contractor it chooses to implement this repository create sufficient and transparent safeguards to ensure this data is not shared with other stakeholders in any way, particularly since this data could be used for their own financial benefit.

In addition, we encourage the agency to make clear that the data submitted to the repository would only be used for the purpose of identifying 340B drug units in the calculation of the Medicare Part D inflation rebates. Should the agency decide to use this data for any other purpose, we urge the agency to provide ample notice, justification and an opportunity for stakeholders to provide feedback. For example, the agency's 340B claims data repository could be used by HRSA in its implementation of the 340B rebate model pilot program. Though we do not support the rebate model pilot program, if the agency does move forward with it, this would be an acceptable use case and have encouraged HRSA to implement in our feedback on that proposal.

Given that the agency proposes to test the claims data repository beginning in fall 2026, we ask the agency to reconsider using the estimation percentage methodology it proposed in last year's proposed rule as an interim mechanism to estimate 340B drug

[17] https://www.hrsa.gov/opa/340b-model-pilot-program

units in calculating the Medicare Part D inflation rebates. The agency's estimation percentage methodology, which relies on data provided by the 340B Prime Vendor Program, provides the agency with a sufficient estimate of the 340B drug units for exclusion in the Medicare inflation rebate calculations. While we acknowledge that this estimation methodology is not perfect, the proposed claims-based methodology is far more complex and prone to errors than the estimation percentage methodology. That methodology involves simple arithmetic, dividing the total number of units of a drug purchased under the 340B program by the total units sold of that drug and applying that percentage to the total Part D units for that drug. Further, the estimation percentage methodology more effectively mitigates the miscounting of 340B drug units subject to delays and denials under the 340B rebate model pilot program. **Thus, we strongly recommend the agency finalize this estimation percentage methodology to identify Part D drug units purchased under the 340B program while it tests and ultimately implements a 340B claims data repository.**

MEDICARE SHARED SAVINGS PROGRAM

Participation Options Under the BASIC Track

CMS proposes to reduce the number of years that an accountable care organization (ACO) can participate in a one-sided model of the BASIC track from seven to five to encourage participation in two-sided risk models. Specifically, for agreement periods beginning on or after Jan. 1, 2027, an ACO that is entering the BASIC track's glide path at Level A may remain under a one-sided model for all subsequent performance years of its first five-year agreement period. For its second and subsequent agreement periods, the ACO must enter under Level E of the BASIC track, or the ENHANCED track if eligible. This proposal would limit an ACO's participation under the BASIC track's glide path to one agreement period and also limit the ACO's time under a one-sided model to a maximum of five performance years.

If CMS finalizes this proposal, we urge the agency not to reduce the one-sided risk period below five years in the future as well as to consider additional flexibility for rural and safety net providers. Requiring ACOs to assume downside risk too quickly may disincentivize program participation and reduce their potential to positively impact the quality and cost of care furnished to beneficiaries.

Eligibility and Financial Reconciliation Requirements

CMS proposes to modify eligibility and financial reconciliation requirements related to the statutory requirement that ACOs have at least 5,000 assigned Medicare fee-for-service (FFS) beneficiaries. Under current regulations, an ACO meets this threshold if 5,000 or more beneficiaries are historically assigned to the ACO participants in each of the three benchmark years. Beginning CY 2017, the agency proposes ACOs must have at least 5,000 assigned beneficiaries in benchmark year (BY) 3 but could have fewer in BY1, BY2 or both. CMS also proposes safeguards against potential volatility in

expenditures resulting from this change. Specifically, ACOs with fewer than 5,000 assigned beneficiaries in BY1, BY2 or both may only enter the BASIC track, and shared savings and losses would be capped if an ACO has fewer than 5,000 assigned beneficiaries in any of the three BYs.

The AHA supports this proposal, as it would help maintain continuous ACO participation in the program. ACOs that could otherwise successfully participate in the program but are unable to meet the current thresholds for assigned beneficiaries would benefit from this policy change.

Extreme and Uncontrollable Circumstances Policies and Cyberattacks

CMS proposes to expand the application of extreme and uncontrollable circumstances policies to ACOs affected by cyberattacks. This policy would apply retroactively beginning with performance year 2025.

We support this proposal and its retroactive application to CY 2025. Health care providers are increasingly the target of cyberattacks, including ransomware and malware, which can cause disruption to patient care, operations and financial systems.

ACO Participant Change of Ownership Scenarios

CMS proposes to require ACOs to update their ACO participant lists outside of the annual change request cycle to reflect certain changes of ownership (CHOWs) of participant entities. Specifically, the proposal would apply when a CHOW results in a TIN that is newly enrolled in Medicare with no prior Medicare billing claims history during the performance year. CMS proposes similar requirements for ACOs' SNF-affiliate CHOWs.

The AHA supports this change, as it would help ACOs maintain sufficient assigned beneficiary counts to meet eligibility requirements. If these changes are not reflected during the performance year, an ACO's assigned beneficiary population could fall below the statutory threshold of 5,000, potentially disrupting its program participation.

Beneficiary Assignment Methodology

CMS proposes revising the list of primary care services used for assignment to add new behavioral health integration and psychiatric collaborative care management add-on services furnished with advanced primary care management services. **We support CMS' proposal to expand the eligible codes for beneficiary assignment.**

Health Equity Adjustment

CMS proposes to remove the health equity adjustment (HEA) originally adopted in the CY 2023 PFS final rule. This adjustment added points to an ACO's MIPS quality performance category score if the ACO served a high proportion of beneficiaries who were from underserved neighborhoods, eligible for the Medicare Part D Low-income Subsidy or dually eligible for Medicare and Medicaid. The agency believes that the HEA is no longer necessary due to more recently adopted score adjustments and incentives (namely, the eCQM/MIPS CQM reporting incentive and the Complex Organization Adjustment).

The AHA shares CMS' goal of improving the quality of care for all patients. As CMS removes the HEA, we urge the agency to continue assessing and implementing ways to account for the complex interplay between provider performance and community-level factors. The AHA has advocated that quality measurement programs include mechanisms to account for non-medical risk factors on outcomes such as readmissions and mortality. While the quality of care provided by ACOs is an important determinant of performance, patient outcomes can also be influenced by poverty; a lack of primary care, home health and rehabilitation services in the community; a dearth of transportation options that enable patients to go to follow up appointments; and challenges adhering to dietary restrictions or health promoting activities. Failure to account for these factors in quality measurement and value programs can inadvertently penalize providers who care for large numbers of patients facing these challenges.

We encourage CMS to consider the administration's approaches in this space in other programs. For example, as part of the Transforming Episode Accountability Model, CMS has recently adopted a new beneficiary-economic risk adjustment variable in determining model participant performance and is using a community deprivation index score. While the AHA believes CMS should provide additional transparency and details around the methodology, CMS could consider adapting this approach to the Medicare Shared Savings Program and other value programs in which performance depends heavily on outcomes influenced by community-level factors.

<u>CAHPS for MIPS</u>

Beginning with CY 2027, CMS proposes to require approved survey vendors to administer the CAHPS for MIPS Survey via web-based survey mode in addition to mail and phone. **The AHA supports this proposal, as it would likely increase response rates while reducing burden on patients. We encourage the agency to continue to refine the various CAHPS surveys to remove duplication and make it easier for providers to gather and use information on patient experience.** We suggest that the agency ensure that the addition of the web-based survey mode does not substantially increase the cost of vendor contracts.

<u>Toward Digital Quality Measurement in CMS Quality Programs, Including for the Medicare Shared Savings Program — Request for Information</u>

CMS reiterates its goals to facilitate the transfer of electronic health information to support quality measurement efforts, patient self-management and ultimately improved clinical outcomes. The agency sets a goal of transitioning to a fully digital quality measure (dQM) landscape that promotes interoperability and increases the value of reporting quality measure data. As such the agency seeks feedback on a variety of components related to the transition to dQMs for Medicare Shared Savings (MSSP) and MIPS.

In general, the AHA agrees that a digital and interoperable quality measurement enterprise is a laudable long-term goal that could have positive and far-reaching impacts on quality of care and the provider experience. As we have commented in response to the FY 2026 IPPS proposed rule[18] and the Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ASTP/ONC) on the Health Technology Ecosystem RFI[19], the AHA also sees significant potential in expanding the use of FHIR, as this standard is more flexible than many other available frameworks. At the same time, transitioning to only FHIR-based dQMs in federal programs will prove to be a staggeringly complex task. As CMS and ASTP/ONC continue their dQM work, the AHA offers several overarching recommendations.

First, while FHIR-based reporting holds promise, the overarching goal for its quality measurement programs should remain as measuring the highest priority opportunities to improve care. In other words, the pursuit of adopting particular reporting standards should not come at the expense of ensuring the measures are a meaningful reflection of quality and providing usable information to hospitals to improve care.

Second, we urge the agencies not to set arbitrary dates for standards adoption. As CMS and ASTP/ONC have previously articulated, dQMs could integrate data from a wide range of sources, including hospital administrative systems, clinical assessment data, case management systems, EHRs, instruments (e.g., wearable medical devices), patient portals, health information exchanges (HIEs) and registries, and "other sources." Hospitals do not manage some of these sources themselves, yet their performance on a dQM could be linked to such data. We are concerned that the accuracy and reliability of dQMs could be compromised by poor data quality from outside sources. For this reason, the pace of conversion should be based on the results of field testing and feasibility studies rather than an arbitrary deadline.

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[18] https://www.aha.org/system/files/media/file/2025/06/aha-comments-on-cms-fy-2026-inpatient-prospective-payment-system-proposed-rule-letter-6-10-2025.pdf

[19] https://www.aha.org/system/files/media/file/2025/07/aha-comments-on-the-cms-and-astp-onc-request-for-information-re-the-health-technology-ecosystem-letter-6-16-2025.pdf

Third, we support CMS' concept of allowing transitional reporting options for FHIR-based eCQMs in MSSP and MIPS. Similar to IPPS, CMS would allow for up to two years of reporting using either existing eCQM reporting standards (QDM-based) or new FHIR-based standards to give clinicians participating in CMS programs, health IT developers and CMS an opportunity to gradually transition, make any necessary corrections and gather lessons learned. We appreciate CMS' sensitivity to the need for ramp-up time for providers. Indeed, we would expect that providers may need to implement workflow changes and EHR system upgrades to accommodate FHIR-based reporting, both of which take time and resources. However, we encourage CMS to assess the extent to which the availability of two sets of reporting standards for a single measure could introduce variation into measure performance rates. To the extent that variation is large, the agency may need to consider peer grouping approaches for reporting — one for traditional eCQMs and the other for FHIR-based standards — to ensure that providers are being compared fairly.

Lastly, the AHA encourages the agencies to advance efforts to align digital quality measurement across the public and private sectors. Hospitals have long aspired to an approach to quality measurement that enables them to report data only once and have it used for multiple purposes. Unfortunately, providers have long faced discordant reporting requirements among federal, state and private sector quality reporting and value programs. Even when the measure topics are the same, often there are differences in measure design across programs that result in the need for duplicative data collection, excess costs and confusion. As CMS and ASTP/ONC advance a plan for dQMs, we encourage the agencies to prioritize the development of dQMs that are usable across the public and private sectors and across programs. We look forward to working with the agencies to provide feedback on these and other issues to advance data interoperability and reporting.

QUALITY PAYMENT PROGRAM

Mandated by MACRA, the QPP began on Jan. 1, 2017, and includes two tracks: the default MIPS and a track for clinicians with a sufficient level of participation in certain APMs.

MIPS Value Pathways

In prior rulemaking, CMS adopted a framework for MVPs that the agency intends as an eventual replacement for the traditional MIPS program. MVPs organize the measure and reporting requirements for each MIPS category around specific medical conditions, clinical specialties or episodes of care. In this rule, CMS proposes policies on subgroup reporting to support the eventual transition to MVP reporting; the agency also proposes to add six MVPs beginning with the CY 2026 performance period.

Subgroup reporting. An MVP participant could be an individual MIPS eligible clinician, single specialty group, APM Entity or subgroup of a multispecialty group; as finalized in

prior rulemaking and as of 2026, multispecialty groups will no longer be able to report MVPs as a single group and must instead divide into and report as subgroups or individuals (or continue with traditional MIPS reporting).

In this proposed rule, however, CMS acknowledges the challenges of multispecialty groups designated as small practices (with 15 or fewer eligible clinicians assigned to their TIN) splitting into smaller subgroups. Thus, the agency proposes to add small multispecialty practices as eligible to report an MVP beginning with the CY 2026 performance year. CMS also proposes that, instead of using claims data to determine if a group is a single specialty or a multispecialty small practice, the agency would require attestation upon registration by the practice that it meets the appropriate group definition. **The AHA supports this proposal and appreciates that CMS acknowledges the nuances in multispecialty practice that cannot be sufficiently captured by claims data alone.** We encourage the agency to extend similar considerations in other programs, such as the proposed ASM in this same rule.

New and updated MVPs. CMS proposes six new MVPs: Diagnostic Radiology, Interventional Radiology, Neuropsychology, Pathology, Podiatry and Vascular Surgery. **The AHA supports the addition of these six new MVPs available for voluntary participation beginning with the CY 2026 performance period.**

MIPS Promoting Interoperability Performance Category

CMS proposes several policies and measure updates for the MIPS PI performance category. Below are our specific comments on proposals.

Modifying the Security Risk Analysis Measure. Beginning with the CY 2026 performance period/2028 MIPS payment year, CMS proposes to expand the existing security risk analysis measure to attest "yes" to conducting both security risk analysis and now security risk management activities. **The AHA does not object to this proposal as conducting security risk management activities aligns with expectations under HIPAA.** However, we continue to echo reservations we have previously expressed regarding "yes" attestations being required to receive full scoring credit. When CMS adopted performance-based scoring approaches for performance categories, the agency's goal was to provide differential rewards based on how providers perform to incentivize the adoption of a particular practice rather than an across-the-board requirement.

Modifying the High Priority Practices SAFER Guide Measure. CMS adopted the High Priority Practices Safety Assurance Factors for EHR Resilience (SAFER) Guide measure under the Protect Patient Health Information Objective in the PI performance category beginning with the CY 2022 performance period/2024 MIPS payment year. Developed by the ASTP/ONC, the SAFER assessment included nine guides that ask providers to assess the safety and effectiveness of their EHR implementation, proactively identify potential vulnerabilities and adopt a "culture of safety" with respect to

the use of EHRs in their organizations. Beginning in the CY 2024 PFS final rule, CMS modified the requirements for the High Priority Practices SAFER Guide measure to require MIPS eligible clinicians to conduct, and attest ‘‘yes’’ to having completed, an annual self-assessment using the High Priority Practices SAFER Guide. In early 2025, ASTP updated SAFER guides to cover eight areas instead of nine.

Beginning with the CY 2026 reporting / 2028 payment year, CMS proposes to modify the SAFER guideline measure to require that hospitals conduct the annual SAFER Guides self-assessments and attest a “yes” response accounting for the completion of the self-assessment for all eight of the updated SAFER guides. **The AHA continues to urge CMS not to require hospitals to attest “yes” to completing the SAFER Guides annually.** We note the considerable length of each of the eight guides, and the level of administrative effort required to complete them, especially for providers with fewer resources. Furthermore, we believe the requirement to complete the SAFER guide assessment likely overlaps with the Security Risk Analysis measure with the same PI performance category objective, especially since CMS has proposed to expand the security risk assessment measure to include security risk management as referenced above.

Lastly, as mentioned above, the concept of requiring hospitals to attest “yes” on this or any other PI measure is not consistent with the program’s performance-based scoring design.

At the same time, we appreciate CMS’ focus on ensuring the safety of the implementation and use of EHR technology. We believe these efforts can be most effectively advanced through the dissemination of more modernized approaches and guidelines to EHR safety and not necessarily using a measure in a PI program.

New Optional Public Health Reporting Using TEFCA Bonus Measure. In the proposed rule, beginning with the CY 2026 reporting / 2028 payment period, the agency proposes to add an optional bonus measure under the Public Health and Clinical Data Exchange objective. The bonus measure would support using the Trusted Exchange Framework and Common Agreement® (TEFCA) to exchange data with a public health agency.

The AHA supports this proposal. However, we are uncertain as to how many providers will benefit from the bonus points in the measure. As a general matter, the AHA appreciates CMS’ interest in modernizing approaches to exchanging data between hospitals and public health agencies. The use of the TEFCA framework may help to create a foundation for strengthened data exchange. However, the TEFCA framework is an inherently bi-directional framework that requires a range of stakeholders — hospitals, public health agencies, health information networks and EHR vendors — to participate and have the technical capabilities to support data exchange. Hospitals have shared with the AHA that their public health agencies often have underdeveloped technological infrastructure and limited staffing capabilities to build more robust and technically sophisticated approaches to data exchange.

For these reasons, we encourage CMS to assess clinician experiences with adopting this measure to inform future policy development efforts. This would help the agency ascertain barriers to TEFCA participation and the speed at which to adopt any additional TEFCA-related measures in the PI performance category.

Measure Suppression Policy. CMS also proposes a measure suppression policy to provide CMS with the flexibility to not score a measure for circumstances outside the control of MIPS-eligible clinicians meeting the requirements of the MIPS PI performance category. The agency proposes to extend this measure suppression policy to eligible hospitals and critical access hospitals (CAHs) participating in the Medicare PI Program as well.

The AHA supports this proposal and agrees that there are circumstances outside of providers' control that may warrant measure suppression within MIPS and PIP. At the same time, we encourage CMS to have mechanisms to ensure they get stakeholder feedback on the circumstances that may lead to the need for measure suppression. The agency identified a list of examples where measure suppression may be warranted, like outdated or conflicting technical standards or circumstances affecting the measure such that measurement may result in inaccurate or misleading results. However, providers can help inform whether these criteria are met and can also provide necessary feedback on the breadth and duration of the circumstances affecting the ability to fulfill the measure requirement. CMS could consider establishing a webpage or email inbox to communicate these issues to the agency.

Additionally, CMS proposes that while suppressed measures would still need to be reported, they would not affect the score for the applicable objective. **If the measure requires suppression due to circumstances like conflicting technical standards, it is unclear what utility there would be in continuing to report the measure. We would encourage the agency to therefore allow voluntary reporting for the period in which the measure is suppressed.**

Proposal to Suppress the Electronic Case Reporting Measure. CMS proposes to exclude the Electronic Case Reporting measure from scoring under the MIPS PI performance category for the CY 2025 performance period and the Medicare PIP for the EHR reporting period in CY 2025.

The agency is proposing to suppress the measure since the Centers for Disease Control and Prevention has paused electronic case reporting registration and onboarding of new health care organizations to establish a more efficient and automated process. Due to this pause, some MIPS-eligible clinicians, eligible hospitals and CAHs may not meet the electronic case reporting registration and onboarding requirements by the end of the performance period and EHR reporting period in CY 2025. **We agree that the measure should be suppressed as this pause in registration and onboarding may impact providers' ability to meet requirements**

by the end of the performance/reporting period. However, if the measure is suppressed, providers should not be required to report. This is because there is no way to distinguish whether a provider did not meet requirements due to circumstances outside of their control.

Advanced APMs

Clinicians who participate in Advanced APMs are eligible for various incentives. These include lump-sum incentive payments, exemption from MIPS reporting requirements and payment adjustments, and a higher differential PFS conversion factor beginning in CY 2026. CMS previously finalized the criteria by which clinicians will be determined to be qualifying APM participants (QPs) to receive these incentives.

For CY 2026, QPs receive a lump-sum incentive payment equal to 1.88% of their payments for covered professional services furnished in CY 2025. Unless Congress acts to amend the statute, these incentive payments will end after CY 2026. In addition, beginning with the CY 2025 performance period/CY 2027 payment year, the statutory thresholds to achieve QP status increased from 50% to 75% under the payment amount method, and from 35% to 50% percent under the patient count method.

We urge CMS to work with Congress to extend the Advanced APM incentive payments and maintain reasonable thresholds for clinicians to qualify as QPs. While the movement to value-based care holds tremendous promise, the transition has been slower than anticipated, and further efforts are needed to drive long-term system transformations. The incentive payments prevent attrition in value-based care models and provide crucial resources to hospitals and health systems. Although clinicians who participate in Advanced APMs will receive a slightly higher update to the conversion factor beginning in CY 2026, this alone will not ensure clinicians join or remain in these models. Incentive payments enable clinicians and hospitals to invest the necessary resources in care redesign and coordination, as well as technology infrastructure, to participate successfully in value-based care.

Individual QP determinations. Currently, QP determinations are made at the APM entity level except in certain circumstances. This means all eligible clinicians within the APM entity have the same status and are assessed on group performance. This policy has led to conflicting goals for APM entities, namely, to ensure all their eligible clinicians achieve QP status while meeting the objectives of the Advanced APMs in which they participate. To address this tension, CMS proposes to make QP determinations at both the individual clinician and APM entity level, beginning with the CY 2026 performance period. Under the proposal, eligible clinicians would qualify as QPs if they meet or exceed the payment or patient count thresholds either individually or at the APM entity level during the performance period. This would allow for QP determinations for individual clinicians whose APM entity may not qualify.

The AHA supports this proposal as it would remove barriers to participation in Advanced APMs for individual clinicians. We agree that this policy change would recognize the importance of individual clinician contributions to value-based care, particularly for models that are condition-specific or focused on an episode of care.

Attribution-eligible beneficiary definition. Beginning with the CY 2026 performance period, CMS proposes to modify one of its attribution-eligible beneficiary criteria for calculating the threshold score used for QP determinations. The agency would use claims for all covered professional services (instead of only E/M services under the current definition) to identify attribution-eligible beneficiaries for all Advanced APMs. The agency initially proposed, but did not finalize, this change for CY 2025 as it expected to propose a comprehensive approach to QP determination in future rulemaking that might include this as an element.

The AHA does not support this proposal. We are concerned that this change would make it more difficult for ACOs that include a range of specialists to meet the QP thresholds because the ACO attribution methodology is based on primary care services, which largely overlap with E/M services. Expanding the number of clinicians and services that account for an ACO's QP determination would increase the attribution-eligible beneficiary population without an increase in the number of attributed beneficiaries. In other words, the numerator (attributed beneficiaries) would remain the same, but the denominator would grow substantially. A vast majority of clinicians achieve QP status through participation in an ACO, so this change could have substantial unintended consequences at the ACO level.

Differential conversion factor impact on benchmarks. While not addressed in the proposed rule, if the higher differential conversion factor afforded QPs beginning in CY 2026 is included in spending calculations, it would make it inappropriately more challenging for ACOs to reduce their spending below benchmarks. We encourage CMS to exclude these essential payment increases from ACO spending and benchmark calculations.